Division of Medical Services
P.O. Box 1437, Slot S295, Little Rock, AR 72203-1437
P: 501.682.8292 F: 501.682.1197

MEMORANDUM

TO: Interested Persons and Providers

FROM: Elizabeth Pitman, Director, Division of Medical Services

DATE: June 13, 2024

SUBJ: Physician Assistant and Clinical Nurse Specialist as other licensed practitioners

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 in writing, no later than July 13, 2024.

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

NOTICE OF RULEMAKING

The Department of Human Services 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: §§ 25-10-129, 20-76-201, and 20-77-107.

Effective September 1, 2024, the Division of Medical Services (DMS) issues a rule to implement provisions of Acts 303 and 872 of 2023. Those Acts allow Physician Assistants to be identified as a treating provider and receive payment for services rendered and allow Clinical Nurse Specialists to enroll as a Primary Care Provider and receive payment for services rendered, with each subject to certain requirements. This rule will increase the number of providers available to meet the needs of Arkansas Medicaid beneficiaries, especially in rural areas of the state. This rule allows physician assistants and clinical nurse specialists to bill their services at 80% of the physician's rate. There is no fiscal impact.

To implement this rule, DMS issues two new Medicaid Provider Manuals, "Physician Assistant" and "Clinical Nurse Specialist", to ensure providers understand enrollment, coverage, reimbursement, and procedures required for participation in the Arkansas Medicaid Programs. The rule also necessitates amendment of the Arkansas Medicaid State Plan and other provider manuals to include information related to the practice of physician assistants and clinical nurse specialists within the scope of their licenses as now allowed by the Acts. Revisions of the manuals include updates to current practices and typographic or grammatical corrections.

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. You may also access and download the proposed rule at ar.gov/dhs-proposed-rules. Public comments must 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 **July 13, 2024**. 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. 4502201653

Elizabeth Pitman, Director
Division of Medical Services

TOC not required

221.100 ARKids First-B Medical Care Benefits

~~2-1-22~~9-1-24

Listed below are the covered services for the ARKids First-B program. This chart also includes benefits, whether Prior Authorization or a Primary Care Physician (PCP) referral is required~~,~~ and specifies the cost-sharing requirements.

Program Services	Benefit Coverage and Restrictions	Prior Authorization/ PCP Referral*	Co-payment/ Coinsurance/ Cost Sharing Requirement**
Ambulance (Emergency Only)	Medical Necessity	None	$10 per trip
Ambulatory Surgical Center	Medical Necessity	PCP Referral	$10 per visit
Audiological Services (only Tympanometry, CPT procedure code****, when the diagnosis is within the ICD range (View ICD codes.))	Medical Necessity	None	None
Certified Nurse-Midwife	Medical Necessity	PCP Referral	$10 per visit
Chiropractor	Medical Necessity	PCP Referral	$10 per visit
Dental Care	Routine dental care and orthodontia services	None – PA for inter-periodic screens and orthodontia services	$10 per visit
Durable Medical Equipment	Medical Necessity $500 per state fiscal year (July 1 through June 30) minus the coinsurance/cost-share. Covered items are listed in Section 262.120	PCP Referral and Prescription	10% of Medicaid allowed amount per DME item cost-share
Emergency Dept. Services			
Emergency	Medical Necessity	None	$10 per visit
Non-Emergency	Medical Necessity	PCP Referral	$10 per visit
Assessment	Medical Necessity	None	$10 per visit
Family Planning	Medical Necessity	None	None
Federally Qualified Health Center (FQHC)	Medical Necessity	PCP Referral	$10 per visit

Program Services	Benefit Coverage and Restrictions	Prior Authorization/ PCP Referral*	Co-payment/ Coinsurance/ Cost Sharing Requirement**
Home Health	Medical Necessity (10 visits per state fiscal year (July 1 through June 30)	PCP Referral	$10 per visit
Hospital, Inpatient	Medical Necessity	PA on stays over 4 days if age 1 or over	10% of first inpatient day
Hospital, Outpatient	Medical Necessity	PCP referral	$10 per visit
Inpatient Psychiatric Hospital and Psychiatric Residential Treatment Facility	Medical Necessity	PA & Certification of Need is required prior to admittance	10% of first inpatient day
Immunizations	All per protocol	None	None
Laboratory & X-Ray	Medical Necessity	PCP Referral	$10 per visit
Medical Supplies	Medical Necessity Benefit of $125/mo. Covered supplies listed in Section 262.110	PCP Prescriptions PA required on supply amounts exceeding $125/mo	None
Mental and Behavioral Health, Outpatient	Medical Necessity	PCP Referral PA on treatment services	$10 per visit
School-Based Mental Health	Medical Necessity	PA Required (See Section 250.000 of the School-Based Mental Health provider manual.)	$10 per visit
Nurse Practitioner, Physician Assistant, Clinical Nurse Specialist	Medical Necessity	PCP Referral	$10 per visit
Physician	Medical Necessity	PCP referral to specialist and inpatient professional services	$10 per visit
Podiatry	Medical Necessity	PCP Referral	$10 per visit
Prenatal Care	Medical Necessity	None	None
Prescription Drugs	Medical Necessity	Prescription	Up to $5 per prescription (Must use generic, if available)***
Preventive Health Screenings	All per protocol	PCP Administration or PCP Referral	None

Program Services	Benefit Coverage and Restrictions	Prior Authorization/ PCP Referral*	Co-payment/ Coinsurance/ Cost Sharing Requirement**
Rural Health Clinic	Medical Necessity	PCP Referral	$10 per visit
Speech-Language Therapy	Medical Necessity 4 evaluation units (1 unit =30 min) per state fiscal year 4 therapy units (1 unit=15 min) daily	PCP Referral Authorization required on extended benefit of services	$10 per visit
Occupational Therapy	Medical Necessity 2 evaluation units per state fiscal year	PCP Referral Authorization required on extended benefit of services	$10 per visit
Physical Therapy	Medical Necessity 2 evaluation units per state fiscal year	PCP Referral Authorization required on extended benefit of services	$10 per visit
Vision Care			
Eye Exam	One (1) routine eye exam (refraction) every 12 months	None	$10 per visit
Eyeglasses	One (1) pair every 12 months	None	None

*Refer to your Arkansas Medicaid specialty provider manual for prior authorization and PCP referral procedures.

**ARKids First-B beneficiary cost-sharing is capped at 5% of the family's gross annual income.

***ARKids First-B beneficiaries will pay a maximum of $5.00 per prescription. The beneficiary will pay the provider the amount of co-payment that the provider charges non-Medicaid purchasers up to $5.00 per prescription.

******View or print the procedure codes for ARKids First-B procedures and services.**

222.710 Introduction

~~2-1-22~~9-1-24

The ARKids First-B Program supports preventive medicine for beneficiaries by reimbursing primary care ~~physicians~~providers (PCPs) who provide medical preventive health screens and qualified screening providers to whom PCPs refer beneficiaries. ARKids First-B outreach efforts vigorously promote the program's emphasis on preventive medical health care. Beneficiary cost sharing does not apply to covered preventive medical health screens, including those for newborns.

The supplemental eligibility response request to an ARKids First-B beneficiary's identification card will indicate to the provider the date of the beneficiary's last preventive health screen

View or print the procedure codes for ARKids First-B procedures and services.

This information should be reviewed and verified, along with the beneficiary's eligibility, prior to performing a service. This information will assist the beneficiary's PCP or preventive health screen provider in determining the beneficiary's eligibility for the service and ensuring that preventive health screens are performed in a timely manner in compliance with the periodicity chart for ARKids First-B beneficiaries.

Newborn screens do not require PCP referral.

Certified nurse-midwives may provide newborn screens ONLY.

Nurse practitioners, physician assistants, and clinical nurse specialists in addition to newborn preventive health screens, are authorized to provide other preventive health screens with a PCP referral. **Refer to Section 262.130** for preventive health screens procedure codes.

TOC not required

204.101 Documentation of Services

~~7-1-17~~9-1-24

Home Health Providers must maintain the following records for patients of all ages.

A. Patient assessments.

B. Plans of care.

C. Physical therapy evaluations.

D. Treatment plans when applicable.

E. Case notes.

F. Progress notes from each visit by nurses, aides, physical therapy assistants and physical therapists.

G. *Pro re natal* (PRN) visits and the medical justification for each such unscheduled visit.

H. A face-to-face encounter with the beneficiary must meet the following requirements:

1. Regarding initiation of Home Health services, the face-to-face encounter must be related to the primary reason the beneficiary requires Home Health services and must occur within the ninety (90) days before or the thirty (30) days after the start of services.
2. Regarding initiation of medical equipment, the face-to face encounter must be related to the primary reason the beneficiary requires medical equipment and must occur no more than six (6) months prior to the start of services.
3. Conducted by one of the following practitioners:
   a. The primary care ~~physician~~provider;~~.~~
   b. A nurse practitioner working in collaboration with the primary care ~~physician~~provider;~~.~~
   c. A certified nurse midwife by the scope of practice;~~.~~
   d. A physician assistant under the supervision of the primary care physician according to Arkansas Medicaid Physician Policy. Physician assistant services are services furnished according to A.C.A § 17-105-101 and rules and regulations issued by the Arkansas State Medical Board. Physician assistants are dependent medical practitioners practicing under the supervision of the physician, for which the physician takes full responsibility;~~. The service is not considered to be separate from the physician's service.~~
   e. The attending acute or post-acute physician; or~~.~~
   f. A clinical nurse specialist working in collaboration with the primary care provider.
4. The non-physician must communicate the clinical findings of that face-to-face to the ordering physician. ~~-~~Those clinical findings must be incorporated into a document included in the beneficiary's medical record.
5. The physician ordering the services must assure clinical correlation between the face-to-face encounter and the associated Home Health document:
   a. The primary reason the patient requires Home Health services.
   b. The start of Home Health services.

c. The practitioner who conducted the encounter and the date of the encounter.

d. The face-to-face encounter may occur through telemedicine, when applicable to the program manual of the performing provider of the encounter.

E. No payment may be made for medical equipment, supplies or appliances unless the primary care physician or allowed non-physician practitioner documents a face-to-face encounter with the beneficiary consistent with the requirements as listed in D.3.

213.600 Certified Nurse-Midwife Services Benefit Limit

~~3-15-10~~9-1-24

Beneficiaries age 21 and older are limited to ~~twelve~~sixteen (16~~2~~) 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, services provided by a physician assistant, services provided by a clinical nurse specialist, or any combination ~~of~~ thereof ~~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 limit of sixteen (16)~~twelve~~ visits per state fiscal year.

The following services are counted toward the sixteen (16)~~2~~ 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

G. Physician Assistant services

H. Clinical Nurse Specialist services

I. Federally Qualified Health Center

Global obstetric fees are not counted against the sixteen (16)~~2~~-visit limit. ~~-~~Itemized obstetric office visits are counted in the 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.

215.200 Family Planning Coverage Information

~~1-1-24~~9-1-24

A. Arkansas Medicaid encourages reproductive health and family planning by reimbursing physicians, physician assistants, clinical nurse specialists, nurse practitioners, certified nurse-midwives, clinics, and hospitals for a comprehensive range of family planning services.

1. Family planning services do not require a PCP referral.
2. Medicaid beneficiaries' family planning services benefits are in addition to their other medical benefits, when providers bill the services specifically as family planning services.
3. Family Planning prescriptions are unlimited and do not count toward the benefit limit.
4. Extension of benefits is not available for family planning services.
5. Abortion is not a family planning service in the Arkansas Medicaid Program.

B. Other than full coverage aid categories, Arkansas Medicaid covers one basic family planning examination and three periodic family planning visits per client, per state fiscal year (July 1 through June 30). Refer to Sections 215.200 through 215.260 of this manual for service descriptions and coverage information.

C. Certified nurse-midwives desiring to participate in the Medicaid Family Planning Services Program may do so by providing the services listed in Sections 215.210 through 215.260, to Medicaid beneficiaries of childbearing age.

D. Certified nurse-midwives preferring not to provide family planning services may refer their patients to other providers. DHS County Offices maintain listings of local and area providers qualified to provide family planning services. Listed providers include:

1. Arkansas Department of Health local health units
2. Obstetricians and gynecologists
3. Nurse practitioners
4. Rural Health Clinics
5. Federally Qualified Health Centers
6. Family planning clinics
7. Physicians
8. Physician Assistants
9. Clinical Nurse Specialists

E. Effective 1/1/24, providers are allowed to bill for Long-Acting Reversible Contraception (LARC) devices and professional services immediately after childbirth and during post-partum, while the beneficiary remains in an inpatient setting.

Billing guidelines:

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

F. Complete billing instructions for family planning services are in Sections 215.200-215.260.

215.250 Contraception

~~12-1-21~~9-1-24

A. Prescription and Non-Prescription Contraceptives

1. Medicaid pays for birth control pills and other prescription contraceptives as a family planning prescription benefit.
2. Medicaid pays for non-prescription contraceptives as a family planning benefit, when a certified nurse-midwife writes a prescription for them.

B. Contraceptive Implant Systems

1. Medicaid covers the contraceptive implant systems, including implants and supplies.
2. Medicaid covers insertion, removal and removal with reinsertion.

C. Intrauterine Devices (IUDs)

1. Medicaid pays for IUDs as a family planning benefit.
2. Alternatively, Medicaid reimburses physicians, nurse practitioners, physician assistants, clinical nurse specialists, certified nurse-midwives and clinics who supply the IUD at the time of insertion.
3. Medicaid pays physicians, nurse practitioners, physician assistants, clinical nurse specialists, certified nurse-midwives and clinics for IUD insertion and removal.

D. Medroxyprogesterone Acetate

1. Medicaid covers medroxyprogesterone acetate injections for birth control.

SECTION II - CLINICAL NURSE SPECIALIST

CONTENTS

TOC required

200.000 CLINICAL NURSE SPECIALIST GENERAL INFORMATION

201.000 Arkansas Medicaid Requirements for Participation in the Clinical Nurse Specialist Program 9-1-24

The Arkansas Medicaid Program enrolls clinical nurse specialists for participation in the Clinical Nurse Specialist Program. Clinical Nurse Specialist Program providers must meet the Provider Participation and enrollment requirements contained within Section 140.000 of this manual as well as the following criteria to be eligible to participate in the Arkansas Medicaid Program:

A. The provider must be licensed by the state authority in the state in which services are furnished.

B. The following documents must be submitted with the provider application and Medicaid contract:

1. A copy of all certifications and licenses verifying compliance with enrollment criteria for the specialty to be practiced. (See Section 201.300 of this manual.)
2. Providers have the option of enrolling in the Title XVIII (Medicare) Program. If enrolled in Title XVIII, the provider must inform the Medicaid Provider Enrollment Unit of his or her Medicare number. Out-of-state providers must submit a copy of their Title XVIII (Medicare) certification.
3. Providers who have prescriptive authority must furnish documentation of their prescriptive authority certification. Any changes in prescriptive authority must be immediately reported to Arkansas Medicaid.

201.001 Electronic Signatures 9-1-24

Medicaid will accept electronic signatures provided the electronic signatures comply with Arkansas Code § 25-31-103 et seq.

201.100 Group Providers 9-1-24

Group providers of Clinical Nurse Specialist services must meet the following criteria in order to be eligible for participation in the Arkansas Medicaid Program.

If a Clinical Nurse Specialist is a member of a group, each individual Clinical Nurse Specialist and the group must both enroll according to the following criteria:

A. Each individual Clinical Nurse Specialist within the group must enroll following the criteria established in Section 201.000.

B. All group providers are “pay to” providers only. The service must be performed and billed by a Medicaid-enrolled, registered Clinical Nurse Specialist within the group.

201.200 Providers in Arkansas and Bordering States 9-1-24

Providers in Arkansas and the six (6) bordering states (Louisiana, Mississippi, Missouri, Oklahoma, Tennessee, and Texas) that satisfy Arkansas Medicaid participation requirements may be enrolled as **routine services providers**.

Routine services providers may furnish and claim reimbursement for services covered by Arkansas Medicaid, subject to benefit limitations and coverage restrictions set forth in this manual.

201.210 Providers in Non-Bordering States 9-1-24

A. Providers in states not bordering Arkansas may enroll in the Arkansas Medicaid program as limited services providers only after they have provided services to an Arkansas Medicaid eligible beneficiary and have a claim or claims to file with Arkansas Medicaid.

To enroll, a non-bordering state provider must download an Arkansas Medicaid application and contract from the Arkansas Medicaid website and submit the application, contract, and claim to Arkansas Medicaid Provider Enrollment. A provider number will be assigned upon approval of the provider application and the Medicaid contract. **View or print the provider enrollment and contract package (Application Packet). View or print Provider Enrollment Unit Contact information**.

B. Limited services providers remain enrolled for one year.

1. If a limited services provider provides services to another Arkansas Medicaid beneficiary during the year of enrollment and bills Medicaid, the enrollment may continue for one (1) year past the most recent claim's last date of service, if the enrollment file is kept current.
2. During the enrollment period, the provider may file any subsequent claims directly to the Medicaid fiscal agent.
3. Limited services providers are strongly encouraged to file subsequent claims through the Arkansas Medicaid website because the front-end processing of web-based claims ensures prompt adjudication and facilitates reimbursement.

201.300 Certification for Clinical Nurse Specialist 9-1-24

The registered Clinical Nurse Specialist must be certified as a registered Clinical Nurse Specialist by the state in which services are furnished.

Clinical Nurse Specialist must hold certification from a nationally recognized certifying body approved by the state in which services are furnished. Certification must be in the category and the specialty for which the clinical nurse specialist is educationally prepared.

202.000 Medical Records Clinical Nurse Specialists are Required to Keep 9-1-24

A. Clinical Nurse Specialists are required to keep the following records and, upon request, to furnish the records to authorized representatives of the Arkansas Division of Medical Services and the state Medicaid Fraud Unit and to representatives of the Centers for Medicare and Medicaid Services (CMS):

1. History and physical examinations.
2. Chief complaint on each visit.
3. Tests and results.
4. Diagnoses.
5. Service or treatment, including prescriptions, or a referral to a physician for prescriptions, and record of physician referral or consultation.
6. Signature or initials of the Clinical Nurse Specialist after each visit.
7. Copies of records pertinent to any and all services delivered by the Clinical Nurse Specialist and billed to Medicaid.
8. Records must include the service date of each service billed to Medicaid.

B. Patient records must support the levels of service billed to Medicaid, in accordance with the American Medical Association's Common Procedural Terminology (CPT) standards.

C. All required records must be kept for a period of five (5) years from the ending date of service; or, until all audit questions, appeal hearings, investigations, or court cases are resolved, whichever period is longer.

D. Furnishing patient medical records on request to authorized individuals and agencies listed above in part A is a contractual obligation of providers enrolled in the Medicaid Program. Failure to furnish medical records upon request may result in the imposition of sanctions. (See Section 142.300 for additional information regarding record keeping requirements).

E. All documentation must be made available to representatives of the Division of Medical Services during normal business hours at the time of an audit conducted by the Medicaid Field Audit Unit. All documentation must be available at the provider's place of business. If an audit determines that recoupment is necessary, there will be only thirty (30) days after the date of the recoupment letter in which additional documentation will be accepted. Additional documentation will not be accepted at a later date.

203.000 The Clinical Nurse Specialist's Role in Home Health Services 9-1-24

203.010 Home Health and the Primary Care Provider (PCP) Case Management Program (ConnectCare) 9-1-24

A. Home health care requires a PCP referral except in the following circumstances:

1. Medicaid does not require Medicare beneficiaries to enroll with PCPs; therefore, a PCP referral is not required for home health services for Medicare/Medicaid dual-eligibles.
2. Obstetricians and Gynecologists may authorize and direct medically necessary home health care for postpartum complications without obtaining a PCP referral.

B. A PCP may refer a beneficiary to a specific home health agency only if he or she ensure the beneficiary's freedom of choice by naming at least one (1) alternative agency.

1. PCPs, authorized attending physicians and home health agencies must maintain all required PCP referral documentation in the beneficiary's clinical records.
2. PCP referrals must be renewed when specified by the PCP or every sixty (60) days, whichever period is shorter.

C. PCP referral is not required to revise a plan of care during a period covered by a current referral, but the agency must forward copies of the signed and dated assessment and the revision to the PCP.

203.020 Documentation of Services 9-1-24

Home Health providers must maintain the following records for patients of all ages:

A. Signed and dated patient assessments and plans of care, including physical therapy evaluations and treatment plans, when applicable.

B. Signed and dated case notes and progress notes from each visit by nurses, aides, physical therapists, and physical therapy assistants.

C. Signed and dated documentation of *pro re nata* (PRN) visits, which must include the following:

1. The medical justification for each such unscheduled visit.
2. The patient's vital signs and symptoms.
3. The observations of and measures taken by agency staff and reported to the physician.
4. The physician's comments, observations, and instructions.

D. Verification, by means of physician or approved non-physician practitioner, documentation that there was a face-to-face encounter with the beneficiary that meets the following requirements:

1. For the initiation of home health services, the face-to-face encounter must be related to the primary reason the beneficiary requires home health services and must occur within the ninety (90) days before or the thirty (30) days after the start of services.
2. For the initiation of medical equipment, the face-to-face encounter must be related to the primary reason the beneficiary requires medical equipment and must occur no more than six (6) months prior to the start of services.
3. The face-to-face encounter may be conducted by one (1) of the following practitioners:
   a. The primary care provider;
   b. A Clinical Nurse Specialist;
   c. A certified nurse midwife by the scope of practice;
   d. A physician assistant under the supervision of the primary care physician according to Arkansas Medicaid Physician Policy. Physician assistant services are services furnished according to AR Code § 17-105-101 (2012) and rules and regulations issued by the Arkansas State Medical Board. Physician assistants are dependent medical practitioners practicing under the supervision of the physician, for which the physician takes full responsibility;
   e. For beneficiaries admitted to home health immediately after an acute or post-acute stay, the attending acute or post-acute physician; or
   f. An Advanced Practice Registered Nurse or Registered Nurse Practitioner.
4. The allowed non-physician practitioner performing the face-to-face encounter must communicate the clinical findings of that encounter to the ordering provider. These clinical findings must be incorporated into a written or electronic document included in the beneficiary's medical record.
5. To assure clinical correlation between the face-to-face encounter and the associated home health services, the provider ordering the services must:
   a. Document that the face-to-face encounter, which is related to the primary reason the patient requires home health services, occurred within the required timeframes prior to the start of home health services.
   b. Indicate the practitioner who conducted the encounter, and the date of the encounter.
6. The face-to-face encounter may occur through telemedicine when applicable to the program manual of the performing provider of the encounter.

E. No payment may be made for medical equipment, supplies, or appliances to the extent that a face-to-face encounter requirement would apply as durable medical equipment (DME) under the Medicare program, unless the primary care provider or allowed non-physician practitioner documents a face-to-face encounter with the beneficiary consistent with the requirements. The face-to-face encounter may be performed by any of the practitioners described in D.3. with the exception of nurse-midwives.

F. Copies of current signed and dated plans of care, including interim and short-term plan-of-care modifications.

G. Copies of plans of care, PCP referrals, case notes, or other documents, for all previous episodes of care within the period of required record retention.

H. The registered nurse's instructions to home health aides, detailing the aide's duties at each visit.

I. The registered nurse's (or physical therapist's when applicable) notes from supervisory visits.

203.030 Plan of Care Review **9-1-24**

A. All home health services are at the direction of the patient's PCP or authorized attending physician.

B. The physician, in consultation with the patient and professional staff, is responsible for establishing the plan of care, specifying the type(s), frequency, and duration of services.

C. Medicaid requires the PCP or authorized attending physician to review the patient's plan of care as often as necessary to address changes in the patient's condition, but no less often than every sixty (60) days.

1. The physician establishes the start date of each new, renewed, or revised plan of care. A "renewed" plan of care is a plan of care that has been reviewed in accordance with the sixty (60) day requirement and has been authorized by the PCP or authorized attending physician to continue, either with or without revision. A "revised" plan of care is a plan of care developed in response to a change in the patient's condition that necessitates prompt review by the physician and reassessment by the case nurse.

2. The PCP or authorized attending physician must have performed a comprehensive (see Physician's Common Procedural Terminology for guidelines regarding comprehensive evaluation and management procedures) physical examination with medical history or history update within the twelve (12) months preceding the start date of a new plan of care, the first date of service in an extended benefit period, or the beginning date of service in a revised or renewed plan of care.

203.040 Program Criteria for Home Health Services **9-1-24**

A. A Medicaid beneficiary is eligible for home health services only if he or she has had a comprehensive physical examination and a medical history or history update by his or her PCP or authorized attending physician within the twelve (12) months preceding the beginning date of a new plan of care, the first date of service in an extended benefit period or the beginning date of service in a revised or renewed plan of care.

B. The appropriateness of home health services is determined by the beneficiary's PCP or authorized attending physician.

1. An individual's PCP or authorized attending physician determines whether the patient needs home health services, the scope and frequency of those services, and the duration of the services.

2. The PCP or authorized attending physician is responsible for coordination of the patient's care, both in-home and outside the home.

C. Some examples of individuals for whom home health services may be suitable are those who need the following:

1. Specialized nursing procedures with regard to catheters or feeding tubes.

2. Detailed instructions regarding self-care or diet.

3. Rehabilitative services administered by a physical therapist.

D. Some beneficiaries may require home health services of very short duration while they or their caregivers receive training enabling them to provide for particular medical needs with little or no assistance from the home health agency.

E. Some individuals may need only intermittent monitoring or skilled care. When an individual's skilled care is so infrequent that more than sixty (60) days elapse between services, that individual requires a new assessment and a new plan of care for each episode of care, unless the physician documents that the interval without such care is no detriment and appropriate to the treatment of the beneficiary's illness or injury.

203.050 Home Health Place of Service 9-1-24

Home health services may be provided in any normal setting in which normal life activities take place, other than a hospital, nursing facility or intermediate care facility for individuals with intellectual disabilities (ICF/IID), or any setting in which payment is or could be made under Medicaid for inpatient services that include room and board. Home health services cannot be limited to services furnished to beneficiaries who are homebound. The single exception to this policy permits Medicaid to reimburse a home health agency for providing nursing services to an ICF/IID resident on a short-term basis if the only alternative to home health services is inpatient admission to a hospital or a skilled nursing facility. Medicaid supplies, equipment, and appliances suitable for use may be provided in any setting in which normal life activities take place.

203.060 Intravenous Therapy in a Patient's Home (Home IV Therapy) 9-1-24

Home IV therapy is a skilled nursing service that is included in coverage of LPN and RN home health visits. Home IV therapy is available to a Medicaid-eligible individual who is stabilized on a course of treatment and requires continued IV therapies in the home for several days or weeks. Medicaid requirements for establishing and maintaining home IV therapy are:

A. **A Medicaid-eligible individual may qualify for home IV therapy only if he or she has had a face-to-face encounter with their physician or the allowed non-physician practitioner.**

B. The registered nurse employed by the Home Health provider must assess the patient and the patient's need for home IV therapy.

C. The PCP or authorized attending physician, in consultation with the Home Health provider, establishes and authorizes a home health plan of care that includes the physician's instructions for IV therapy.

D. The physician prescribes the IV drug(s).

1. Prescriptions for IV drugs are subject to applicable Medicaid Pharmacy program policy and Medicaid program benefit limits.

2. The client, the client's representative, or the Home Health provider may obtain the drug(s) under the client's prescription drug benefit.

3. The pharmacy bills Medicaid or the patient, in accordance with Medicaid program policy, for the IV drugs.

E. The plan of care must include the following:

1. Details regarding the patient training that will occur, describing the type, the amount, and the frequency of self-care the patient will learn and perform.

2. Realistic training goals.

3. The projected date by which skilled nursing care will end or decrease because the client will be capable of self-care or of a designated portion of her or his self-care.

   a. The registered nurse must visit and reassess the client before the projected date that the complete or partial self-care is to commence.

   b. The home health agency in consultation with the PCP or authorized attending physician must terminate or revise the plan of care, basing its determination on the degree of self-care of which the client has become capable.

F. The Home Health provider or a provider enrolled in the Arkansas Medicaid Prosthetics program may furnish the IV therapy supplies. Regardless of the source of the supplies, the Home Health provider is responsible for the deployment and management of the IV therapy supplies and for the documentation of their medical deployment and management.

G. The Home Health provider must report the patient's status to the PCP or authorized attending physician in accordance with the physician's prescribed schedule in the plan of care.

203.070 Registered Nurse Supervision of Home Health Aide Services 9-1-24

A. The supervising registered nurse must issue written instructions to the home health aide.

1. The instructions must specify the aide's specific duties at each visit.

2. The aide must note that he or she has performed each task and note, with written justification of the omission, which tasks he or she did not perform.

B. If a beneficiary is receiving home health aide services only, the registered nurse must visit the beneficiary at least once every sixty (60) days to assess his or her condition and to evaluate the quality of service provided by the home health aide.

C. If a beneficiary is receiving only physical therapy and home health aide services, with no skilled nursing services, either the registered nurse or the qualified physical therapist may make this required supervisory visit.

203.080 Medical Supplies and Diapers/Underpads 9-1-24

When billing for these services, which are benefit-limited to a maximum number of dollars per month, providers must bill according to the **calendar** month. **Providers may not span calendar months when billing for medical supplies and diapers or underpads.** The date of delivery is the date of service. Providers may not enter different dates for "from" and "through" dates of service.

Supplies are healthcare-related items that are consumable or disposable, or cannot withstand repeated use by more than one (1) individual, and are required to address an individual medical disability, illness, or injury.

Equipment and appliances are items that are primarily and customarily used to serve a medical purpose; generally are not useful to an individual in the absence of a disability, illness or injury; can withstand repeated use; and can be reusable or removable. Medical coverage of equipment and appliances is not restricted to items covered as durable medical equipment in the Medicare program.

Arkansas has a list of preapproved medical equipment, supplies and appliances for administrative ease, but the state is prohibited from having absolute exclusions of coverage on medical equipment, supplies or appliances. Items not available on the preapproval list may be requested on a case-by-case basis. When denying a request, the state must inform the beneficiary of the right to a fair hearing.

203.100 The Clinical Nurse Specialist's Role in the Pharmacy Program 9-1-24

Medicaid covers prescription drugs in accordance with policies and regulations set forth in this section and pursuant to orders (prescriptions) from authorized prescribers. The Arkansas Medicaid Program complies with the Medicaid Prudent Pharmaceutical Purchasing Program (MPPPP) which was enacted as part of the Omnibus Budget Reconciliation Act (OBRA) of 1990. **This law requires Medicaid to limit coverage to drugs manufactured by pharmaceutical companies that have signed rebate agreements.** A numeric listing of approved pharmaceutical companies and their respective labeler codes is located on the Arkansas Division of Medical Services (DMS) Pharmacy website. **View or print numeric listing of approved pharmaceutical companies and their respective labeler codes**. Except for drugs in the categories excluded from coverage, Arkansas Medicaid covers all drug products manufactured by companies with listed labeler codes.

A Clinical Nurse Specialist with prescriptive authority (verified by the Certificate of Prescriptive Authority Number issued by the licensing authority of the state in which services are furnished) may only prescribe legend drugs and controlled substances identified in the state licensing rules and regulations. Medicaid reimbursement will be limited to prescriptions for drugs in these schedules.

Prescribers must obtain the latest information regarding prescription drug coverage at the website listed in the contact information for DHS or its designated Pharmacy Vendor. **View or print contact information for the DHS designated Pharmacy Vendor.**

203.101 Tamper Resistant Prescription Applications 9-1-24

Section 7002(b), which amends section 1903(i) of the Social Security Act (the Act) (42 U.S.C. section 1936b(i)) by adding new paragraph (23), states that payment shall not be made for ". . . amounts expended for medical assistance for covered outpatient drugs (as defined in section 1927(k)(2) for which the prescription was executed in written (and non-electronic) form unless the prescription was executed on a tamper-resistant pad." This provision becomes effective on October 1, 2007. The tamper-resistant pad requirement of section 7002(b) applies to all outpatient drugs, including over-the-counter drugs in States that reimburse for prescriptions for such items. Section 1927(k)(3) of the Act provides exceptions to section 1927(k)(2) for drugs provided in nursing facilities, intermediate care facilities for individuals with intellectual disabilities, and other specified institutional and clinical settings. Such drugs in these settings (to the extent that they are not separately reimbursed) are exceptions to section 1927(k)(2), and, therefore, are not subject to the tamper-resistant pad requirement of section 7002(b). Section 7002(b) is applicable regardless of whether Medicaid is the primary or secondary payer of the prescription being filled.

See the CMS website for technical information:

https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/FraudAbuseforProfs/TRP.html

Regardless of whether Medicaid is the primary or secondary payer of the prescription being filled, this rule applies to all non-electronic Medicaid-covered outpatient drugs except:

1. Emergency fills of non-controlled or controlled dangerous substances for which a prescriber provides the pharmacy with a verbal, faxed, electronic or compliant written prescription within seventy-two (72) hours after the date on which the prescription was filled; and

2. Drugs provided in nursing facilities, intermediate care facilities for individuals with intellectual disabilities and other federally specified institutional and clinical settings so long as those drugs are not billed separately to Medicaid, for example, those billed by an individual pharmacy provider.

For purposes of this rule, "electronic prescriptions" include e-prescriptions transmitted to the pharmacy, prescriptions faxed to the pharmacy or prescriptions communicated to the pharmacy by telephone by a prescriber.

203.200 The Clinical Nurse Specialist's Role in the Child Health Services (EPSDT) Program 9-1-24

The Child Health Services (EPSDT) program is a federally mandated child health component of Medicaid. It is designed to bring comprehensive health care to individuals eligible for medical assistance from birth until their 21st birthday. The purpose of this program is to detect and treat health problems in the early stages and to provide preventive health care, including necessary immunizations. Child Health Services (EPSDT) combines case management and support services with periodic screening, as well as diagnostic and treatment services delivered.

A primary care provider (PCP) may refer a child to a clinical nurse specialist to administer an EPSDT screen. A provider of clinical nurse specialist services may recommend to the PCP that an EPSDT screen could be necessary for any child that is thought to need one. If a clinical nurse specialist discovers a problem as a result of an EPSDT screen, or receives a referral as a result of an EPSDT screen, clinical nurse specialist services may be provided after consulting with the child's PCP. This does not prevent the clinical nurse specialist from choosing to enroll as a PCP and carry a beneficiary caseload in the Medicaid PCCM program.

A. Treatment means physician, hearing, visual, dental, clinical nurse specialist services, and any other type of medical care and services recognized under State law to prevent or correct disease or abnormalities detected by screening or by diagnostic procedures.

B. Clinical nurse specialists and other health professionals who do Child Health Services (EPSDT) screening may diagnose and treat health problems discovered during the screening or may refer the child to other appropriate sources for treatment.

C. If a condition is diagnosed through a Child Health Services (EPSDT) screen that requires a treatment service not normally covered under the Arkansas Medicaid Program, the service will also be considered for reimbursement if it is medically necessary and permitted under federal Medicaid regulations.

D. Clinical Nurse Specialists may bill a sick visit and a periodic Child Health Services (EPSDT) screening for a patient on the same date of service. This visit must be billed electronically, or on paper using form CMS-1500. **View a form CMS-1500 sample form.**

Refer to Section I of this manual for additional information. Providers of Child Health Services (EPSDT) should refer to the Child Health Services (EPSDT) provider manual.

203.300 The Clinical Nurse Specialist's Role in the ARKids First-B Program 9-1-24

The ARKids First-B Program, established by Arkansas Act 407 of 1997, extends health care coverage to Arkansas's uninsured children. The health care delivery network for ARKids First-B Program is ConnectCare. ConnectCare is the Primary Care Provider (PCP) Managed Care Program utilized by the Arkansas Medicaid Program.

Preventive health screens are covered in the ARKids First–B Program for ARKids First-B eligible children from birth through eighteen (18) years of age. Preventive health screens are similar to EPSDT screens. With the exception of routine newborn care, preventive health screens must be performed by the primary care provider (PCP) or referred by the PCP to an appropriate provider for screening. If a clinical nurse specialist receives a referral from the child's PCP for a screen and a problem is discovered, treatment may be provided with consultation from the PCP.

Clinical Nurse Specialists enrolled as a Medicaid provider may request an ARKids First-B provider manual for participation in the ARKids First-B Program. Providers should refer to their ARKids First-B provider manual for more information.

203.400 Clinical Nurse Specialist's Role in Early Intervention Reporting for Children from Birth to Three Years of Age 9-1-24

Part C of the Individuals with Disabilities Education Act (IDEA '97) mandates the provision of early intervention services to infants and toddlers, ages birth to thirty-six (36) months of age. Health care providers offering any early intervention services to an eligible child must refer the child to the Division of Developmental Disabilities Services for possible enrollment in First Connections, the Part C Early Intervention Program in Arkansas. Federal regulations at 34 CFR 303.321.d.2.ii require health care professionals to refer potentially eligible children within two (2) days of identifying them as candidates for early intervention.

A. A child must be referred if he or she is age birth to three (3) years and meets one (1) or more of the following criteria:

1. Developmental delay – a delay of twenty-five (25%) or greater in one (1) of the following areas of development:
   a. Physical (gross or fine motor).
   b. Cognitive.
   c. Communication.
   d. Social or emotional.
   e. Adaptive and self-help skills.
2. Diagnosed physical or mental condition – examples of such conditions include but are not limited to:
   a. Down's Syndrome and chromosomal abnormalities associated with mental condition.
   b. Congenital syndromes associated with delays such as Fetal Alcohol Syndrome, intra-uterine drug exposure, prenatal rubella, severe microcephaly, and macrocephaly.
   c. Maternal Acquired Immune Deficiency Syndrome (AIDS).
   d. Sensory impairments such as visual or hearing disorders.

B. The Division of Developmental Disabilities Services (DDS) within the Department of Human Services is the lead agency for early intervention as required in Part C of IDEA in Arkansas. Referrals to First Connections may be made either through the DDS Service Coordinator for the child's county of residence or directly to a DDS licensed community program.

203.500 The Clinical Nurse Specialist's Role in Family Planning Services 9-1-24

Arkansas Medicaid encourages reproductive health and family planning by covering a comprehensive range of family planning services provided by nurse practitioners and other providers. Medicaid beneficiaries' family planning services are in addition to their other medical benefits. Family planning services do not require PCP referral.

A. Refer to Sections 214.321 through 214.333 of the manual for family planning coverage information.

B. Refer to Sections 252.430 and 252.431 of the manual for family planning services special billing instructions and procedure codes.

203.600 The Clinical Nurse Specialist's Role in Hospital Services 9-1-24

A. Medicaid covers medically necessary hospital services, within the constraints of the Medicaid Utilization Management Program (MUMP) and applicable benefit limitations. (Refer to Section 214.711.)

B. The care and treatment of a patient must be under the direction of a licensed physician, a licensed nurse practitioner, a licensed clinical nurse specialist, a certified nurse-midwife, or dentist with hospital staff affiliation.

C. DHS or its designated vendor reviews all inpatient hospital transfers and all inpatient stays longer than four (4) days for the Medicaid Utilization Management Program (MUMP).

DHS or its designated vendor also completes post-payment reviews of hospital stays for medical necessity determinations. **View or print contact information to obtain the DHS or designated vendor step-by-step process for requesting extension of inpatient stays.**

D. Hospital claims are also subject to review by the Medicaid Peer Review Committee or the Medical Director for the Medicaid Program.

1. If Medicaid denies a hospital's claim for lack of medical necessity, payments to clinical nurse specialists for evaluation and management services incidental to the hospitalization are subject to recoupment by the Medicaid agency.
2. Clinical Nurse Specialists and hospitals may not bill a Medicaid beneficiary for a service Medicaid has declared not medically necessary.
3. Clinical Nurse Specialists and hospitals may not bill inpatient services previously denied for lack of medical necessity as outpatient services.

203.700 The Clinical Nurse Specialist's Role in Preventing Program Abuse 9-1-24

A. The Arkansas Medicaid Program has the responsibility for assuring quality medical care for its beneficiaries along with protecting the integrity of the funds supporting the program. The Division of Medical Services is committed to this goal by providing staff and resources to the prevention, detection, and correction of abuse. However, this task can only be accomplished through the cooperation and support of the provider community. The clinical nurse specialist is many times in a position to detect certain program abuses.

B. A clinical nurse specialist who has reason to suspect either beneficiary or provider abuse or unacceptable quality of care should contact the Utilization Review Section of Arkansas Division of Medical Services. An investigation will then be made. **View or print the Arkansas Division of Medical Services Utilization Review Section contact information**.

C. Examples of the types of abuse you may detect include:

1. Beneficiary over-utilization of services;
2. Beneficiary misuse or inappropriate utilization of services;
3. Beneficiary misuse of I.D. card;
4. Poor quality of service; or
5. Provider over-utilization or abuse.

204.000 Role of Quality Improvement Organization (QIO) 9-1-24

The Quality Improvement Organization (QIO) reviews all federally and state funded hospital inpatient services. The purpose of such review is the promotion of effective, efficient, and economical delivery of health care services of proper quality and assurance that such services conform to appropriate professional standards. QIO reviews are mandated to assure that federal payment for such services will take place only when they are determined to be medically necessary, consistent with professionally recognized health care standards, and provided in the most appropriate setting and location.

A pattern of aberrant practice may result in a clinical nurse specialist having his or her waiver of liability revoked. Once a clinical nurse specialist has lost his or her waiver of liability, one hundred percent (100%) of his or her admissions are reviewed by QIO. After the appeal process, QIO forwards any denials to the state agency for recoupment of funds.

210.000 PROGRAM COVERAGE

211.000 Introduction 9-1-24

The Medical Assistance (Medicaid) Program is designed to assist eligible Medicaid beneficiaries in obtaining medical care within the guidelines specified in Section I of this manual. All Medicaid benefits are based upon medical necessity. See the Glossary of this manual for "medical necessity" definition.

212.000 Clinical Nurse Specialist 9-1-24

A clinical nurse specialist, as applicable to this program, is a licensed professional nurse who meets the participation requirements and enrollment criteria for advanced practice nursing as defined by the state licensing authority.

The clinical nurse specialist provides direct care to individuals, families, and other groups in a variety of settings including homes, hospitals, nursing homes, offices, industries, schools, and other institutions and health care settings. The service provided by the clinical nurse specialist is directed toward the delivery of primary, secondary, and tertiary care that focuses on the achievement and maintenance of optimal functions in the population.

The clinical nurse specialist engages in independent decision-making about the health care needs of clients and collaborates with health professionals and others in making decisions about other health care needs. The clinical nurse specialist plans and initiates health care programs as a member of the health care team. The clinical nurse specialist is directly accountable and responsible for the quality of care provided.

213.000 Scope 9-1-24

The scope of the Clinical Nurse Specialist Program includes Medicaid covered services provided by pediatric, family, obstetric-gynecologic (women's health care), and gerontological nurse practitioners in accordance with state and federal regulations.

Services provided through the Clinical Nurse Specialist Program include:

A. Assessment and diagnostic services.

B. Development and implementation of treatment plans.

C. Evaluation of client outcomes.

D. Referrals to appropriate providers when the health status of the Medicaid-eligible individual requires additional diagnostic and treatment services based on the health status of the individual.

214.000 Coverage 9-1-24

Many clinical nurse specialist services covered by the Arkansas Medicaid Program have coverage restrictions or are benefit limited. Coverage restrictions are the circumstances under which certain services will be covered. Benefit limits are the limits on the quantity of covered services that Medicaid-eligible individuals may receive. Benefit limits for some services may be extended if medically necessary. See Sections 214.000 through 214.800 and Section 252.484 for information about covered clinical nurse specialist services with restrictions, benefit limits, or both.

214.100 Exclusions 9-1-24

Exclusions are those services not covered in the Arkansas Medicaid Clinical Nurse Specialist Program and any covered services furnished by a clinical nurse specialist that are not within the scope of practice of the clinical nurse specialist as defined by the state licensing authority and by the national certifying body. Services are not covered when provided by an employed or contracted clinical nurse specialist who is not enrolled as a participant in the Clinical Nurse Specialist Program.

Medicaid does not cover services that are not medically necessary or are not generally accepted by the medical profession. Medicaid does not cover services that are not properly documented by diagnoses that certify medical necessity.

214.200 General Clinical Nurse Specialist Services 9-1-24

A. Services provided by a clinical nurse specialist include initial visits and established patient visits for:

1. Diagnosis and evaluation.
2. Treatment services.
3. Health management services for prevention and early intervention.
4. Appropriate referrals to other health care providers for diagnostic and treatment services.

B. Some services (for example: pelvic exams, prostate massages, and removal of sutures) are not considered a separate service from an office visit.

214.210 Clinical Nurse Specialist Services Benefit Limits 9-1-24

A. For clients twenty-one (21) years of age or older, Clinical Nurse Specialist services provided in a physician office, an APRN office, a Clinical Nurse Specialist 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;
8. Clinical Nurse Specialist services in the office, patient's home, or nursing facility; and
9. Physician Assistant services.

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

Global obstetric fees are not counted against the visit limit. Itemized obstetric office visits are not counted in the 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.

214.300 Reserved 9-1-24

214.310 Reserved 9-1-24

214.320 Reserved 9-1-24

214.321 Family Planning Services for Women in Aid Category 61, PW 9-1-24

Women in Aid Category 61, Pregnant Women (PW), are eligible for all Medicaid-covered family planning services through the last day of the month in which the 60th day postpartum falls.

Aid Category 61 PW Unborn Child does not include family planning benefits.

214.330 Family Planning Coverage Information 9-1-24

A. Arkansas Medicaid encourages reproductive health and family planning by reimbursing clinical nurse specialists for a comprehensive range of family planning services.

1. Family planning services do not require a PCP referral.
2. Medicaid beneficiaries' family planning services benefits are in addition to their other medical benefits when providers bill the services specifically as family planning services.
3. Family planning prescriptions are unlimited and do not count toward the benefit limit.
4. Extension of benefits is not available for family planning services.
5. Abortion is not a family planning service in the Arkansas Medicaid Program.

B. Other than full coverage aid categories, Arkansas Medicaid covers one (1) basic family planning examination and three (3) periodic family planning visits per client, per state fiscal year (July 1 through June 30). Refer to Sections 214.321 through 214.333 of this manual for service description and coverage information.

C. Clinical Nurse Specialists desiring to participate in the Medicaid Family Planning Services Program may do so by providing the services listed in Sections 214.321 through 241.333 to Medicaid beneficiaries of childbearing age.

D. Clinical Nurse Specialists preferring not to provide family planning services may refer their patients to other providers. DHS County Offices maintain listings of local and area providers qualified to provide family planning services. Listed providers include:

1. Arkansas Department of Health local health units;
2. Obstetricians and gynecologists;
3. Physicians;
4. Rural Health Clinics;
5. Federally Qualified Health Centers;
6. Family planning clinics;
7. Physicians; and

8. Certified Nurse-Midwives.

E. Complete billing instructions for family planning services are in Sections 252.430 through 252.431 of this manual.

214.331 Clinical Nurse Specialist Basic Family Planning Visit 9-1-24

Medicaid covers one (1) basic family planning visit per beneficiary per Arkansas state fiscal year (July 1 through June 30). The basic visit comprises the following:

A. Medical history and medical examination, including head, neck, breast, chest, pelvis, abdomen, extremities, weight, and blood pressure.

B. Counseling and education regarding:

1. Breast self-exam.
2. The full range of contraceptive methods available.
3. HIV and STD prevention.

C. Prescription for any contraceptives selected by the beneficiary.

D. Laboratory services, including, as necessary:

1. Pregnancy test.
2. Hemoglobin and hematocrit.
3. Sickle cell screening.
4. Urinalysis testing for albumin and glucose.
5. Papanicolaou (PAP) smears for cervical cancer.
6. Testing for sexually transmitted diseases.

214.332 Clinical Nurse Specialist Periodic Family Planning Visit 9-1-24

Medicaid covers three (3) periodic family planning visits per beneficiary per Arkansas state fiscal year (July 1 through June 30). The periodic visit includes follow-up medical history, weight, blood pressure, and counseling regarding contraceptives and possible complications of contraceptives. The purpose of the periodic visit is to evaluate the patient's contraceptive program, renew or change the contraceptive prescription, and to provide the patient with additional opportunities for counseling regarding reproductive health and family planning.

214.333 Contraception 9-1-24

A. Prescription and Non-Prescription Contraceptives:

1. Medicaid covers birth control pills and other prescription contraceptives as a family planning prescription benefit.
2. Medicaid covers non-prescription contraceptives as a family planning benefit when a qualified prescriber writes a prescription for them.

B Contraceptive Implant Systems:

1. Medicaid covers the contraceptive implant systems, including implants and supplies.
2. Medicaid covers insertion, removal, and removal with reinsertion.

C. Intrauterine Device (IUD):

1. Medicaid pays for IUDs as a family planning benefit.

2. Alternatively, Medicaid reimburses providers who supply the IUD at the time of insertion.

3. Medicaid pays providers for IUD insertion and removal.

D. Medroxyprogesterone Acetate:

Medicaid covers medroxyprogesterone acetate injections for birth control.

E. Sterilization:

1. All adult (twenty-one (21) years of age or older) male or female Medicaid beneficiaries who are mentally competent are eligible for sterilization procedures as long as they remain Medicaid-eligible.

2. Medicaid covers Occlusion by Placement of Permanent Implants. Coverage includes the procedure, the implant device, and follow-up procedures as specified in Section 252.430.

3. Refer to Sections 252.430 through 252.431 of this manual for family planning procedure codes and billing instructions for family planning services.

214.400 Reserved **9-1-24**

214.500 Laboratory and X-Ray Services Referral Requirements **9-1-24**

A clinical nurse specialist referring a Medicaid beneficiary for laboratory, radiology, or machine testing services must specify an ICD diagnosis code for each test ordered, *and include in the order,* pertinent supplemental diagnosis supporting the need for the test(s).

A. Diagnostic facilities, hospital labs, and outpatient departments performing reference diagnostics rely on the referring clinical nurse specialist to establish medical necessity.

B. The diagnoses provide documentation of medical necessity to the reference diagnostic facilities performing the tests.

C. Clinical nurse specialists must follow the Centers for Medicare and Medicaid Services (CMS) requirements for medical claim diagnosis coding when submitting diagnosis coding with their orders for diagnostic tests.

D. The Medicaid agency will enforce the CMS requirements for diagnosis coding, as those requirements are set forth in the ICD volume concurrent with the referral dates and the claim dates of service.

E. The following ICD diagnosis codes may not be utilized (**View ICD Codes.**).

Medicaid regulations regarding collection, handling, and conveyance of specimens are as follows:

A. Reimbursement will not be made for specimen handling fees.

B. A specimen collection fee may be allowed only in circumstances including: (1) drawing a blood sample through venipuncture (for example: inserting into a vein a needle with syringe or vacutainer to draw the specimen); or, (2) collecting a urine sample by catheterization.

The following procedure codes should be used when billing for specimen collection:

View or print the procedure codes for Clinical Nurse Specialist and Nurse Practitioner services.

NOTE: The P codes listed are the Urinary Collection Codes.

Reimbursement for laboratory procedures requiring a venous blood specimen includes the collection fee when performed by the same provider. If laboratory procedures requiring a venous blood specimen are performed in the office and other laboratory procedures are sent to a reference laboratory on the same date of service, no collection fee may be billed.

Independent laboratories must meet the requirements to participate in Medicare. Independent laboratories may only be paid for laboratory tests they are certified to perform. Laboratory services rendered in a specialty for which an independent laboratory is not certified are not covered and claims for payment of benefits for these services will be denied.

214.510 Diagnostic Laboratory and Radiology/Other Services Benefit Limits 9-1-24

A. The Medicaid Program's diagnostic laboratory services benefit limit and radiology/other services benefit limit each apply to the outpatient setting.

1. Radiology/other services include without limitation diagnostic X-rays, ultrasounds, and electronic monitoring or machine tests, such as electrocardiograms (ECG or EKG).
2. All the benefit limits in this section are calculated per State Fiscal Year (SFY: July 1 through June 30).
3. Diagnostic laboratory services and radiology/other services defined as Essential Health Benefits by the U.S. Preventive Services Task Force (USPSTF) are exempt from counting toward either of the two (2) new annual caps.

View or print the essential health benefit procedure codes.

B. Medicaid established a maximum amount (benefit limit) of five-hundred-dollar ($500) per SFY for diagnostic laboratory services and five hundred dollars ($500) per SFY for radiology/other services for beneficiaries twenty-one (21) years of age and older. Exceptions are listed below:

1. There is no diagnostic laboratory services benefit limit or radiology/other services benefit limit for beneficiaries under twenty-one (21) years of age.
2. There is no benefit limit on diagnostic laboratory services related to family planning. (Refer to Section 252.431 of this manual for the family planning-related clinical laboratory procedures.)
3. There are no benefit limits on diagnostic laboratory services or radiology/other services that are performed as emergency services and approved by DHS or its designated vendor for payment as emergency services.

   View or print contact information to obtain the DHS or designated vendor step-by-step process for requesting extension of benefits.
4. Claims with the following primary diagnoses are exempt from diagnostic laboratory services or radiology/other services benefit limits:
   a. Malignant Neoplasm (**View ICD Codes**);
   b. HIV disease and AIDS (**View ICD Codes**);
   c. Renal failure (**View ICD Codes**);
   d. Pregnancy* (**View ICD Codes**); or
   e. Opioid Use Disorder (OUD) when treated with Medication Assisted Treatment (MAT). (**View ICD OUD Codes.**) Designated diagnostic laboratory tests will be exempt from the diagnostic laboratory services benefit limit when the diagnosis is OUD. (**View Laboratory and Screening Codes.**)

C. *Obstetric (OB) ultrasounds and fetal non-stress tests have benefit limits and are not exempt from Extension of Benefits request requirements. (See Section 214.630 for additional coverage information.)

D. Extension of benefit requests are considered for clients who require supportive treatment, such as dialysis, radiation therapy, or chemotherapy for maintaining life.

E. Benefits may be extended for other conditions documented as medically necessary.

214.600 Obstetrical Services 9-1-24

The Arkansas Medicaid Program covers obstetrical services for Medicaid-eligible clients in *full* coverage aid categories with a medically verified pregnancy.

Aid category 61, PW clients are eligible for full range Medicaid coverage. Aid category 61, PW pregnant women's eligibility ends on the last day of the month in which the 60th postpartum day falls.

214.610 Covered Clinical Nurse Specialist Obstetrical Services 9-1-24

Covered clinical nurse specialist obstetrical services may be provided when medically necessary and are *limited* to antepartum and postpartum care. Appropriate referrals will be made to a physician or a certified nurse-midwife for complete obstetrical services to include delivery.

214.620 Risk Management Services for High-Risk Pregnancy 9-1-24

A clinical nurse specialist may provide risk management services if he or she employ the professional staff indicated in service descriptions below. If a clinical nurse specialist does not choose to provide high-risk pregnancy services but believes the patient would benefit from such services, he or she may refer the patient to a clinic that offers the services.

Covered risk management services described in parts A through E below are considered as one (1) service with a benefit limit of thirty-two (32) cumulative units. The early discharge home visit described in part F is considered as a separate service.

A. Risk Assessment

Risk assessment is defined as a medical, nutritional, and psychosocial assessment by a clinical nurse specialist or a registered nurse on the clinical nurse specialist's staff, to designate patients as high or low risk.

1. Medical assessment, using the Hollister Maternal and Newborn Record System or equivalent form, includes:
   a. Medical history;
   b. Menstrual history; and
   c. Pregnancy history.
2. Nutritional assessment includes:
   a. 24-hour diet recall;
   b. Screening for anemia; and
   c. Weight history.
3. Psychosocial assessment includes criteria for an identification of psychosocial problems that may adversely affect the patient's health status.

Maximum: Two (2) units per pregnancy

B. Case Management Services

Case management services are provided by a clinical nurse specialist, nurse practitioner, a licensed social worker, or registered nurse, to assist pregnant women eligible under Medicaid, in gaining access to needed medical, social, educational, and other services (examples include, but are not limited to, locating a source of services, making an appointment for services, arranging transportation, arranging hospital admission, locating a physician to deliver a newborn, and following up to verify that the patient kept her appointment, rescheduling the appointment).

Maximum: One (1) unit per month. A minimum of two (2) contacts per month must be provided. A case management contact may be with the patient, other professionals, family, or other caregivers.

C. Perinatal Education

Educational classes provided by a health professional (physician, public health nurse, nutritionist, or health educator) include:

1. Pregnancy;
2. Labor and delivery;
3. Reproductive health;
4. Postpartum care;
5. Nutrition in pregnancy; and
6. Maximum: Six (6) classes (units) per pregnancy.

D. Nutrition Consultation — Individual

Nutrition consultation services provided for high-risk pregnant women by a registered dietitian or a nutritionist eligible for registration by the Commission on Dietetic Registration must include at least one (1) of the following:

1. An evaluation to determine health risks due to nutritional factors with development of a nutritional care plan; and
2. Nutritional care plan follow-up and reassessment as indicated.

Maximum: Nine (9) units per pregnancy

E. Social Work Consultation

Services provided for high-risk pregnant women by a licensed social worker must include at least one (1) of the following:

1. An evaluation to determine health risks due to psychosocial factors with development of a social work care plan
2. Social work plan follow-up, appropriate intervention and referrals

Maximum: Six (6) units per pregnancy

F. Early Discharge Home Visit

If a physician or certified nurse-midwife chooses to discharge a low-risk mother and newborn from the hospital early (less than twenty-four (24) hours after delivery), the physician or certified nurse-midwife may provide a home visit to the mother and baby within seventy-two (72) hours of the hospital discharge. The physician or certified nurse-midwife may request an early discharge home visit from any clinic that provides perinatal services. Visits will be done by the physician or certified nurse-midwife's order (includes a hospital discharge order).

A home visit may be ordered for the mother and infant discharged later than twenty-four (24) hours if there is specific medical reason for home follow-up.

Billing instructions and procedure codes may be found in **Section 252.450**.

214.630 Fetal Non-Stress Test 9-1-24

The fetal non-stress test is *limited to two (2) per pregnancy per beneficiary*. If it is necessary to exceed this limit, the clinical nurse specialist must request an extension of benefits and submit documentation that establishes medical necessity. Refer to Section 214.900 of this manual for procedures to request extension of benefits. Refer to **Section 252.451** of this manual for billing instructions and the procedure code.

The post-procedural visits are covered within the 10-day period following the fetal non-stress test.

214.700 Reserved 9-1-24

214.710 Inpatient Services 9-1-24

Clinical nurse specialist inpatient services must meet the Medicaid requirement of medical necessity. The Quality Improvement Organization (QIO) will deny payments for inpatient admissions and subsequent inpatient services when they determine that inpatient care was not necessary. Inpatient services are subject to QIO review for medical necessity whether the clinical nurse specialist's supervising physician admitted the patient, or whether Medicaid deemed the inpatient status criteria in Section 214.711.

The attending clinical nurse specialist's supervising physician must document the medical necessity of admitting a patient to observation status, whether the patient's condition is emergent or non-emergent. Clinical nurse specialist and hospital claims for hospital observation services are subject to post-payment review to verify medical necessity.

214.711 Medicaid Utilization Management Program (MUMP) 9-1-24

The Medicaid Utilization Management Program (MUMP) determines covered lengths of stay in inpatient acute care and general hospitals, in state and out of state.

Length-of-stay determinations are made by the Quality Improvement Organization (QIO), under contract to the Arkansas Medicaid Program.

Individuals in all Medicaid eligibility categories and all age groups, except beneficiaries under one (1) year of age, are subject to this policy. Medicaid beneficiaries under one (1) year of age at the time of admission are exempt from the MUMP policy for dates of service before their first birthday. Refer to item "E" below for the procedure to follow when a child's first birthday occurs during an inpatient stay.

The procedures for the MUMP are as follows:

A. Medicaid will reimburse hospitals for up to four (4) days of inpatient service with no pre-certification requirement, except for admissions by transfer from another hospital.

B. If the attending clinical nurse specialist determines the patient should not be discharged by the fifth day of hospitalization, a hospital medical staff member may contact DHS or its designated vendor and request an extension of inpatient days.

View or print contact information to obtain the DHS or designated vendor step-by-step process for requesting extension of inpatient stays.

C. The number of days allowed for an extension will be based on medical judgment utilizing Medicaid guidelines.

D. When a Medicaid beneficiary reaches one (1) year of age during an inpatient stay, the days from the admission date through the day before the patient's birthday are exempt from the MUMP policy. MUMP policy becomes effective on the one-year birthday. The patient's birthday is the first day of the four (4) days not requiring MUMP certification. If the stay continues beyond the fourth day (inclusive) of the patient's first birthday, hospital staff must apply for MUMP certification of the additional days.

E. Additional extensions may be requested as needed.

F. Reconsideration reviews of denied extensions may be requested by sending the medical record to AFMC through regular mail or expedited by overnight express. The hospital will be notified by the next working day of the decision.

G. Calls for extension of days may be made at any point from the fourth day of stay through discharge. However, the provider must accept the financial liability should the stay not meet the necessary medical criteria for inpatient services. If the provider chooses to delay calling for extension verification and the services are denied based on medical necessity, the beneficiary may not be held liable. All calls will be limited to ten (10) minutes to allow equal access to all providers.

H. Inpatient stays for bone marrow, liver, heart, lung, skin, and pancreas and kidney transplant procedures are excluded from this review program.

I. A retrospective or post-payment random sample review will be conducted for all admissions, including inpatient stays of four (4) days or less, to ensure that medical necessity for the services is substantiated.

J. Admissions of retroactive eligible beneficiary: If eligibility is identified while the patient is still an inpatient, the hospital may request retrospective review of those days already used past the original four (4) for a determination of post-authorization and concurrent evaluation of future extended days.

If the retroactive eligible beneficiary is not identified until after discharge, and the hospital files a claim and receives a denial for any days past the original four allowed, the hospital may request post-extension evaluation approval of the denied days. If granted, the claim may be refiled. If the length of stay is more than thirty (30) days, the provider shall submit the entire medical record to DHS or its designated vendor for review.

K. Claims submitted without an extension will result in automatic denials of any days billed beyond the fourth day. The only exceptions are for claims reflecting third party liability and patients with retroactive Medicaid eligibility described in items G and J above.

L. If a patient is transferred from one (1) facility to another, the receiving facility must contact DHS or its designated vendor within twenty-four (24) hours of admitting the patient to qualify the inpatient stay. If an admission falls on a weekend or holiday, the provider may contact DHS or its designated vendor on the first working day following the weekend or holiday.

M. The certification process for extensions of inpatient days described in this section is a separate requirement from the prior authorization process. If a procedure requires prior authorization, the provider must request and receive prior authorization for the procedure code to be reimbursed.

N. If a provider fails to contact DHS or its designated vendor for an extension of inpatient days due to the patient's having private insurance or Medicare Part A and later receives a denial due to non-covered service, lost eligibility, benefits exhausted, or similar, then post-

certification of days past the original four (4) days may be obtained by the following procedures:

1. Send a copy of the denial notice received from the third-party payer to DHS or its designated vendor.
2. Include a note requesting post-certification, the full name of the requester, and a phone number where the requester may be reached.

Upon receipt of the denial copy and the provider request, a coordinator will call the provider and obtain certification information.

O. If a third-party insurer pays for an approved number of days, Medicaid will not grant an extension for days beyond the number of days approved by the private insurer.

214.712 Evaluation and Management 9-1-24

A. Medicaid covers clinical nurse specialist evaluation and management services for hospital inpatients on Medicaid-covered inpatient days only. The single exception to this policy is that Medicaid will cover discharge day management. Medicaid does not remit the hospitals per diem for the day of discharge unless it is also the admission day. Medicaid reimburses clinical nurse specialists for medically necessary discharge day management unless the clinical nurse specialist evaluation and management services for that day are included in another service, or unless the clinical nurse specialist does not customarily bill private-pay patients for discharge day management.

B. The Medicaid Program covers only one (1) evaluation and management service per day, regardless of how many times the clinical nurse specialist sees the patient.

C. The Medicaid Program covers standby or detention services when requested by a physician that involves prolonged attendance without direct (face-to-face) patient contact. When providing standby services, the clinical nurse specialist must not be providing care or services to other patients during this period. Service is covered when provided in the inpatient hospital setting and is limited to one (1) unit per date of service.

D. The Medicaid Program will recover payments to clinical nurse specialists for inpatient evaluation and management services on days for which the hospital's inpatient claims are denied (or would be denied, if filed) for:

1. Exceeding benefit limits;
2. Failure to pre-certify inpatient days, when applicable; or
3. Lack of medical necessity.

214.713 Professional Components of Diagnostic and Therapeutic Procedures 9-1-24

Medicaid reimbursement to hospitals for inpatient services includes the non-professional components (technical components) such as machine tests, laboratory tests, and radiology procedures provided to inpatients.

Reimbursement to clinical nurse specialists and independent laboratories for laboratory and radiology services for inpatients is solely for the professional component of machine tests, radiology services, and anatomical laboratory services.

Medicaid does not pay for technical components of diagnostic procedures (or complete procedures that include a technical component) or for clinical laboratory procedures performed in the course of diagnosing and treating a hospital inpatient. Hospitals must furnish or purchase those ancillary services.

214.714 Inpatient Hospital Benefit Limits 9-1-24

A. There is an annual benefit limit of twenty (24) medically necessary days per state fiscal year (July 1 through June 30) for Medicaid beneficiaries twenty-one (21) years of age and older. Once the beneficiary exhausts the twenty-four-day annual limit, reimbursement for any additional inpatient hospital days will be reduced to four hundred dollars ($400) per day and are subject to recoupment if later determined not medically necessary.

B. There is no inpatient hospital benefit limit for beneficiaries under twenty-one (21) years of age in the Child Health Services (EPSDT) Program.

214.720 Outpatient Hospital Services 9-1-24

For the purpose of coverage and reimbursement determination, outpatient hospital clinical nurse specialist services are divided into two (2) types of service.

214.721 Emergency Services 9-1-24

Clinical nurse specialist outpatient hospital visits are covered as an emergency when the beneficiary's medical condition constitutes an emergency medical condition. (Refer to the Glossary of this manual for the definition of emergency services.)

Services not considered as emergency services are covered with primary care provider approval, or the beneficiary may be billed for the services.

214.722 Non-Emergency Services 9-1-24

Coverage of non-emergency clinical nurse specialist services in an outpatient hospital setting is restricted to a visit charge and the professional component for machine tests, radiology, and anatomical laboratory procedures.

214.800 Occupational, Physical, and Speech-Language Therapy 9-1-24

A. Medicaid covers occupational, physical, and speech-language therapy services for eligible beneficiaries under twenty-one (21) years of age in the Child Health Services (EPSDT) Program by qualified occupational, physical, or speech-language therapy providers. Therapy services are not covered as clinical nurse specialist services. The following is provided for the clinical nurse specialist's information.

B. Occupational, Physical, and Speech-Language therapies are covered for beneficiaries in the ARKids A and ARKids B program benefits.

C. Therapy services for individuals twenty-one (21) years of age and older are only covered when provided through the following Medicaid Programs: Adult Developmental Day Treatment (ADDT), Hospital or Critical Access Hospital (CAH), Rehabilitative Hospital, Home Health, Hospice and Physician. Refer to these Medicaid provider manuals for conditions of coverage and benefit limits.

D. All therapy services for beneficiaries under twenty-one (21) years of age require a referral for evaluation utilizing the form DMS-640 and a separate form DMS-640 for the written prescription from the patient's primary care provider (PCP) or attending physician if the beneficiary is exempt from PCP Managed Care Program requirements. A referral for therapy services must be renewed every twelve (12) months. After the initial referral using the form DMS-640 and initial prescription, utilizing a separate form DMS-640, subsequent referrals and prescriptions for continued therapy may be made at the same time using the same DMS-640. The prescription for treatment is valid for one (1) year unless the prescribing physician specifies a shorter period.

E. The PCP or attending physician must complete and sign the DMS-640 for beneficiaries under twenty-one (21) years of age. The PCP or attending physician must initiate a referral and prescription for beneficiaries over twenty-one (21) years of age. An original signature is required when making a referral or prescribing a therapy service. An electronic signature is acceptable on either document, provided it is in compliance with Arkansas Code 25-31-103. A copy of the prescription must be maintained in the beneficiary's records. The original prescription is to be maintained by the physician. **View or print form DMS-640** (for beneficiaries under twenty-one (21) years of age).

F. For range of benefits, see the following procedure codes: **View or print the procedure codes for therapy services**.

Extended therapy services may be provided based on medical necessity, for Medicaid beneficiaries under twenty-one (21) years of age.

Occupational, physical, and speech-language therapies are subject to the benefit limit of twelve (12) outpatient hospital visits per state fiscal year (SFY) for beneficiaries twenty-one (21) years of age and over. Benefit Extensions may be provided for therapy services, based on medical necessity, for Medicaid beneficiaries twenty-one (21) years of age and over when provided within a covered program.

214.810 Occupational, Physical and Speech Therapy Guidelines for Retrospective Review 9-1-24

Though clinical nurse specialists are not reimbursed for occupational, physical, or speech therapy services, it is important for the clinical nurse specialist to be aware of Medicaid's guidelines to document medical necessity. For Arkansas Medicaid guidelines applicable to therapy services, please refer to the Occupational, Physical and Speech Therapy Services provider manual.

214.811 Occupational and Physical Therapy Guidelines 9-1-24

Occupational, physical and speech therapists must adhere to the specific guidelines for retrospective review.

A. Therapy services for individuals must be medically necessary for the treatment of the individual's medical condition as prescribed by the individual's PCP. Clinical Nurse Specialists are not reimbursed for occupational or physical therapy services.

1. The services must be considered under accepted standards of practice to be a specific and effective treatment for the patient's condition.
2. The services must be of such a level of complexity, or the patient's condition must be such that the services required can be safely and effectively performed only by or under the supervision of a qualified physical therapist.
3. There must be reasonable expectation that therapy will result in a meaningful improvement or a reasonable expectation that therapy will prevent a worsening of the condition (See medical necessity definition in the Glossary of this manual).

A diagnosis alone is not sufficient documentation to support the medical necessity of therapy. Assessment for physical therapy includes a comprehensive evaluation of the patient's physical deficits and functional limitations, treatment planned, and goals to address each identified problem.

B. Frequency, Intensity, and Duration of Physical Therapy Services:

Frequency, intensity, and duration of therapy services should always be medically necessary and realistic for the age of the child and the severity of the deficit or disorder.

Therapy is indicated if improvement will occur as a direct result of these services and if there is a potential for improvement in the form of functional gain.

1. Monitoring: May be used to ensure that the child is maintaining a desired skill level or to assess the effectiveness and fit of equipment such as orthotics and other durable medical equipment. Monitoring frequency should be based on a time interval that is reasonable for the complexity of the problem being addressed.
2. Maintenance Therapy: Services that are performed primarily to maintain range of motion or to provide positioning services for the patient do not qualify for physical therapy services. These services can be provided to the child as part of a home program that can be implemented by the child's caregivers and do not necessarily require the skilled services of a physical therapist to perform safely and effectively.
3. Duration of Services: Therapy services should be provided if reasonable progress is made toward established goals. If reasonable functional progress cannot be expected with continued therapy, then services should be discontinued, and monitoring or establishment of a home program should be implemented.

C. Progress Notes:

1. Child's name.
2. Date of service.
3. Time in and time out of each therapy session.
4. Objectives addressed (should coincide with the plan of care).
5. A description of specific therapy services provided daily, and the activities rendered during each therapy session, along with a form measurement.
6. Progress notes must be legible.
7. Therapists must sign each date of entry with a full signature and credentials.
8. Graduate students must have the supervising physical therapist co-sign progress notes.

214.812 Speech-Language Therapy Retrospective Review Guidelines 9-1-24

A. Speech-language therapy services must be medically necessary to the treatment of the individual's illness or injury. To be considered medically necessary, the following conditions must be met:

1. The services must be considered under accepted standards of practice to be a specific and effective treatment for the patient's condition.
2. The services must be of such a level of complexity, or the patient's condition must be such that the services required can be safely and effectively performed only by or under the supervision of a qualified speech and language pathologist.
3. There must be reasonable expectation that therapy will result in meaningful improvement or a reasonable expectation that therapy will prevent a worsening of the condition. (See medical necessity in glossary of the Arkansas Medicaid manual.)

A diagnosis alone is not sufficient documentation to support the medical necessity of therapy. Assessment for speech-language therapy includes a comprehensive evaluation of the patient's speech language deficits and functional limitations, treatment plan, and goals to address each identified problem.

B. Evaluations:

To determine that speech-language therapy services are medically necessary, an evaluation must contain the following information:

1. Date of evaluation.
2. Child's name and date of birth.
3. Diagnosis specific to therapy.
4. Background information including pertinent medical history; and, if the child is twelve (12) months of age or younger, gestational age.
5. Standardized test results, including all subtest scores, if applicable. Test results, if applicable, should be adjusted for prematurity (when less than thirty-seven (37) weeks gestation) if the child is twelve (12) months of age or younger this should be noted in the evaluation.
6. An assessment of the results of the evaluation including recommendations for frequency and intensity of treatment.
7. The child should be tested in their native language; if not, an explanation must be provided in the evaluation.
8. Signature and credentials of the therapist performing the evaluation.

The mental measurement yearbook is the standard reference to determine good reliability and validity of the test(s) administered in the evaluation.

C. Birth to Three:

1. — (minus) 1.5 SD (standard score of 77) below the mean in two (2) areas (expressive, receptive) or a — (minus) 2.0 SD (standard score of 70) below the mean in one area to qualify for language therapy.
2. Two (2) language tests must be reported with at least one (1) of these being a global norm-referenced standardized test with good reliability and validity. The second test may be criterion referenced.

214.900 Procedures for Obtaining Extension of Benefits 9-1-24

A. Clinical nurse specialists who perform diagnostic laboratory services, radiology, or other services within their scope of practice may request extension of benefits for those services if the patient has exhausted the benefit limit.

1. Diagnostic laboratory services benefits are limited to five hundred dollars ($500) per State Fiscal Year (SFY: July 1 through June 30) and radiology/other services benefits are limited to five hundred dollars ($500) per SFY.
2. Radiology/other services include without limitation diagnostic X-rays, ultrasounds, and electronic monitoring or machine tests, such as electrocardiograms (ECG or EKG).
3. Diagnostic laboratory services and radiology or other services defined as Essential Health Benefits by the U.S. Preventive Services Task Force (USPSTF) are exempt from counting toward either of the two (2) new annual caps.

B. To request an extension of benefits for diagnostic laboratory services or radiology/other services, use the following procedures.

214.910 Extension of Benefits for Diagnostic Laboratory and Radiology/Other Services 9-1-24

A. The Medicaid Program's diagnostic laboratory services benefit limit and radiology/other services benefit limit each apply to the outpatient setting.

1. Diagnostic laboratory services benefits are limited to five hundred dollars ($500) per State Fiscal Year (SFY: July 1 through June 30), and radiology/other services benefits are limited to five hundred dollars ($500) per SFY.

2. Radiology/other services include without limitation diagnostic X-rays, ultrasounds, and electronic monitoring or machine tests, such as electrocardiograms (ECG or EKG).

B. Requests for extension of benefits for diagnostic laboratory services or radiology/other services must be submitted to DHS or its designated vendor.

View or print contact information to obtain the DHS or designated vendor step-by-step process for requesting extension of benefits.

1. Requests for extension of benefits are considered only after a claim is filed and is denied because the patient's five-hundred-dollar ($500) benefit limit for either diagnostic laboratory services or radiology/other services is exhausted.

2. Submit with the request a copy of the Medical Assistance Remittance and Status Report reflecting the claim's denial for exhausted benefits. Do not send a claim.

3. Diagnostic laboratory services and radiology/other services defined as Essential Health Benefits by the U.S. Preventive Services Task Force (USPSTF) are exempt from counting toward either of the two (2) new annual caps.

C. A request for extension of benefits must be received within ninety (90) calendar days of the date of benefit limit denial.

D. Additional information will be requested, as needed, to process a benefit extension request. Reconsiderations of additional requested information are not available. Failure to provide requested information within the specified time will result in a technical denial.

E. Correspondence regarding benefit extension requests and requests for reconsideration of denied benefit extension requests do not constitute documentation or proof of timely claim filing.

214.920 Completion of Form DMS-671, "Request For Extension of Benefits for Clinical, Outpatient, Diagnostic Laboratory and Radiology/Other Services." **9-1-24**

A. The Medicaid Program's diagnostic laboratory services limit and radiology/other services benefit limit each apply to the outpatient setting.

1. Diagnostic laboratory services benefits are limited to five hundred dollars ($500) per State Fiscal Year (SFY: July 1 through June 30), and radiology/other services benefits are limited to five hundred dollars ($500) per SFY.

2. Radiology/other services include without limitation diagnostic X-rays, ultrasounds, and electronic monitoring or machine tests, such as electrocardiograms (ECG or EKG).

3. Diagnostic laboratory services and radiology/other services defined as Essential Health Benefits by the U.S. Preventive Services Task Force (USPSTF) are exempt from counting toward either of the two (2) new annual caps.

B. Requests for extension of benefits for clinical services (such as physician's visits or Clinical nurse specialist visits), outpatient services (meaning, hospital outpatient visits), diagnostic laboratory services (meaning, laboratory tests) and radiology/other services must be submitted to DHS or its designated vendor for consideration.

View or print contact information to obtain the DHS or designated vendor step-by-step process for requesting extension of benefits.

1. Consideration of requests for extension of benefits requires correct completion of all fields on the "Request for Extension of Benefits for Clinical, Outpatient, Diagnostic Laboratory, and Radiology/Other Services" form (Form DMS-671). **View or print Form DMS-671.**
2. Complete instructions for accurate completion of Form DMS-671 (including indication of required attachments) accompany the form. All forms are listed and accessible in **Section V** of each provider manual.

214.930 Documentation Requirements 9-1-24

A. The Medicaid Program's diagnostic laboratory services benefit limit and radiology/other services benefit limit each apply to the outpatient setting.

1. Diagnostic laboratory services benefits are limited to five hundred dollars ($500) per State Fiscal Year (SFY: July 1 through June 30), and radiology/other services benefits are limited to five hundred dollars ($500) per SFY.
2. Radiology or other services include without limitation diagnostic X-rays, ultrasounds, and electronic monitoring or machine tests, such as electrocardiograms (ECG or EKG)
3. Diagnostic laboratory services and radiology or other services defined as Essential Health Benefits by the U.S. Preventive Services Task Force (USPSTF) are exempt from counting toward either of the two (2) new annual caps.

B. To request extension of benefits for any services with benefit limits, all applicable records that support the medical necessity of extended benefits are required.

C. Documentation requirements are as follows.

1. Clinical records *must:*
   a. Be legible and include records supporting the specific request;
   b. Be signed by the performing provider;
   c. Include clinical, outpatient, and emergency room records for dates of service in chronological order;
   d. Include related diabetic and blood pressure flow sheets;
   e. Include a current medication list for the date of service;
   f. Include the obstetrical record related to a current pregnancy when applicable; and
   g. Include clinical indication for diagnostic laboratory and radiology/other services ordered with a copy of orders for diagnostic laboratory and radiology/other services signed by the prescriber.
2. Diagnostic laboratory and radiology/other reports *must* include:
   a. Clinical indication for diagnostic laboratory and radiology/other services ordered;
   b. Signed orders for diagnostic laboratory and radiology/other services;
   c. Results signed by the performing provider; and
   d. Current and all previous ultrasound reports, including biophysical profiles and fetal non-stress tests when applicable.

214.940 Reconsideration of Extensions of Benefits Denial 9-1-24

A. Any reconsideration request for denial of extension of benefits must be received at AFMC within thirty (30) days of the date of denial notice. The following information is required from providers requesting reconsideration of denial:

1. Return a copy of the current NOTICE OF ACTION denial letter with re-submissions.
2. Return all previously submitted documentation as well as additional information for reconsideration.

B. Only one reconsideration is allowed. Any reconsideration request that does not include required documentation will be automatically denied.

C. Further clinical documentation shall be requested when deemed necessary to complete the medical review.

214.950 Reserved 9-1-24

214.951 Appealing an Adverse Decision 9-1-24

When the Division of Medical Services (DMS) denies a benefit extension request for laboratory and x-ray services, and the beneficiary wishes to appeal the denial, the beneficiary may request a fair hearing.

An appeal request must be in writing and received by the Appeals and Hearings Section of the Department of Human Services within thirty-five (35) days of the date on the letter from DMS explaining the denial. Appeal requests must be submitted to the Department of Human Services Appeals and Hearings Section. **View or print the Department of Human Services Appeals and Hearings Section contact information.**

214.952 Requesting Initiation or Continuation of Services Pending the Outcome of an Appeal 9-1-24

A. Services will be continued automatically, pending the outcome of an appeal. A beneficiary may opt out of continued services by contacting the Appeals and Hearings office when a notice of adverse action is received.

1. When such requests to stop services are made and received by the Appeals and Hearings Section, DMS will authorize discontinuance of the services and notify the provider and beneficiary.

B. If the beneficiary loses the appeal, DMS will take action to recover from the beneficiary Medicaid's payments for the services that were provided pending the outcome of the appeal.

215.000 Fluoride Varnish Treatment 9-1-24

Arkansas Medicaid covers fluoride varnish application, ADA code, performed by physicians who have completed the online training program approved by the Arkansas Department of Health, Office of Oral Health.

View or print the procedure codes for Clinical Nurse Specialist and Nurse Practitioner services.

Eligible physicians may delegate the application to a nurse or other licensed health care professional under his or her supervision that has also completed the online training. The online training course can be accessed at **http://ar.train.org**. Each provider must maintain documentation to establish his or her successful completion of the training and submit a copy of the certificate of completion to Provider Enrollment.

220.000 PRIOR AUTHORIZATION

221.000 Procedure for Obtaining Prior Authorization 9-1-24

A. Certain medical and surgical procedures are not covered without prior authorization, because of federal requirements or because of the elective nature of the surgery.

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 extension of benefits.**

1. Prior authorization determinations are in accordance with established medical 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 service does not guarantee eligibility for a beneficiary. Payment is subject to verification that the beneficiary is Medicaid-eligible at the time services are provided.

221.100 Post-Procedural Authorization 9-1-24

Post-procedural authorization will be granted only for emergency procedures for beneficiaries twenty-one (21) years of age and older. Requests for post-authorization of an emergency procedure must be applied for on the first working day after the procedure is 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 displayed in the electronic eligibility verification response.

221.110 Post-Procedural Authorization Process for Beneficiaries Under Age 21 9-1-24

A. Providers performing surgical procedures that require prior authorization are allowed sixty (60) days from the date of service to obtain a prior authorization number if the beneficiary is under twenty-one (21) years of age.

B. The following post-procedural authorization process must be followed when obtaining an authorization number.

1. 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.**

2. 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**.

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

4. Consultants are responsible for DHS or its designated vendor having their required and restricted procedures added to the PA file. They will be given the prior authorization number at the time of contact on cases that are approved.

Providers must obtain prior authorization for procedures requiring authorization in order to prevent risk of denial due to lack of medical necessity.

221.200 Prescription Prior Authorization 9-1-24

Prescription drugs are available for reimbursement under the Arkansas Medicaid Program when prescribed by a clinical nurse specialist with prescriptive authority. Certain prescription drugs may require prior authorization. It is the responsibility of the prescriber to request and obtain the

prior authorization. Information may be obtained from DHS or its designated vendor. **View or print contact information to obtain the DHS or designated vendor prescription drug information.**

The following information is available:

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.

221.300 Procedures that Require Prior Authorization 9-1-24

Medical or surgical procedures that are generally restricted to the outpatient setting no longer require prior authorization for inpatient services.

222.000 Appeal Process for Medicaid Beneficiaries 9-1-24

When the Division of Medical Services denies coverage of services the beneficiary may request a fair hearing of the reconsideration decision of the denial of services from the Department of Human Services.

The appeal request must be in writing and received by the Appeals and Hearings Section of the Department of Human Services within thirty-five (35) days of the date on the letter explaining the denial. Appeal requests must be submitted to the Department of Human Services Appeals and Hearings Section. **View or print the Department of Human Services Appeals and Hearings Section contact information**.

230.000 REIMBURSEMENT

231.000 Method of Reimbursement 9-1-24

Medicaid reimbursement for clinical nurse specialist services is based on the lesser of the amount billed or the Title XIX maximum allowable.

231.010 Fee Schedules 9-1-24

Arkansas Medicaid provides fee schedules on the ~~Arkansas Medicaid~~Division of Medical Services website. ~~The fee schedule link is located at **https://medicaid.mmis.arkansas.gov/** under the provider manual section~~**View available fee schedules**. The fees represent the fee-for-service reimbursement methodology.

Fee schedules do not address coverage limitations or special instructions applied by Arkansas Medicaid before final payment is determined.

Procedure codes and fee schedules do not guarantee payment, coverage or amount allowed. Information may be changed or updated at any time to correct a discrepancy or error. Arkansas Medicaid always reimburses the lesser of the amount billed or the Medicaid maximum.

232.000 Rate Appeal Process 9-1-24

A provider may request reconsideration of a program decision by writing to the Assistant Director, Division of Medical Services. This request must be received within twenty (20) calendar days following the application of policy or procedure or the notification of the provider of its rate. Upon receipt of the request for review, the Assistant Director will determine the need for a program or provider conference and will contact the provider to arrange a conference if

needed. Regardless of the program decision, the provider will be afforded the opportunity for a conference, if he or she so wish, for a full explanation of the factors involved and the program decision. Following review of the matter, the Assistant Director will notify the provider of the action to be taken by the Division within twenty (20) calendar days of receipt of the request for review or the date of the program or provider conference.

If the decision of the Assistant Director, Division of Medical Services is unsatisfactory, the provider may then appeal the question to a standing rate review panel established by the Director of the Division of Medical Services. The rate review panel will include one (1) member of the Division of Medical Services, a representative of the provider association, and a member of the Department of Human Services (DHS) management staff, who will serve as chairman.

The request for review by the rate review panel must be postmarked within fifteen (15) calendar days following the notification of the initial decision by the Assistant Director, Division of Medical Services. The rate review panel will meet to consider the question(s) within fifteen (15) calendar days after receipt of a request for such appeal. The question(s) will be heard by the panel and a recommendation will be submitted to the Director of the Division of Medical Services.

250.000 BILLING PROCEDURES

252.000 Introduction to Billing 9-1-24

Clinical nurse specialist providers use the CMS-1500 form to bill the Arkansas Medicaid Program on paper for services provided to eligible Medicaid beneficiaries. Each claim may contain charges for only one (1) beneficiary.

Section III of this manual contains information about available options for electronic claim submission.

252.000 CMS-1500 Billing Procedures

252.100 Reserved 9-1-24

252.110 Billing Protocol for Computed Tomographic Colonography (CT) 9-1-24

A. The following procedure codes are covered for CT colonography for beneficiaries of all ages.

View or print the procedure codes for Clinical Nurse Specialist and Nurse Practitioner services.

B. Billing protocol for CT colonography procedure codes:

1. CT colonography is billable electronically or on paper claims.
2. For the Clinical Nurse Specialist, the above listed procedure codes are only payable for the technical component.

See Section 252.442 for additional information about the technical component.

252.120 Reserved 9-1-24

252.130 Special Billing Instructions 9-1-24

A. Use the following procedure codes for billing.

View or print the procedure codes for Clinical Nurse Specialist and Nurse Practitioner services.

B. For consideration of any claims with payable CPT or HCPCS unlisted procedure codes, the provider must submit a paper claim that includes a description of the service that is being represented by that unlisted code on the claim form. Documentation that further describes the service provided must be attached and must include justification for medical necessity.

All other billing requirements must be met in order for payment to be approved.

252.131 Molecular Pathology **9-1-24**

The following Molecular Pathology codes require prior authorization from the Arkansas Foundation for Medical Care. See Sections 221.000 through 221.300 for prior authorization procedures.

View or print the procedure codes for Clinical Nurse Specialist and Nurse Practitioner services.

252.132 Special Billing Requirements for Lab and X-Ray Services **9-1-24**

For consideration of payable unlisted CPT/HCPCS drug procedure codes:

A. The provider must submit a paper claim that includes a description of the drug being represented by the unlisted procedure code on the claim form.

B. Documentation that further describes the drug provided must be attached and must include justification for medical necessity.

C. All other billing requirements must be met in order for payment to be approved.

View or print the procedure codes for Clinical Nurse Specialist and Nurse Practitioner services.

252.200 Reserved **9-1-24**

252.210 National Place of Service (POS) Codes **9-1-24**

Electronic and paper claims now require the same National Place of Service code.

Place of Service	POS Codes
Inpatient Hospital	21
Outpatient Hospital	22
Office	11
Patient's Home	12
Day Care Facility	99
Nursing Facility	32
Skilled Nursing Facility	31
Ambulance	41
Other Locations	99

252.300 Billing Instructions – Paper Claims Only 9-1-24

Bill Medicaid for clinical nurse specialist services with form CMS-1500. The numbered items in the following instructions correspond to the numbered fields on the claim form. **View a sample form CMS-1500.**

Carefully follow these instructions to help the Arkansas Medicaid fiscal agent efficiently process claims. Accuracy, completeness, and clarity are essential. Claims cannot be processed if necessary information is omitted.

Forward completed claim forms to the Claims Department. **View or print the Claims Department contact information.**

NOTE: A provider delivering services without verifying beneficiary eligibility for each date of service does so at the risk of not being reimbursed for the services.

252.310 Completion of CMS-1500 Claim Form 9-1-24

Field Name and Number	Instructions for Completion
1. (type of coverage)	Not required.
1a. INSURED'S I.D. NUMBER (For Program in Item 1)	Beneficiary's or participant's 10-digit Medicaid or ARKids First-A or ARKids First-B identification number.
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)	Beneficiary's or participant's last name and first name.
3. PATIENT'S BIRTH DATE	Beneficiary's or participant's date of birth as given on the individual's Medicaid or ARKids First-A or ARKids First-B identification card. Format: MM/DD/YY.
SEX	Check M for male or F for female.
4. INSURED'S NAME (Last Name, First Name, Middle Initial)	Required if insurance affects this claim. Insured's last name, first name, and middle initial.
5. PATIENT'S ADDRESS (No., Street)	Optional. Beneficiary's or participant's complete mailing address (street address or post office box).
CITY	Name of the city in which the beneficiary or participant resides.
STATE	Two-letter postal code for the state in which the beneficiary or participant resides.
ZIP CODE	Five-digit zip code; nine digits for post office box.
TELEPHONE (Include Area Code)	The beneficiary's or participant's telephone number or the number of a reliable message, contact, or emergency telephone.
6. PATIENT RELATIONSHIP TO INSURED	If insurance affects this claim, check the box indicating the patient's relationship to the insured.
7. INSURED'S ADDRESS (No., Street)	Required if insured's address is different from the patient's address.
CITY	
STATE	

Field Name and Number	Instructions for Completion
ZIP CODE	
TELEPHONE (Include Area Code)	
8. RESERVED	Reserved for NUCC use.
9. OTHER INSURED'S NAME (Last name, First Name, Middle Initial)	If patient has other insurance coverage as indicated in Field 11d, the other insured's last name, first name, and middle initial.
a. OTHER INSURED'S POLICY OR GROUP NUMBER	Policy or group number of the insured individual.
b. RESERVED	Reserved for NUCC use.
SEX	Not required.
c. RESERVED	Reserved for NUCC use.
d. INSURANCE PLAN NAME OR PROGRAM NAME	Name of the insurance company.
10. IS PATIENT'S CONDITION RELATED TO:	
a. EMPLOYMENT? (Current or Previous)	Check YES or NO.
b. AUTO ACCIDENT?	Required when an auto accident is related to the services. Check YES or NO.
PLACE (State)	If 10b is YES, the two-letter postal abbreviation for the state in which the automobile accident took place.
c. OTHER ACCIDENT?	Required when an accident other than automobile is related to the services. Check YES or NO.
d. CLAIM CODES	The "Claim Codes" identify additional information about the beneficiary's condition or the claim. When applicable, use the Claim Code to report appropriate claim codes as designated by the NUCC. When required to provide the subset of Condition Codes, enter the condition code in this field. The subset of approved Condition Codes is found at **www.nucc.org** under Code Sets.
11. INSURED'S POLICY GROUP OR FECA NUMBER	Not required when Medicaid is the only payer.
a. INSURED'S DATE OF BIRTH	Not required.
SEX	Not required.
b. OTHER CLAIM ID NUMBER	Not required.
c. INSURANCE PLAN NAME OR PROGRAM NAME	Not required.

Field Name and Number	Instructions for Completion
d. IS THERE ANOTHER HEALTH BENEFIT PLAN?	When private or other insurance may or will cover any of the services, check YES and complete items 9, 9a and 9d. Only one (1) box can be marked.
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE	Enter "Signature on File," "SOF" or legal signature.
13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE	Enter "Signature on File," "SOF" or legal signature.
14. DATE OF CURRENT: ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)	Required when services furnished are related to an accident, whether the accident is recent or in the past. Date of the accident. Enter the qualifier to the right of the vertical dotted line. Use Qualifier 431 Onset of Current Symptoms or Illness; 484 Last Menstrual Period.
15. OTHER DATE	Enter another date related to the beneficiary's condition or treatment. Enter the qualifier between the left-hand set of vertical, dotted lines. The "Other Date" identifies additional date information about the beneficiary's condition or treatment. Use qualifiers: 454 Initial Treatment 304 Latest Visit or Consultation 453 Acute Manifestation of a Chronic Condition 439 Accident 455 Last X-Ray 471 Prescription 090 Report Start (Assumed Care Date) 091 Report End (Relinquished Care Date) 444 First Visit or Consultation
16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION	Not required.
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	Name and title of referral source, whether an individual (such as a PCP) or a clinic or other facility.
17a. (blank)	Not required.
17b. NPI	Enter NPI of the referring provider
18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES	When the serving or billing provider's services charged on this claim are related to a beneficiary's or participant's inpatient hospitalization, enter the individual's admission and discharge dates. Format: MM/DD/YY.

Field Name and Number	Instructions for Completion
19. ADDITIONAL CLAIM INFORMATION	Identifies additional information about the beneficiary's condition or the claim. Enter the appropriate qualifiers describing the identifier. See **www.nucc.org** for qualifiers.
20. OUTSIDE LAB?	Not required.
$ CHARGES	Not required.
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY	Enter the applicable ICD indicator to identify which version of ICD codes is being reported. Use "9" for ICD-9-CM. Use "0" for ICD-10-CM. Enter the indicator between the vertical, dotted lines in the upper right-hand portion of the field. Diagnosis code for the primary medical condition for which services are being billed. Use the appropriate version of the International Classification of Diseases. List no more than 12 ICD diagnosis codes. Relate lines A-L to the lines of service in 24E by the letter of the line. Use the highest level of specificity.
22. RESUBMISSION CODE	Reserved for future use.
ORIGINAL REF. NO.	Any data or other information listed in this field does not and will not adjust, void, or otherwise modify any previous payment or denial of a claim. Claim payment adjustments, voids, and refunds must follow previously established processes in policy.
23. PRIOR AUTHORIZATION NUMBER	The prior authorization or benefit extension control number if applicable.
24A. DATE(S) OF SERVICE	The "from" and "to" dates of service for each billed service. Format: MM/DD/YY. 1. On a single claim detail (one (1) charge on one (1) line), bill only for services provided within a single calendar month. 2. Some providers may bill on the same claim detail for two (2) or more sequential dates of service within the same calendar month when the provider furnished equal amounts of the service on each day of the date sequence.
B. PLACE OF SERVICE	Enter the appropriate place of service code. See Section 252.200 for codes.
C. EMG	Check "Yes" or leave blank if "No." EMG identifies if the service was an emergency.
D. PROCEDURES, SERVICES, OR SUPPLIES	
CPT/HCPCS	Enter the correct CPT or HCPCS procedure code from Sections 252.100 through 252.132.
MODIFIER	Modifier(s) if applicable.

Field Name and Number	Instructions for Completion
E. DIAGNOSIS POINTER	Enter the diagnosis code reference letter (pointer) as shown in Item Number 21 to relate to the date of service and the procedures performed to the primary diagnosis. When multiple services are performed, the primary reference letter for each service should be listed first; other applicable services should follow. The reference letter(s) should be A-L or multiple letters as applicable. The "Diagnosis Pointer" is the line letter from Item Number 21 that relates to the reason the service(s) was performed.
F. $ CHARGES	The full charge for the service(s) totaled in the detail. This charge must be the usual charge to any client, patient, or other beneficiary of the provider's services.
G. DAYS OR UNITS	The units (in whole numbers) of service(s) provided during the period indicated in Field 24A of the detail. .
H. EPSDT/Family Plan	Enter E if the services resulted from a Child Health Services (EPSDT) screening or referral.
I. ID QUAL	Not required.
J. RENDERING PROVIDER ID #	Enter the 9-digit Arkansas Medicaid provider ID number of the individual who furnished the services billed for in the detail or
NPI	Enter NPI of the individual who furnished the services billed for in the detail.
25. FEDERAL TAX I.D. NUMBER	Not required. This information is carried in the provider's Medicaid file. If it changes, please contact Provider Enrollment.
26. PATIENT'S ACCOUNT NO.	Optional entry that may be used for accounting purposes; use up to sixteen (16) numeric or alphabetic characters. This number appears on the Remittance Advice as "MRN."
27. ACCEPT ASSIGNMENT?	Not required. Assignment is automatically accepted by the provider when billing Medicaid.
28. TOTAL CHARGE	Total of Column 24F—the sum all charges on the claim.
29. AMOUNT PAID	Enter the total of payments previously received on this claim. Do not include amounts previously paid by Medicaid. *Do **not** include in this total the automatically deducted Medicaid or ARKids First-B co-payments.
30. RESERVED	Reserved for NUCC use.

Field Name and Number	Instructions for Completion
31. SIGNATURE OF PROVIDER OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS	The provider or designated authorized individual must sign and date the claim certifying that the services were personally rendered by the provider or under the provider's direction. "Provider's signature" is defined as the provider's actual signature, a rubber stamp of the provider's signature, an automated signature, a typewritten signature, or the signature of an individual authorized by the provider rendering the service. The name of a clinic or group is not acceptable.
32. SERVICE FACILITY LOCATION INFORMATION	If other than home or office, enter the name and street, city, state, and zip code of the facility where services were performed.
a. (blank)	Not required.
b. (blank)	Not required.
33. BILLING PROVIDER INFO & PH #	Billing provider's name and complete address. Telephone number is requested but not required.
a. (blank)	Enter NPI of the billing provider or
b. (blank)	Enter the 9-digit Arkansas Medicaid provider ID number of the billing provider.

252.400 Special Billing Procedures

252.410 Clinic or Group Billing 9-1-24

Providers who wish to have payment made to a group practice or clinic must enroll as a group practice. When billing, enter the Clinic/Group pay-to Provider Identification Number in Field 33 after "GRP#." Enter the performing provider identification number in Field 24K. If more than one (1) clinical nurse specialist in a group practice provides services for a beneficiary, the clinic may bill for all their services on the same claim limited only by the size of the claim format.

Procedure code is payable when provided in the inpatient hospital setting by a clinical nurse specialist.

View or print the procedure codes for Clinical Nurse Specialist and Nurse Practitioner services.

252.420 Evaluations and Management

252.421 Initial Visit 9-1-24

The American Medical Association's *Current Procedures Terminology* (CPT) codes should be used only for the first visit of a new patient. Each subsequent visit should be billed using an established patient code. A distinction is made in CPT codes for new or established patients for office visits, home visits, nursing facility, visits, and emergency room visits. Refer to the latest edition of the CPT.

Providers are allowed to bill one (1) new patient visit procedure code per beneficiary, per attending provider in a three (3) year period.

252.422 Detention Time (Standby Service) 9-1-24

View or print the procedure codes for Clinical Nurse Specialist and Nurse Practitioner services.

Procedure code must be used by clinical nurse specialists when billing for detention time.

One (1) unit equals thirty (30) minutes. A maximum of one (1) unit per date of service may be billed.

Procedure code is payable when provided in the inpatient hospital setting by a clinical nurse specialist.

252.423 Inpatient Hospital Visits 9-1-24

Each clinical nurse specialist is limited to billing one (1) day of care for each inpatient hospital covered days, regardless of the number of hospital visits rendered.

252.424 Hospital Discharge Day Management 9-1-24

View or print the procedure codes for Clinical Nurse Specialist and Nurse Practitioner services.

Procedure code, hospital discharge day management, may not be billed by providers on the same date of service as an initial or subsequent hospital care code, procedures. Initial hospital care codes and subsequent hospital care codes may not be billed on the day of discharge.

252.425 Nursing Home Visits 9-1-24

The appropriate CPT procedure codes should be used when billing for clinical nurse specialist visits in a nursing facility.

252.426 Specimen Collections 9-1-24

The policy in regard to collection, handling and conveyance of specimens is:

A. Reimbursement will not be made for specimen handling fees.

B. A specimen collection fee may be allowed only in circumstances including: (1) drawing a blood sample through venipuncture (for example: inserting into a vein a needle with syringe or vacutainer to draw the specimen); or (2) collecting a urine sample by catheterization.

The following codes should be used when billing for specimen collection:

View or print the procedure codes for Clinical Nurse Specialist and Nurse Practitioner services.

252.428 Services Not Considered a Separate Service from an Office Visit 9-1-24

Some services (examples include, but are not limited to, pelvic examinations, prostate massages, and removal of sutures) are not considered a separate service from an office visit. The charge for such services should be included in the office visit charge. Billing should be under the office visit procedure code that reflects the appropriate level of care. Procedure code should never be used for billing routine pelvic examinations, but should be used only when a pelvic examination is done under general anesthesia.

View or print the procedure codes for Clinical Nurse Specialist and Nurse Practitioner services.

252.429 Health Examinations for ARKids First B Beneficiaries and Medicaid Beneficiaries Under Age 21 **9-1-24**

Providers should refer to the Child Health Services (EPSDT) Provider manual and the ARKids First-B Provider manual for covered services and billing procedures.

252.430 Family Planning Services Program Procedure Codes **9-1-24**

A. Family planning services are covered for beneficiaries in full coverage aid categories or Aid Category 61 (PW-PL). For information regarding additional aid categories, see Section 124.000. **All procedure codes in these tables require a primary diagnosis code of family planning in each claim detail. Please note: See the tables below within this section to determine restrictions applicable to some procedures**. Laboratory procedure codes covered for family planning are listed in **Section 252.431**.

B. Sterilization

A copy of the properly completed Sterilization Consent Form (DMS-615), with all items legible, must be attached to each sterilization claim submitted from each provider before payment may be approved. Providers include hospitals, physicians, anesthesiologists, and assistant surgeons. It is the responsibility of the physician performing the sterilization procedure to distribute correct legible copies of the signed consent form (DMS-615) to the hospital, anesthesiologist, and assistant surgeon.

Though prior authorization is not required, an improperly completed Sterilization Consent Form (DMS-615) results in the delay or denial of payment for the sterilization procedures. The checklist lists the items on the consent form that are reviewed before payment is made for any sterilization procedure. Use this checklist before submitting any consent form and claim for payment to be sure that all criteria have been met. **View or print form DMS-615 (English) and the checklist. View or print form DMS-615 (Spanish) and the checklist**.

C. The following procedure code table explains the family planning visit services payable to clinical nurse specialists.

NOTE: The procedure codes with the modifiers indicated below denote the Arkansas Medicaid description.

View or print the procedure codes for Clinical Nurse Specialist and Nurse Practitioner services.

D. The following procedure code table explains family planning codes payable to clinical nurse specialists. Use the FP modifier for family planning services.

*Bill using modifiers FP, SA.

**Reimbursement for laboratory procedures requiring a venous blood specimen includes the collection fee when performed by the same provider. Use modifier FP for family planning services.

E. The following procedure codes are payable to clinical nurse specialists

F. The following procedure code table explains the pathology procedure code payable to clinical nurse specialists

NOTE: The procedure code with the modifiers indicated below denotes the Arkansas Medicaid description.

Family planning laboratory codes are found in **Section 252.431**.

252.431 Family Planning Laboratory Procedure Codes 9-1-24

Family planning services are covered for beneficiaries in full coverage aid categories and Aid Category 61 (PW-PL). For information regarding additional aid categories, see Section 124.000. For eligible beneficiaries, these codes are payable when used for purposes other than family planning. Claims require modifier FP when the service diagnosis indicates family planning.

A. The following procedure code table contains family planning laboratory procedure codes.

View or print the procedure codes for Clinical Nurse Specialist and Nurse Practitioner services.

*Procedure codes are limited to one (1) unit per beneficiary per state fiscal year.

**Payable only to pathologists and independent labs.

***Requires FP modifier only.

¤See points B and C below for information regarding this procedure code.

B. Laboratory codes payable to **non-hospital-based clinical nurse specialists.**

The following procedure code table contains laboratory services payable to non-hospital-based clinical nurse specialists.

NOTE: The procedure codes with the modifiers indicated below denote the Arkansas Medicaid description.

C. Laboratory codes payable to **hospital-based clinical nurse specialists.**

The following procedure code table describes the laboratory services payable to hospital-based clinical nurse specialists.

NOTE: The procedure codes with the modifiers indicated below denote the Arkansas Medicaid description.

252.438 National Drug Codes (NDCs) 9-1-24

Effective for claims with dates of service on or after January 1, 2008, Arkansas Medicaid implemented billing protocol per the Federal Deficit Reduction Act of 2005. This explains policy and billing protocol for providers that submit claims for drug HCPCS/CPT codes with dates of service on and after January 1, 2008.

The Federal Deficit Reduction Act of 2005 mandates that Arkansas Medicaid require the submission of National Drug Codes (NDCs) on claims submitted with Healthcare Common Procedure Coding System, Level II/Current Procedural Terminology, 4th edition (HCPCS/CPT) codes for **drugs** administered. The purpose of this requirement is to assure that the State Medicaid Agencies obtain a rebate from those manufacturers who have signed a rebate agreement with the Centers for Medicare and Medicaid Services (CMS).

A. Covered Labelers

Arkansas Medicaid, by statute, will only pay for a drug procedure billed with an NDC when the pharmaceutical labeler of that drug is a covered labeler with Centers for Medicare and Medicaid Services (CMS). A “covered labeler” is a pharmaceutical manufacturer that has entered into a federal rebate agreement with CMS to provide each state a rebate for products reimbursed by Medicaid Programs. A covered labeler is identified by the first five (5) digits of the NDC. To assure a product is payable for administration to a Medicaid beneficiary, compare the labeler code (the first five (5) digits of the NDC) to the list of covered labelers which is maintained on the **DHS contracted Pharmacy vendor** website.

A complete listing of **"Covered Labelers"** is located on the website. See Diagram 1 for an example of this screen. The effective date is when a manufacturer entered into a rebate agreement with CMS. The *Labeler termination date* indicates that the manufacturer no longer participates in the federal rebate program and therefore the products cannot be reimbursed by Arkansas Medicaid on or after the *termination date*.

Diagram 1

Labeler ID	Labeler Name	Contract Begin Date	Contract End Date
00002	ELI LILLY AND COMPANY	01/01/1991	01/01/3000
00003	E.R. SQUIBB & SONS, LLC.	01/01/1991	01/01/3000
00004	GENENTECH, INC.	01/01/1991	01/01/3000
00006	MERCK SHARP & DOHME CORP.	01/01/1991	01/01/3000
00007	GLAXOSMITHKLINE LLC	01/01/1991	01/01/3000
00008	WYETH PHARMACEUTICALS LLC,	01/01/1991	01/01/3000
00009	PHARMACIA AND UPJOHN COMPANY LLC	01/01/1991	01/01/3000
00013	PFIZER LABORATORIES DIV PFIZER INC	01/01/1991	01/01/3000
00014	PFIZER, INC	01/01/1991	01/01/3000
00015	MEAD JOHNSON AND COMPANY	01/01/1991	01/01/3000
00023	ALLERGAN INC	01/01/1991	01/01/3000
00024	SANOFI-AVENTIS, US LLC	01/01/1991	01/01/3000
00025	PFIZER LABORATORIES DIV PFIZER INC	01/01/1991	01/01/3000
00026	BAYER HEALTHCARE LLC	01/01/1991	01/01/3000
00032	ABBVIE INC.	01/01/1991	01/01/3000

For a claim with drug HCPCS/CPT codes to be eligible for payment, the detail date of service must be prior to the *NDC termination date*. The NDC termination date represents the shelf-life expiration date of the last batch produced, as supplied on the Centers for Medicare and Medicaid Services (CMS) quarterly update. The date is supplied to CMS by the drug manufacturer or distributor.

Arkansas Medicaid will deny claim details with drug HCPCS/CPT codes with a detail date of service equal to or greater than the NDC termination date.

When completing a Medicaid claim for administering a drug, indicate the HIPAA standard 11-digit NDC with no dashes or spaces. The 11-digit NDC is comprised of three (3) segments or codes: a 5-digit labeler code, a 4-digit product code, and a 2-digit package code. The 10-digit NDC assigned by the FDA printed on the drug package must be changed to the 11-digit format by inserting a leading zero (0) in one (1) of the three (3) segments. Below are examples of the FDA assigned NDC on a package changed to the appropriate 11-digit HIPAA standard format. Diagram 2 displays the labeler code as five (5) digits with leading zeros; the product code as four (4) digits with leading zeros; the package code as two (2) digits without leading zeros, using the "5-4-2" format.

Diagram 2

00123	0456	78
LABELER CODE (5 digits)	**PRODUCT CODE (4 digits)**	**PACKAGE CODE (2 digits)**

NDCs submitted in any configuration other than the 11-digit format will be rejected and denied. NDCs billed to Medicaid for payment must use the 11-digit format without dashes or spaces between the numbers.

See Diagram 3 for sample NDCs as they might appear on drug packaging and the corresponding format which should be used for billing Arkansas Medicaid:

Diagram 3

10-digit FDA NDC on PACKAGE	Required 11-digit NDC (5-4-2) Billing Format
12345 6789 1	12345678901
1111-2222-33	01111222233
01111 456 71	01111045671

B. Drug Procedure Code (HCPCS/CPT) to NDC Relationship and Billing Principles

HCPCS/CPT codes and any modifiers will continue to be billed per the policy for each procedure code. However, the NDC and NDC quantity of the administered drug is now also required for correct billing of drug HCPCS/CPT codes. To maintain the integrity of the drug rebate program, it is important that the specific NDC from the package used at the time of the procedure be recorded for billing. HCPCS/CPT codes submitted using invalid NDCs or NDCs that were unavailable on the date of service will be rejected and denied. We encourage you to enlist the cooperation of all staff members involved in drug administration to assure collection or notation of the NDC from the actual package used. It is not recommended that billing of NDCs be based on a reference list, as NDCs vary from one (1) labeler to another, from one (1) package size to another, and from one (1) time period to another.

Exception: There is no requirement for an NDC when billing for vaccines, radiopharmaceuticals, and allergen immunotherapy.

I. Claims Filing

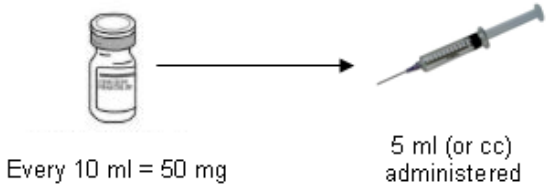
The HCPCS/CPT codes billing units and the NDC quantity do not always have a one-to-one relationship.

Example 1: The HCPCS/CPT code may specify up to seventy-five milligrams (75mg) of the drug whereas the NDC quantity is typically billed in units, milliliters, or grams. If the patient is provided two (2) oral tablets, one at twenty-five milligrams (25mg) and one at fifty milligrams (50mg), the HCPCS/CPT code unit would be 1 (one (1) total of seventy-five milligrams 75mg)) in the example whereas the NDC quantity would be 1 each (one (1) unit of the twenty-five milligram (25mg) tablet and one (1) unit of the fifty milligram (50mg) tablet). See Diagram 4.

Diagram 4

Example 2: If the drug in the example is an injection of five milliliters (5ml) or cc of a product that was fifty milligrams (50mg) per ten milliliters (10ml) of a ten milliliter (10ml) single-use vial, the HCPCS/CPT code unit would be 1 (one (1) unit of twenty-five milligrams (25mg)) whereas the NDC quantity would be 5 (five milliliters (5ml)). In this example, five milliliters (5ml) or twenty-five milliliters (25mg) would be documented as wasted. See Diagram 5. For billing wastage, see bullets A (Electronic Claims Filing) and B (Paper Claims Filing) below.

Diagram 5



HCPCS/CPT Code Unit = 1
(one 25 mg unit of Drug B)

NDC Quantity = 5 for the 5 ml administered

Waste = 5 ml or 25 mg
(for the 5 ml or 25 mg not administered)

A. Electronic Claims Filing – 837P (Professional) and 837I (Outpatient)

Providers are instructed to bill as follows:

- One (1) NDC for a procedure – 1st/only detail shall be billed with no modifier.
- Two (2) NDCs for same procedure – 1st detail shall be billed with a KP and 2nd gets billed with a KQ modifier.
- Three (3) NDCs for same procedure – 1st detail shall be billed with a KP and 2nd & 3rd detail get billed with a KQ modifier.
- Four (4) or more NDCs for same procedure – submit via paper claim.
- Wastage of each NDC shall be billed on a separate line with a JW modifier.

NOTE: The NDCs listed above are not the same (unless with a JW modifier). Same NDCs shall be billed on a single line with appropriate units.

NOTE: CMS definitions of modifiers:

- KP = First drug of a multiple drug unit dose formulation.
- KQ = Second or subsequent drug of a multiple drug unit dose formulation.
- JW = Drug wastage.

B. Paper Claims Filing – CMS-1500

Providers are instructed to bill as follows:

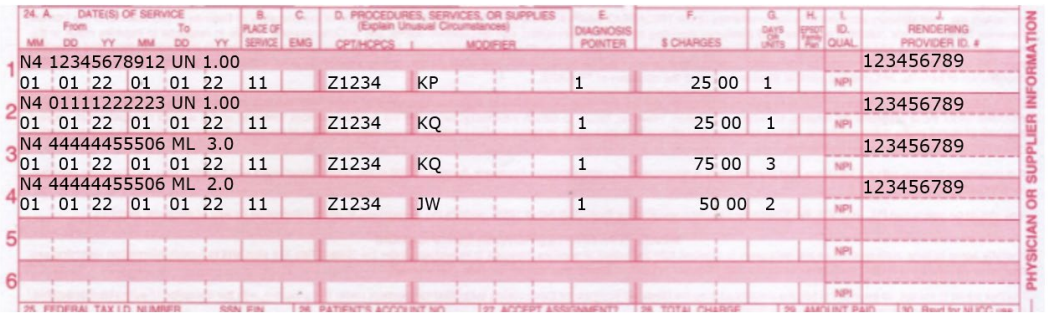
- One (1) NDC for a procedure – 1st/only detail shall be billed with no modifier.
- Two (2) NDCs for same procedure – 1st detail shall be billed with a KP and 2nd gets billed with a KQ modifier.
- Three (3) NDCs for same procedure – 1st detail shall be billed with a KP and 2nd & 3rd detail get billed with a KQ modifier.
- Four (4) or more NDCs for same procedure – 1st detail shall be billed with a KP and 2nd and subsequent details shall be billed with a KQ modifier.
- Wastage of each NDC shall be billed on a separate line with a JW modifier.

NOTE: CMS definitions of modifiers:

- KP = First drug of a multiple drug unit dose formulation.
- KQ = Second or subsequent drug of a multiple drug unit dose formulation.

- JW = Drug wastage.

Diagram 6



	24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL	J. RENDERING PROVIDER ID. #
1	N4 12345678912 UN 1.00											123456789
	01 01 22	01 01 22	11		Z1234	KP	1	25 00	1		NPI	
2	N4 01111222223 UN 1.00											123456789
	01 01 22	01 01 22	11		Z1234	KQ	1	25 00	1		NPI	
3	N4 44444455506 ML 3.0											123456789
	01 01 22	01 01 22	11		Z1234	KQ	1	75 00	3		NPI	
4	N4 44444455506 ML 2.0											123456789
	01 01 22	01 01 22	11		Z1234	JW	1	50 00	2		NPI	
5											NPI	
6											NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN | 26. PATIENT'S ACCOUNT NO. | 27. ACCEPT ASSIGNMENT? | 28. TOTAL CHARGE | 29. AMOUNT PAID | 30. Rsvd for NUCC use | 31. PHYSICIAN OR SUPPLIER INFORMATION

II. Adjustments

Paper adjustments for paid claims filed with NDC numbers will not be accepted. Any original claim will have to be voided and a replacement claim will need to be filed. Providers have the option of adjusting a paper or electronic claim electronically.

III. Record Retention

Each provider must retain all records for five (5) years from the date of service or until all audit questions, dispute or review issues, appeal hearings, investigations or administrative/judicial litigation to which the records may relate are concluded, whichever period is longer.

At times, a manufacturer may question the invoiced amount, which results in a drug rebate dispute. If this occurs, you may be contacted requesting a copy of your office records to include documentation pertaining to the billed HCPCS/CPT code. Requested records may include NDC invoices showing purchase of drugs and documentation showing what drug (name, strength, and amount) was administered and on what date, to the beneficiary in question.

252.439 Billing of Multi-Use and Single-Use Vials 9-1-24

Arkansas Medicaid follows the billing protocol per the Federal Deficit Reduction Act of 2005 for drugs.

A. Multiple units may be billed when applicable. Take-home drugs are not covered. Drugs loaded into an infusion pump are not classified as “take-home drugs.” Refer to payable CPT code ranges.

View or print the procedure codes for Clinical Nurse Specialist and Nurse Practitioner services.

B. When submitting Arkansas Medicaid drug claims, drug units should be reported in multiples of the dosage included in the HCPCS procedure code description. If the dosage given is not a multiple of the number provided in the HCPCS code description the provider shall round up to the nearest whole number in order to express the HCPCS description number as a multiple.

1. **Single-Use Vials:** If the provider must discard the remainder of a **single-use vial** or other package after administering the prescribed dosage of any given drug, Arkansas Medicaid will cover the amount of the drug discarded along with the amount administered. Discarded drugs shall be billed on a separate detail line with a JW (Drug wastage) modifier.

2. **Multi-Use Vials**: Multi-use vials are not subject to payment for any discarded amounts of the drug. The units billed must correspond with the units administered to the beneficiary.

3. **Documentation:** The provider must clearly document in the patient's medical record, the actual dose administered, in addition to the exact amount wasted, and the total amount the vial is labeled to contain.

Remember to verify the milligrams given to the patient and then convert to the proper units for billing.

Follow the Centers for Disease Control (CDC) requirements for safe practices regarding expiration and sterility of multi-use vials.

252.440 Reserved 9-1-24

252.441 Family/Group Psychotherapy 9-1-24

The following psychotherapy procedure codes are payable by the Arkansas Medicaid Program for family or group psychotherapy:

View or print the procedure codes for Clinical Nurse Specialist and Nurse Practitioner services.

Procedure codes are payable when the place of service is the beneficiary's home, the physician's office, a hospital or a nursing home. Procedure codes are payable when the patient is not present; however, the patient may be present during the session, when appropriate.

252.442 Radiology and Laboratory Procedure Codes 9-1-24

The technical component radiology procedure codes listed on the Clinical Nurse Specialist fee schedule are payable when performed in the office place of service (11) if the clinical nurse specialist provider owns the equipment. The technical component must be billed on the claim with modifier TC added to the procedure code on the claim detail.

The payment for laboratory codes listed on the Clinical Nurse Specialist fee schedule is based on Clinical Laboratory Improvement Amendments (CLIA) certification. CLIA-certified providers are not the only providers who may bill for lab procedures performed in the office place of service (11). Clinical nurse specialist providers that bill CLIA-required laboratory procedure codes must have the current CLIA certification on file with the Provider Enrollment Unit.

252.443 Other Covered Injections 9-1-24

Clinical nurse specialists billing the Arkansas Medicaid Program for injections for treatment or immunization purposes should bill the appropriate CPT or HCPCS procedure code for the specific injection provided. The immunization procedure codes and descriptions may be found in the CPT coding book and in this section of this manual.

Providers may bill the immunization procedure codes on either the Child Health Services (EPSDT) DMS-694 claim form or the CMS-1500 form.

If the patient is scheduled for immunization only, the provider will not be permitted to bill for an office visit, but for the immunization only.

The following is an alphabetized list of injections with special instructions for coverage and billing.

View or print the procedure codes for Clinical Nurse Specialist and Nurse Practitioner services.

* Procedure code requires paper billing.

NOTE: Where both a national code and a local code ("Z code") are available, the local code can be used only for dates of service through October 15, 2003; the national code must be used for both electronic and paper claims for dates of service after October 15, 2003. Where only a local code is available, it can be used indefinitely, but it can be billed only on a paper claim. Where only a national code is available, it can be used indefinitely for both electronic and paper claims.

252.444 Billing Procedures for Rabies Immune Globulin and Rabies Vaccine 9-1-24

The following CPT procedure codes are covered for all ages without diagnosis restrictions.

View or print the procedure codes for Clinical Nurse Specialist and Nurse Practitioner services.

These procedure codes require billing on a paper claim with the dosage entered in the units column of the claim form for each date of service. The manufacturer's invoice must be attached to each claim. Reimbursement for each of these procedure codes includes an administrations fee. Medical policy and billing procedures have not changed for these procedure codes.

252.445 Reserved 9-1-24

252.446 Reserved 9-1-24

252.447 Reserved 9-1-24

252.448 Medication Assisted Treatment and Opioid Use Disorder Treatment Drugs 9-1-24

Effective for dates of service on and after **September 1, 2020**, Medication Assisted Treatment for Opioid Use Disorders is available to all qualifying Medicaid beneficiaries when provided by providers who possess an X-DEA license on file with Arkansas Medicaid Provider Enrollment for billing purposes. All rules and regulations promulgated within the Physician's provider manual for provision of this service must be followed.

Effective for dates of services on and after **October 1, 2018**, the following Healthcare Common Procedure Coding System Level II (HCPCS) procedure codes are payable:

View or print the procedure codes for Clinical Nurse Specialist and Nurse Practitioner services.

To access prior approval of these HCPCS procedure codes when necessary, refer to the Pharmacy Memorandums, Criteria Documents and forms found at the **DHS contracted Pharmacy vendor website**.

252.449 Influenza Virus Vaccine 9-1-24

View or print the procedure codes for Clinical Nurse Specialist and Nurse Practitioner services.

A. Procedure code, influenza virus vaccine, split virus, preservative free, for children six to thirty-five (6-35) months of age, is currently covered through the VFC program. Claims for Medicaid beneficiaries must be filed using modifiers **EP** and **TJ**.

For ARKids First-B beneficiaries, use modifier **TJ**.

B. Effective for dates of service on and after October 1, 2005, Medicaid will cover procedure code, influenza virus vaccine, split virus, and preservative free, for three (3) years of age and older.

1. For individuals under nineteen (19) years of age, claims must be filed using modifiers **EP** and **TJ**.
2. For ARKids First-B beneficiaries, use modifier **TJ**.
3. For individuals nineteen (19) years of age and older, no modifier is necessary.

C. Effective for dates of service on and after October 1, 2005, procedure code, influenza virus vaccine, live, for intranasal use, is covered. Coverage is limited to healthy individuals five through forty-nine (5-49) years of age who are not pregnant.

1. When filing claims for children five through eighteen (5-18) years of age, use modifiers **EP** and **TJ**.
2. For ARKids First-B beneficiaries, the procedure code must be billed using modifier **TJ**.
3. No modifier is required for filing claims for beneficiaries nineteen through forty-nine (19-49) years of age.

D. Procedure code, influenza virus vaccine, split virus, for children six through thirty-five (6-35) months of age, is covered. Modifiers **EP** and **TJ** are required.

For ARKids First-B beneficiaries, use modifier **TJ**.

E. Procedure code, influenza virus vaccine, split virus, for use in individuals three (3) years of age and older, will continue to be covered.

1. When filing paper claims for individuals under nineteen (19) years of age, use modifiers **EP** and **TJ**.
2. For ARKids First-B beneficiaries, use modifier **TJ**.
3. No modifier is required for filing claims for beneficiaries nineteen (19) years of age and older.

252.450 Obstetrical Care and Risk Management Services for Pregnancy 9-1-24

Covered clinical nurse specialist obstetrical services are limited to antepartum and postpartum care only. Claims for antepartum and postpartum services are filed using the appropriate office visit CPT procedure code.

A clinical nurse specialist may provide risk management services listed below if he or she receive a referral from the patient's physician or certified nurse-midwife and if the clinical nurse specialist employs the professional staff required. Complete service descriptions and coverage information may be found in Section 214.620 of this manual. The services in the list below are considered to be one (1) service and are limited to thirty-two (32) cumulative units.

View or print the procedure codes for Clinical Nurse Specialist and Nurse Practitioner services.

For an early discharge home visit, use one (1) of the applicable CPT procedure codes.

252.451 Fetal Non-Stress Test 9-1-24

The Fetal Non-Stress Test (procedure code) is limited to two (2) per pregnancy. If it is necessary to exceed this limit, the clinical nurse specialist must request an extension of benefits and submit documentation that establishes medical necessity.

View or print the procedure codes for Clinical Nurse Specialist and Nurse Practitioner services.

252.452 Newborn Care 9-1-24

All newborn services must be billed under the newborn's own Medicaid identification number.

The parent(s) of the newborn will be responsible for applying for and meeting eligibility requirements for a newborn to be certified eligible. 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 Clinical Nurse Specialist and Nurse Practitioner services.

For routine newborn care following a vaginal delivery or C-section, procedure codes must be used one (1) time to cover all newborn care visits by the attending physician, certified nurse-midwife or, if applicable, clinical nurse specialist

The newborn care procedure codes represent the initial Child Health Services (EPSDT) newborn care or screen. This screening includes the physical exam of the baby and the conference(s) with the newborn's parent(s). Payment of these codes is considered a global rate, and subsequent visits may not be billed in addition to these codes.

Procedure codes may be billed on the EPSDT screening paper form DMS-694 or on the electronic claim transaction format. These codes may also be filed on the CMS-1500; paper or electronically. For information on the Child Health Service (EPSDT) Program, call the Provider Assistance Center. **View or print Provider Assistance Center contact information.**

For illness care (such as neonatal jaundice), use procedure codes. Do not use procedure codes in addition to these codes.

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.

ARKids A (EPSDT) requires an EPSDT claim form or CMS-1500 claim form and may be billed electronically or on paper.

ARKids First B requires a CMS-1500 claim form and may be billed electronically or on paper.

252.453 Fluoride Varnish Treatment 9-1-24

View or print the procedure codes for Clinical Nurse Specialist and Nurse Practitioner services.

The American Dental Association (ADA) procedure code is covered by the Arkansas Medicaid Program. This code is payable for beneficiaries under twenty-one (21) years of age. Topical fluoride varnish application benefit is covered every six (6) months plus one (1) day for beneficiaries under twenty-one (21) years of age.

A new specialty code, FC-Fluoride Certification will be tied to provider types 01, 03, 58, and 69. These providers must send proof of their fluoride varnish certification to DHS or its designated vendor before the specialty code will be added to their file in the MMIS. **View or print contact information to obtain the DHS or designated vendor step-by-step process for provider enrollment.** After the specialty code, FC-Fluoride Certification, is added to the provider's file, the provider will be able to bill for procedure code, Topical Application of Fluoride Varnish.

Providers must check the Supplemental Eligibility Screen to verify that the topical fluoride varnish benefit of two (2) per State Fiscal Year (SFY) has not been exhausted. If further treatment is

needed due to severe periodontal disease, then the beneficiary must be referred to a Medicaid dental provider.

NOTE: This service is billed on form CMS-1500 with ADA procedure code (Topical application of fluoride varnish (prophylaxis not included) – child (ages 0-20)). View a form CMS-1500 sample form.

252.454 Tobacco Cessation Products and Counseling Services 9-1-24

A. Tobacco cessation counseling and products are covered services to eligible Medicaid beneficiaries. Tobacco cessation products either prescribed or initiated through statewide pharmacist protocol are available without prior authorization (PA) to eligible Medicaid beneficiaries. Additional information can be found on the **DHS Contracted Pharmacy Vendor website** or in the **Prescription Drug Program Prior Authorization Criteria.**

View or print the procedure codes for Clinical Nurse Specialist and Nurse Practitioner services.

*Exempt from PCP referral requirements.

⁂**(…)** This symbol, along with text in parentheses, indicates the Arkansas Medicaid description of the service. When using a procedure code with this symbol, the service must meet the indicated Arkansas Medicaid description.

B. Two (2) Counseling visits per state fiscal year.

C. Health education can include but is not limited to tobacco cessation counseling services to the parent or legal guardian of the child.

D. Can be billed in addition to an office visit or EPSDT.

E. Sessions do not require a PCP referral.

F. If the beneficiary is under eighteen (18) years of age, and the parent or legal guardian smokes, they can be counseled as well, and the visit billed under the minor's beneficiary Medicaid number. The provider cannot prescribe meds for the parent under the child's Medicaid number. A parent or legal guardian session will count towards the four (4) counselling sessions limit described in section C above.

The provider must complete the counseling checklist and place in the patient records for audit. A copy of the checklist is available at **View or Print Be Well Arkansas Referral Form**.

252.455 Physical Therapy Services Billing 9-1-24

Occupational therapy evaluations and services are payable only to a qualified occupational therapist. Physical therapy evaluations are payable to the clinical nurse specialist. Physical therapy may be payable to the physician when directly provided in accordance with the Occupational, Physical, Speech Therapy Services Manual. The following procedure codes must be used when filing claims for physician provided therapy services. See Glossary - Section IV - for definitions of "group" and "individual" as they relate to therapy services.

View or print the procedure codes for Clinical Nurse Specialist and Nurse Practitioner services.

A provider must furnish a full unit of service to bill Medicaid for a unit of service. Partial units are not reimbursable. Extended therapy services may be requested for physical and speech therapy, if medically necessary, for eligible Medicaid beneficiaries of all ages.

252.456 Laboratory Procedures for Highly Active Antiretroviral Therapy (HAART) 9-1-24

The following CPT procedure codes are covered for Medicaid beneficiaries.

View or print the procedure codes for Clinical Nurse Specialist and Nurse Practitioner services.

252.457 Procedures That Require Prior Authorization 9-1-24

A. The following procedure code requires prior authorization by the Arkansas Foundation for Medical Care (AFMC). (See Section 220.000 of this manual for prior authorization instructions.)

B. The following Molecular Pathology codes require prior authorization from AFMC.

View or print the procedure codes for Clinical Nurse Specialist and Nurse Practitioner services.

252.458 Substitute Clinical Nurse Specialist 9-1-24

To comply with Section 4708 of the Omnibus Budget Reconciliation Act of 1990 (OBRA 90), the Arkansas Medicaid Program implemented the following requirements to adhere to **locum tenens clinical nurse specialist** and **substitute clinical nurse specialist** billing and coverage policies and procedures.

A. Description of Service

Locum tenens and substitute clinical nurse specialist are terms used to describe the relationship of a clinical nurse specialist who is acting as a fill-in for a beneficiary's regular clinical nurse specialist. The regular clinical nurse specialist could be a specialist the beneficiary sees regularly for a chronic condition or a specific problem. A locum tenens or substitute clinical nurse specialist must be the same discipline as the clinical nurse specialist. Documentation of the locum tenens arrangement must include the services provided, the date the services were performed and must be made available upon request. A record of the service would include the date and place of the service, the procedure code, the charge, and the beneficiary involved.

B. Substitute Clinical Nurse Specialist

A substitute clinical nurse specialist is a clinical nurse specialist who is asked by the regular clinical nurse specialist to see a beneficiary in a reciprocal arrangement when the regular clinical nurse specialist is unavailable to see the beneficiary. In the substitute clinical nurse specialist arrangement, the regular clinical nurse specialist reciprocates the substitute clinical nurse specialist by paying the substitute the amount received for the service rendered or by serving in the same capacity in return. For this provision to occur, both the regular and the substitute clinical nurse specialist must be enrolled in Arkansas Medicaid.

The following billing protocol must be utilized for substitute clinical nurse specialist circumstances:

1. The regular clinical nurse specialist office submits the claim and receives payment using the regular Arkansas Medicaid provider number. The payment amount will be the lesser of the billed amount or the Arkansas Medicaid allowed amount for the service provided.
2. The modifier Q5 must be placed in form indicator 24D of the CMS-1500 claim form to indicate services were rendered by a substitute clinical nurse specialist.

3. The substitute clinical nurse specialist arrangement should not exceed fourteen (14) consecutive days. The substitute clinical nurse specialist arrangement does not apply to substitution for clinical nurse specialists in the same medical group with claims submitted in the name of the medical group. (For situations in which a group member substitutes for another, the substitution is noted by listing the substitute group member number as the rendering provider in field 24J on the CMS-1500 claim form, and the Q5 modifier is **not** used. The **group number** is listed as the billing provider.)

C. Locum Tenens Clinical Nurse Specialists

A locum tenens arrangement is made when the regular clinical nurse specialist must leave his/her practice due to illness, vacation, or medical education opportunity and does not want to leave patients without service during this period. The locum tenens clinical nurse specialist usually has no practice of his or her own and moves from area to area as needed. The clinical nurse specialist is usually paid a fixed amount per diem with the status of an independent contractor, not an employee. The locum tenens clinical nurse specialist must meet all state, hospital, and other institutional credentialing requirements. The locum tenens clinical nurse specialist is required to be enrolled in Arkansas Medicaid.

Documentation of the locum tenens arrangement must include the services provided by the locum tenens and when those services were performed and must be made available upon request. A record of the service would include the date and place of the service, the procedure code, the charge, and the beneficiary involved.

The following billing protocol must be utilized for locum tenens clinical nurse specialist circumstances:

1. The regular clinical nurse specialist's office submits their claims for locum tenens services using the regular nurse practitioner's provider identification number.
2. Modifier Q6 is placed in the indicator 24D of the CMS-1500 claim form to indicate services were provided by a locum tenens clinical nurse specialist. The payment amount is the lesser of the billed amount or the Arkansas Medicaid allowed amount for the service provided.
3. Locum tenens arrangements should not exceed sixty (60) days. If a clinical nurse specialist is away more than sixty (60) days, additional locum tenens can be used to fill in for different 60-day periods. This means that various clinical nurse specialists would be required to fill in for different 60-day time periods. Locum tenens is not designed to fill clinical nurse specialist vacancies within a practice.

Exception: In accordance with Public Law 110-173, the exception to the 60-day limit on substitute clinical nurse specialist billing occurs when a clinical nurse specialist is ordered to active military duty in the Armed Forces.

See the table below which compares the requirements for substitute and locum tenens clinical nurse specialists according to Arkansas Medicaid Policy.

REQUIREMENT	SUBSTITUTE Clinical Nurse Specialist	LOCUM TENENSClinical Nurse Specialist
Must be enrolled as an Arkansas Medicaid Provider	Yes	Yes
May be enrolled by the same group as the regular clinical nurse specialist	No	No

REQUIREMENT	SUBSTITUTE Clinical Nurse Specialist	LOCUM TENENSClinical Nurse Specialist
Claims are submitted by the regular clinical nurse specialist's office and that office receives payment	Yes	Yes
Modifier required to identify arrangement	Yes, Q5	Yes, Q6
May use the regular clinical nurse specialist's certification code for PCP authorization	Yes	Yes
Maximum time frame allowed	14 days	60 days

252.460 Outpatient Hospital Services

252.461 Emergency Services 9-1-24

The appropriate CPT procedure codes should be used when billing for clinical nurse specialist visits in an outpatient hospital setting for emergency services.

252.462 Non-Emergency Services 9-1-24

Procedure code should be billed for a non-emergency clinical nurse specialist visit.

View or print the procedure codes for Clinical Nurse Specialist and Nurse Practitioner services.

252.463 Outpatient Hospital Surgical Procedures 9-1-24

For consideration of any claims with payable CPT or HCPCS unlisted procedure codes, the provider must submit a paper claim that includes a description of the service that is being represented by that unlisted code on the claim form. Documentation that further describes the service provided must be attached and must include justification for medical necessity.

All other billing requirements must be met in order for payment to be approved.

252.464 Multiple Surgery 9-1-24

If multiple surgical procedures are done on the same date of service, but not in the same operative session, each should be coded in the "Procedures, Services or Supplies" field as a separate procedure.

252.465 Observation Status 9-1-24

When claims are filed for services provided to a patient in "observation status," clinical nurse specialists must adhere to Arkansas Medicaid definitions of inpatient and outpatient. Observation status is an outpatient designation. Clinical Nurse Specialists must also follow the guidelines and definitions in *Current Procedural Terminology* (CPT), under "Hospital Observation Services" and "Evaluation and Management Services Guidelines."

Arkansas Medicaid criteria determining inpatient and outpatient status:

A. If a patient is expected to remain in the hospital for less than twenty-four (24) consecutive hours, and this expectation is realized, the hospital and the clinical nurse specialist should consider the patient an outpatient (meaning the patient is an outpatient unless the clinical nurse specialist's supervising physician has admitted them as an inpatient).

B. If the clinical nurse specialist or hospital expects the patient to remain in the hospital for twenty-four (24) hours or more, Medicaid deems the patient admitted at the time the patient's medical record indicates the existence of such an expectation, though the clinical nurse specialist's supervising physician has not yet formally admitted the patient.

C. Medicaid also deems a patient admitted to inpatient status at the time they have remained in the hospital for twenty-four (24) consecutive hours, even if the clinical nurse specialist's supervising physician or hospital had no prior expectation of a stay of that or greater duration.

252.466 Billing Examples 9-1-24

The following table gives examples of appropriate clinical nurse specialist claims for several common hospital scenarios. In the table, instructions under the headings "CLINICAL NURSE SPECIALIST MAY BILL…" do not necessarily include all services that the clinical nurse specialist may bill. For instance, the provider may bill for interpretation of X-rays or diagnostic tests, though the table below does not indicate this. The purpose of this table is to illustrate Arkansas Medicaid observation status policy and to give guidance for filing claims related to evaluation and management services.

ARKANSAS MEDICAID OBSERVATION STATUS POLICY ILLUSTRATION

PATIENT IS ADMITTED TO OBSERVATION	PATIENT IS	CLINICAL NURSE SPECIALIST MAY BILL FOR TUESDAY SERVICES:	CLINICAL NURSE SPECIALIST MAY BILL FOR WEDNESDAY SERVICES:
Tuesday, 3:00 PM	Still in Observation Wednesday, 3:00 PM	Appropriate level of Initial Observation Care	Appropriate level of Initial Hospital Care
Tuesday, 3:00 PM	Discharged Wednesday, 12:00 PM (noon)	Appropriate level of Initial Observation Care	Observation care Discharge Day Management
Tuesday, 3:00 PM	Discharged Wednesday, 4:00 PM	Appropriate level of Initial Observation Care	Appropriate level of Initial Hospital Care
Tuesday, 3:00 PM, after outpatient surgery	Discharged Wednesday, 10:00 AM	Outpatient surgery	No evaluation and Management Services
Tuesday, 3:00 PM, after exam in Emergency Department– emergency or non-emergency	Discharged Tuesday, 7:00 PM	Appropriate level of Initial Observation Care	Not Applicable; Patient was Discharged Tuesday

252.470 Prior Authorization Control Number 9-1-24

When billing for procedures that have been prior authorized, the 10-digit prior authorization control number must be entered in the CMS-1500 claim format. See Section 220.000 of this manual for additional information on prior authorization.

252.480 Medicare 9-1-24

When a beneficiary is dually eligible for Medicare and Medicaid and is provided services that are covered by both Medicare and Medicaid, Medicaid will not reimburse for those services if Medicare has not been billed prior to Medicaid billing. The beneficiary cannot be billed for the charges. See Section 142.700 for detailed information regarding Medicare participation and Sections 332.000 through 332.300 for detailed information regarding Medicare-Medicaid Crossover claims procedures.

252.481 Services Prior to Medicare Entitlement 9-1-24

Services that have been denied by Medicare with the explanation "Services Prior to Medicare Entitlement" may be filed with Medicaid. These services should be filed on the CMS-1500 claim form for processing and forwarded to the Inquiry Unit. **View or print the Inquiry Unit contact information**.

These services usually can be filed electronically unless they are covered by Medicare and the beneficiary was 65 or older on the date of service. It may be necessary to attach a copy of the Medicare denial to the claim.

A note of explanation should accompany these claims in order that they may receive special handling.

252.482 Services Not Medicare Approved 9-1-24

Services that are not Medicare approved for patients with joint Medicare/Medicaid coverage usually are not payable by Medicaid unless they are services that are not covered by Medicare, but are covered by Medicaid. There are exceptions and those may require special handling.

252.483 Drug Treatment for Pediatric PANS and PANDAS 9-1-24

A. Effective for dates of service on and after 6/1/2022 drug treatment will be available to all qualifying Arkansas Medicaid beneficiaries when specified conditions are met for one (1) or both of the following conditions:

   1. Pediatric acute-onset neuropsychiatric syndrome (PANS),
   2. Pediatric autoimmune neuropsychiatric disorders associated with streptococcal infections (PANDAS).

B. The drug treatments include off-label treatments, including without limitation intravenous immunoglobulin (IVIG).

C. Medicaid will cover drug treatment for PANS or PANDAS under the following conditions:

   1. The drug treatment must be authorized under a Treatment Plan; and
   2. The Treatment Plan must be established by the approved PANS/PANDAS provider.

D. A Prior Authorization (PA) must be obtained for each treatment. Providers must submit the current Treatment Plan to the Quality Improvement Organization (QIO) along with the request for Prior Authorization. **View or print contact information for the QIO.**

E. The authorized procedure codes and required modifiers are found in the following link:

View or print the procedure codes for Clinical Nurse Specialist and Nurse Practitioner services, including PANS and PANDAS procedure codes.

252.484 Injections, Therapeutic, and Diagnostic Agents 9-1-24

Clinical nurse specialists shall administer injections, therapeutic, and diagnostic agents in accordance with the rules set forth in the Arkansas Medicaid Physician's policy manual and within the scope of their practice guidelines.

View or print the procedure codes for Clinical Nurse Specialist and Nurse Practitioner services.

TOC not required

214.000 PCP Referral Requirements

~~4-1-09~~9-1-24

The primary care ~~physician~~ provider (PCP), the PCP entity (e.g., FQHC), or a medically qualified member of the PCP's staff must administer the periodic complete medical screen, or the PCP may make a referral to another qualified Medicaid provider to administer the screen. Qualified Medicaid providers to whom referrals may be made include Medicaid-enrolled nurse practitioners, clinical nurse specialists, physician assistants, and school based providers certified as comprehensive screening providers. Routine newborn care, dental screens, visual screens, hearing screens and immunizations for childhood diseases are exempt from this referral requirement.

242.100 Procedure Codes

~~2-1-22~~9-1-24

The table below contains procedure codes, the associated modifiers to be used with the individual code, and a description of each EPSDT service.

View or print the procedure codes and modifiers for Child Health Services/Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) services.

⁂**(…)** This symbol, along with text in parentheses, indicates the Arkansas Medicaid description of the service. When using a procedure code with this symbol, the service must meet the indicated Arkansas Medicaid description.

Other coding information found in the chart:

[1] Exempt from PCP referral requirements
[2] Covered when specimen is referred to an independent lab

Electronic and paper claims require use of modifiers. When filing paper claims for a Child Health Services (EPSDT) screening service, the applicable modifier must be entered on the claim form.

See Section 212.000 for Child Health Services (EPSDT) screening terminology.

NOTES

A. Arkansas Medicaid is no longer able to process both a sick visit and an EPSDT screening visit when performed on the same date of service without the appropriate modifier (Modifier 25). Modifier 25 must be indicated in the first position of the second billed service. This change surpasses the Medicaid policy to not bill modifiers on a sick visit when performed on the same date of service as an EPSDT screening.

B. New born screenings can be performed by a Certified Nurse Midwife, Physician Assistant, Clinical Nurse Specialist, or Nurse Practitioner without a PCP referral.

C. Procedure codes, used in conjunction with the **EP and H9 modifiers,** are to be used only for the required intake physical examination for Medicaid beneficiaries in the Arkansas foster care system. (See Section 214.300 for more information.)

D. Claims for EPSDT medical screenings must be billed electronically or by using the CMS-1500 claim form. M**ay be billed on the CMS-1500 claim form, by paper or electronically. (View or print a CMS-1500 sample form.) May also be billed as EPSDT in the electronic transaction format or on the CMS-1500 paper form.**

E. Laboratory/X-ray and immunizations associated with a Child Health Services (EPSDT) screen may be billed on the CMS-1500 claim form.

F. Immunizations and laboratory tests may be billed separately from comprehensive screens.

G. The verbal assessment of lead toxicity risk is part of the complete Child Health Services (EPSDT) screen. The cost for the administration of the risk assessment is included in the fee for the complete screen.

H. May be used for billing in the office place of service (11) for the administration of subcutaneous or IM injections ONLY when the provider administers, but does not supply the drug.

1. Cannot be billed when the medication is administered orally. No fee is billable for drugs administered orally.
2. Cannot be billed to administer any medication given for family planning purposes.
3. Cannot be billed when the drug administered is not FDA approved.

I. Procedure code is payable to physicians for supplies and materials (except eyeglasses), provided by the physician over and above those usually included with the office visit or other services rendered. Procedure code must not be billed for the provision of drug supply samples and may not be billed on the same date of service as a surgery code. Claims require National Place of Service code “11”. Procedure code is limited to beneficiaries under age twenty-one (21).

TOC not required

212.200 FQHC Core Services

~~1-1-22~~9-1-24

Covered FQHC core services are:

A. Physician services;

B. Services and supplies incidental to physician services (including drugs and biologicals that cannot be self-administered);

C. Pneumococcal vaccine and its administration and influenza vaccine and its administration;

D. Services provided by physician assistants, nurse practitioners, clinical nurse specialists, clinical psychologists, clinical social workers, licensed certified social workers, licensed professional counselors, licensed mental health counselors, and licensed marriage and family therapists;

E. Services and supplies incidental to physician assistant, nurse practitioner, clinical nurse specialists, clinical psychologist, clinical social worker, licensed certified social worker, licensed professional counselor, licensed mental health counselor, and licensed marriage and family therapist services as would otherwise be covered if furnished by or incidental to physician services; and

F. ~~Part-time or intermittent nursing care and related medical supplies to a homebound individual, in the case of those FQHCs that are located in an area in which the Secretary of the Department of Health and Human Services has determined there is a shortage of home health agencies.~~ Part-time or intermittent nursing care and related medical supplies (home health) which meets the definition found at 42 CFR 440.70.

212.220 Services Furnished in Collaboration with a Physician

~~2-1-24~~9-1-24

Nurse practitioner and clinical nurse specialist services are performed in collaboration with a physician or physicians. Physician Assistant services are performed under the direction of the physician.

A. Collaboration is a process in which a nurse practitioner, physician assistant, or clinical nurse specialist works with one (1) or more physicians to deliver health care services within the scope of the practitioner's expertise, with medical direction, and appropriate supervision as provided for in jointly developed guidelines or other mechanisms as provided by State law.

B. The collaborating physician does not need to be present with the nurse practitioner when the services are furnished or to make an independent evaluation of each patient who is seen by the nurse practitioner.

C. Medication Assisted Treatment (MAT) for Opioid or Alcohol Use Disorders is available to all qualifying Medicaid beneficiaries. All rules and regulations promulgated within the Physician's provider manual for provision of this service must be followed.

212.230 Services and Supplies "Incident To" a Nurse Practitioner's or Physician Assistant's Services

~~10-13-03~~9-1-24

A. Services and supplies "incident to" a nurse practitioner's , clinical nurse specialist's, or physician assistant's service are covered if the service or supply is:

1. Of a type commonly furnished in physicians'' offices;
2. Of a type commonly furnished either without charge or included in the FQHC's bill;
3. Furnished as an incidental, although integral, part of the professional services furnished by a nurse practitioner, clinical nurse specialist, or physician assistant;
4. In the case of a service, furnished by a member of the clinic's health care staff who is an employee of the clinic and
5. Furnished under the direct supervision of a nurse practitioner, physician assistant, clinical nurse specialist, or a physician as follows:
   a. The nurse practitioner, clinical nurse specialist, physician assistant or physician must be physically present (under the same roof and immediately available for consultation) when the services are furnished and
   b. A nurse practitioner, clinical nurse specialist, or physician assistant may fill this supervisory function only if such a person is permitted to supervise such services under state law and the written policies governing the FQHC.

B. Only drugs and biologicals that cannot be self-administered are included within the scope of this benefit.

214.100 Definition of an FQHC "Core Service" Encounter

~~1-1-22~~9-1-24

A Federally Qualified Health Center (FQHC) "core service" encounter is a face-to-face contact between a patient of the FQHC and a physician, physician assistant, clinical nurse specialist, nurse practitioner, licensed clinical psychologist, licensed clinical social worker, licensed professional counselor, licensed mental health counselor, or licensed marriage and family therapist and includes services and supplies incidental to the face-to-face contact.

220.000 Benefit Limits

~~2-1-24~~9-1-24

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;~~.~~
8. Physician assistant services; and
9. Clinical nurse specialist 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. Family planning surgeries and encounters do not count against the FQHC encounter benefit limit.
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

210.160 Treatment Plan

~~19~~-1-2~~34~~

A plan that is developed in cooperation with the client to deliver specific mental health services to restore, improve, or stabilize the client's mental health condition. Treatment Plans must be updated annually or more frequently if circumstances or needs change significantly, or if the client requests.

Treatment Plans can only be developed by the following clinicians:

A. Independently Licensed Clinicians (Masters/Doctoral)

B. Non-independently Licensed Clinicians (Masters/Doctoral)

C. Advanced Practice Nurse (APN) / Clinical Nurse Specialist

D. Physician

TOC not required

206.000 Documentation of Services ~~79~~-1-~~17~~24

Home Health providers must maintain the following records for patients of all ages; see Section 218.000 for additional documentation guidelines regarding physical therapy for patients under the age of 21. Additional information regarding documentation of services is located in Section 140.000 of this manual.

A. Signed and dated patient assessments and plans of care, including physical therapy evaluations and treatment plans when applicable.

B. Signed and dated case notes and progress notes from each visit by nurses, aides, physical therapy assistants and physical therapists.

C. Signed and dated documentation of pro re nata (PRN) visits, which must include the following:

1. The medical justification for each such unscheduled visit.
2. The patient's vital signs and symptoms.
3. The observations of and measures taken by agency staff and reported to the physician.
4. The physician's comments, observations, and instructions.

D. Verification, by means of physician or approved non-physician practitioner documentation, that there was a face-to-face encounter with the beneficiary that meets the following requirements:

1. For the initiation of home health services, the face-to-face encounter must be related to the primary reason the beneficiary requires home health services and must occur within the 90 days before or within 30 days after the start of services.
2. For the initiation of medical equipment, the face-to-face encounter must be related to the primary reason the beneficiary requires medical equipment and must occur no more than 6 months prior to the start of services.
3. The face-to-face encounter may be conducted by one of the following practitioners:
   a. The primary care ~~physician~~provider~~.~~;
   b. A nurse practitioner working in collaboration with the primary care ~~physician~~provider;~~.~~
   c. A certified nurse midwife by the scope of practice;~~.~~
   d. A physician assistant under the supervision of the primary care physician according to Arkansas Medicaid physician policy. Physician assistant services are services furnished according to AR Code § 17-105-101 (2012) and rules and regulations issued by the Arkansas State Medical Board. Physician assistants are dependent medical practitioners practicing under the supervision of the physician for which the physician takes full responsibility;~~. The service is not considered to be separate from the physician's service.~~
   e. For beneficiaries admitted to home health immediately after an acute or post-acute stay, the attending acute or post-acute physician; or~~.~~
   f. A clinical nurse specialist working in collaboration with the primary care provider.
4. The allowed non-physician practitioner performing the face-to-face encounter must communicate the clinical findings of that face-to-face to the ordering physician or

PCP. Those clinical findings must be incorporated into a written or electronic document included in the beneficiary's medical record.

5. To assure clinical correlation between the face-to-face encounter and the associated home health services, the PCP or physician ordering the services must:
   a. Document the face-to-face encounter, which is related to the primary reason the patient requires home health services, occurred within the required timeframes prior to the start of home health services.
   b. Must indicate the practitioner who conducted the encounter and the date of the encounter.
6. The face-to-face encounter may occur through telemedicine when applicable to the program manual of the performing provider of the encounter.

E. No payment may be made for medical equipment, supplies, or appliances to the extent that a face-to-face encounter requirement would qualify as a durable medical equipment (DME) claim under the Medicare program unless the ~~primary care physician~~PCP or allowed non-physician practitioner documents a face-to-face encounter with the beneficiary consistent with the requirements. The face-to-face encounter may be performed by any of the practitioners described in (D) 3 of this section with the exception of ~~the~~ nurse midwives.

F. Copies of current signed and dated plans of care, including interim and short-term plan-of-care modifications, in each patient's medical records.

G. Copies of plans of care, PCP referrals, case notes, etc., for all previous episodes of care within the period of required record retention.

H. The registered nurse's instructions to home health aides, detailing the aide's duties at each visit.

I. The registered nurse's (or physical therapist's when applicable) notes from supervisory visits.

TOC not required

202.000 Hospital and CAH Medical Record Requirements

~~8-1-05~~9-1-24

A. Hospitals and CAHs must maintain a medical record for each inpatient and outpatient.

1. Medical records must be accurately written, promptly completed, properly filed and retained and accessible.
2. The facility's system of author identification and record maintenance must ensure the integrity of the authentication and protect the security of all recorded entries.

B. The medical record must

1. Justify admission and continued hospitalization,
2. Support the diagnosis and
3. Describe the patient's progress and response to medications and services.

C. All entries must be legible and complete and must be authenticated and dated promptly by the person (identified by name and discipline) who is responsible for ordering, providing, or evaluating the service furnished.

1. The author of each entry must be identified and must authenticate his or her entry.
2. Authentication may include signatures, written initials, or computer entry.

D. All records must document the following, as appropriate:

1. Required primary care ~~physician~~ provider (PCP) or other referrals, when applicable
2. A physical examination, including a health history, performed no more than seven (7) days before admission or within forty-eight (48) hours after admission
3. Admitting diagnosis
4. Results of all consultative evaluations of the patient and appropriate findings by clinical and other staff involved in the care of the patient
5. Documentation of complications, hospital-acquired infections and unfavorable reactions to drugs and anesthesia
6. Properly executed informed consent forms for procedures and treatments specified by the medical staff, or by federal or state law when applicable, to require written patient consent
7. All practitioners' orders, nursing notes, reports of treatment, medication records, radiology and laboratory reports, vital signs and other information necessary to monitor the patient's condition
8. Discharge summary with outcome of hospitalization, disposition of case and provisions for follow-up care
9. Final diagnosis with completion of medical records within 30 days following discharge

215.040 Benefit Limit in Outpatient Diagnostic Laboratory and Radiology/Other Procedures

~~7~~9-1-2~~2~~4

A. Arkansas Medicaid limits claims payment for outpatient diagnostic laboratory services and radiology/other services per beneficiary twenty-one (21) years of age or older.

1. The benefit limits are based on the State Fiscal Year (SFY: July 1 through June 30).
2. Diagnostic laboratory services benefits are limited to five hundred dollars ($500) per SFY, and radiology/other services benefits are limited to five hundred dollars ($500) per SFY.
3. Radiology/other services include without limitation diagnostic X-rays, ultrasounds, and electronic monitoring or machine tests, such as electrocardiograms (ECG or EKG).
4. Diagnostic laboratory services and radiology/other services defined as Essential Health Benefits by the U.S. Preventive Services Task Force (USPSTF) are exempt from counting toward either of the two ~~new~~ annual caps.

View or print the essential health benefit procedure codes.

B. The benefit limits apply to claims payments made to the following providers, individually or in any combination: outpatient hospitals, independent laboratories, physicians, osteopaths, podiatrists, Certified Nurse-Midwives (CNMs), Nurse Practitioners (NP), Physician Assistants, Clinical Nurse Specialists, and Ambulatory Surgical Centers (ASCs).

C. Requests for extensions of both benefits are considered for beneficiaries who require supportive treatment for maintaining life.

D. Extension of these benefits are automatic for patients whose primary diagnosis for the service furnished is in the following list:

1. Malignant neoplasm (**View ICD Codes**);
2. HIV infection and AIDS (**View ICD Codes**);
3. Renal failure (**View ICD Codes**);
4. Pregnancy* (**View ICD Codes**): or
5. Opioid Use Disorder (OUD) when treated with Medication Assisted Treatment (MAT). (**View ICD OUD Codes**) Designated laboratory tests will be exempt from the laboratory services benefit limit when the diagnosis is OUD (**View Laboratory and Screening Codes**).

E. *Obstetric (OB) ultrasounds and fetal non stress tests have benefit limits that are not exempt from Extension of Benefits request requirements. (See Section 215.041 for additional coverage information.)

F. Magnetic Resonance Imaging (MRI) is exempt from the five-hundred-dollar radiology/other services benefit limit. Medical necessity for each MRI must be documented in the beneficiary's medical record. (Refer to Section 270.000 for billing information.)

G. Cardiac catheterization procedures are exempt from the five-hundred-dollar outpatient diagnostic laboratory services benefit limit and the five-hundred-dollar radiology/other benefit limit. Medical necessity for each procedure must be documented in the beneficiaries' medical record.

H. There are no benefit limits on outpatient diagnostic laboratory services or radiology/other services for beneficiaries under twenty-one (21) in the Child Health Services/Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Program, except for the limitations on fetal echography (ultrasound) and fetal non-stress tests.

*OB ultrasounds and fetal non stress tests are not exempt from Extension of Benefits. See Section 215.041 for additional coverage information.

A. Arkansas Medicaid encourages reproductive health and family planning by reimbursing physicians, nurse practitioners, physician assistants, clinical nurse specialists, clinics, and hospitals for a comprehensive range of family planning services.

1. Family planning services do not require a PCP referral.
2. Medicaid beneficiaries' family planning services benefits are in addition to their other medical benefits~~,~~ when providers bill the services specifically as family planning services.
3. Abortion is not a family planning service in the Arkansas Medicaid Program.

B. Hospitals desiring to participate in the Medicaid Family Planning Services Program may do so by providing the services listed in Sections 216.100-216.110, 216.130-216.132, 216.500-216.515, and 216.540-216.550 to Medicaid beneficiaries of childbearing age.

C. Hospitals preferring not to provide family planning services may share with their patients other sources for these services. DHS County Offices maintain listings of local and area providers qualified to provide family planning services. Listed providers include:

1. Arkansas Department of Health local health units
2. Obstetricians and gynecologists
3. Nurse practitioners
4. Rural Health Clinics
5. Federally Qualified Health Centers
6. Family planning clinics
7. Physician Assistants
8. Clinical Nurse Specialists

D. Complete billing instructions for family planning services are in Sections 216.100-216.110, 216.130-216.132, 216.500-216.515, and 216.540-216.550 of this manual.

TOC not required

212.000 Scope

~~6-7-10~~9-1-24

Hyperalimentation services are provided to beneficiaries at their place of residence. "Place of residence" is defined as the beneficiary's own dwelling, an apartment, a relative's home or a boarding home. Hyperalimentation services in the beneficiary's place of residence may be covered only when the therapy is determined to be medically necessary for the patient and is prescribed by a physician, physician assistant, advanced practice registered nurse (APRN), or clinical nurse specialist.

Hospitalization is required to initiate parenteral and enteral, sole source nutrition.

Enteral (sole source) nutrition therapy must meet the criteria listed above and be the sole source of nutrition ~~in order~~ to be covered by Medicaid.

The request for prior authorization for therapy must be submitted on the form DMS-2615. **View or print form DMS-2615 and instructions for completion.** The prescribing physician, physician assistant, advanced practice registered nurse (APRN), or clinical nurse specialist must document the beneficiary's diagnosis and brief medical history that supports the medical necessity of the requested nutritional therapy services. The prescription must specify the frequency, the route, the product name, volume and duration of the requested nutritional therapy.

Documentation describing the beneficiary's or caregiver's training in catheter care; solution preparation and infusion technique to ensure the prescribed therapy can be provided safely and effectively in the beneficiary's place of residence must be available upon request. Hospital records documenting the initiation of parenteral or enteral sole source nutrition must be submitted with the initial prior authorization request for these services.

The Arkansas Medicaid Program does not cover enteral (sole source) nutrition therapy hyperalimentation services for patients residing in a long~~-~~term care facility. Enteral (sole source) nutrition therapy services are included in the per diem amount paid to long term care facilities. Arkansas Medicaid does cover parenteral nutrition therapy services through the Hyperalimentation Program for long term care facility residents.

222.000 Request for Prior Authorization

~~8-1-21~~9-1-24

Requests for prior authorization originate with the provider. The provider is responsible for obtaining the required medical information and necessary prescription information needed for completion of the Request for Prior Authorization and Prescription Form. **View or print form DMS-2615 and instructions for completion**. This form must be signed and dated by the prescribing physician, physician assistant, advanced practice registered nurse (APRN), or clinical nurse specialist.

The request for prior authorization will be reviewed by the Department of Human Services (DHS) or its designated vendor. The documentation submitted with the prior authorization request must support the medical necessity of the requested nutritional therapy. In some cases, additional information may be requested (i.e., original prescription, records from the hospitalization initiating nutritional therapy, nutritional assessment to establish medical necessity for nutritional therapy, etc.).

222.100 Approvals of Prior Authorization Requests

~~8-1-21~~9-1-24

When the PA request is approved, a prior authorization control number will be assigned. Prior authorization approvals are authorized for a maximum of six (6) months (180 days) or for the life of the prescription, whichever is shorter. If the prescribing physician, physician assistant, advanced practice registered nurse (APRN), or clinical nurse specialist documents the beneficiary's condition is chronic and unlikely to change, a prior approval may be authorized for a maximum of twelve (12) months. The effective date of the prior authorization will be the date the patient will begin therapy or the day following the last day of the previous authorization approval.

223.000 Pre-Approval of Hyperalimentation Services

~~8-1-21~~9-1-24

When an eligible Medicaid beneficiary is discharged from the inpatient setting with the continuation of hyperalimentation services in the home, a provider may request a pre-approval for hyperalimentation before the anticipated discharge date. **View or print contact information to obtain the DHS or its designated vendor step-by-step process for requesting pre-approval for hyperalimentation.**

When approved, a prior authorization number will be assigned and will be effective for thirty (30) days. The provider must not bill for hyperalimentation services prior to the date of discharge or bill for services on the same dates of service as the inpatient stay.

If the beneficiary is not discharged within the thirty (30) days, the pre-approval will be void.

When continuation of the therapy is required past the initial thirty (30) day pre-approval, the provider must submit a recertification for prior authorization request with a prescription signed by the prescribing physician, physician assistant, advanced practice registered nurse (APRN), or clinical nurse specialist prior to the end date of the pre-approval.

A pre-approval of hyperalimentation services does not guarantee payment.

242.310 Completion of CMS-1500 Claim Form

~~9-1-14~~9-1-24

Field Name and Number		Instructions for Completion
1.	(type of coverage)	Not required.
1a.	INSURED'S I.D. NUMBER (For Program in Item 1)	Beneficiary's or participant's 10-digit Medicaid or ARKids First-A or ARKids First-B identification number.
2.	PATIENT'S NAME (Last Name, First Name, Middle Initial)	Beneficiary's or participant's last name and first name.
3.	PATIENT'S BIRTH DATE	Beneficiary's or participant's date of birth as given on the individual's Medicaid or ARKids First-A or ARKids First-B identification card. Format: MM/DD/YY.
	SEX	Check M for male or F for female.
4.	INSURED'S NAME (Last Name, First Name, Middle Initial)	Required if insurance affects this claim. Insured's last name, first name, and middle initial.
5.	PATIENT'S ADDRESS (No., Street)	Optional. Beneficiary's or participant's complete mailing address (street address or post office box).
	CITY	Name of the city in which the beneficiary or participant resides.

Field Name and Number		Instructions for Completion
	STATE	Two-letter postal code for the state in which the beneficiary or participant resides.
	ZIP CODE	Five-digit zip code; nine digits for post office box.
	TELEPHONE (Include Area Code)	The beneficiary's or participant's telephone number or the number of a reliable message/contact/ emergency telephone.
6.	PATIENT RELATIONSHIP TO INSURED	If insurance affects this claim, check the box indicating the patient's relationship to the insured.
7.	INSURED'S ADDRESS (No., Street)	Required if insured's address is different from the patient's address.
	CITY	
	STATE	
	ZIP CODE	
	TELEPHONE (Include Area Code)	
8.	RESERVED	Reserved for NUCC use.
9.	OTHER INSURED'S NAME (Last name, First Name, Middle Initial)	If patient has other insurance coverage as indicated in Field 11d, the other insured's last name, first name, and middle initial.
	a. OTHER INSURED'S POLICY OR GROUP NUMBER	Policy and/or group number of the insured individual.
	b. RESERVED	Reserved for NUCC use.
	SEX	Not required.
	c. RESERVED	Reserved for NUCC use.
	d. INSURANCE PLAN NAME OR PROGRAM NAME	Name of the insurance company.
10.	IS PATIENT'S CONDITION RELATED TO:	
	a. EMPLOYMENT? (Current or Previous)	Check YES or NO.
	b. AUTO ACCIDENT?	Required when an auto accident is related to the services. Check YES or NO.
	PLACE (State)	If 10b is YES, the two-letter postal abbreviation for the state in which the automobile accident took place.
	c. OTHER ACCIDENT?	Required when an accident other than automobile is related to the services. Check YES or NO.

Field Name and Number	Instructions for Completion
d. CLAIM CODES	The "Claim Codes" identify additional information about the beneficiary's condition or the claim. When applicable, use the Claim Code to report appropriate claim codes as designated by the NUCC. When required to provide the subset of Condition Codes, enter the condition code in this field. The subset of approved Condition Codes is found at www.nucc.org under Code Sets.
11. INSURED'S POLICY GROUP OR FECA NUMBER	Not required when Medicaid is the only payer.
a. INSURED'S DATE OF BIRTH	Not required.
SEX	Not required.
b. OTHER CLAIM ID NUMBER	Not required.
c. INSURANCE PLAN NAME OR PROGRAM NAME	Not required.
d. IS THERE ANOTHER HEALTH BENEFIT PLAN?	When private or other insurance may or will cover any of the services, check YES and complete items 9, 9a and 9d. Only one box can be marked.
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE	Enter "Signature on File," "SOF" or legal signature.
13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE	Enter "Signature on File," "SOF" or legal signature.
14. DATE OF CURRENT: ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)	Required when services furnished are related to an accident, whether the accident is recent or in the past. Date of the accident. Enter the qualifier to the right of the vertical dotted line. Use Qualifier 431 Onset of Current Symptoms or Illness; 484 Last Menstrual Period.

Field Name and Number	Instructions for Completion
15. OTHER DATE	Enter another date related to the beneficiary's condition or treatment. Enter the qualifier between the left-hand set of vertical, dotted lines. The "Other Date" identifies additional date information about the beneficiary's condition or treatment. Use qualifiers: 454 Initial Treatment 304 Latest Visit or Consultation 453 Acute Manifestation of a Chronic Condition 439 Accident 455 Last X-Ray 471 Prescription 090 Report Start (Assumed Care Date) 091 Report End (Relinquished Care Date) 444 First Visit or Consultation
16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION	Not required.
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	Name and title of referral source, whether an individual (such as a PCP) or a clinic or other facility.
17a. (blank)	Not required.
17b. NPI	Enter NPI of the referring ~~physician~~provider.
18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES	When the serving/billing provider's services charged on this claim are related to a beneficiary's or participant's inpatient hospitalization, enter the individual's admission and discharge dates. Format: MM/DD/YY.
19. ADDITIONAL CLAIM INFORMATION	Identifies additional information about the beneficiary's condition or the claim. Enter the appropriate qualifiers describing the identifier. See **www.nucc.org** for qualifiers.
20. OUTSIDE LAB?	Not required.
$ CHARGES	Not required.

Field Name and Number	Instructions for Completion
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY	Enter the applicable ICD indicator to identify which version of ICD codes is being reported. Use “9” for ICD-9-CM. Use “0” for ICD-10-CM. Enter the indicator between the vertical, dotted lines in the upper right-hand portion of the field. Diagnosis code for the primary medical condition for which services are being billed. Use the appropriate International Classification of Diseases (ICD). List no more than 12 diagnosis codes. Relate lines A-L to the lines of service in 24E by the letter of the line. Use the highest level of specificity.
22. RESUBMISSION CODE ORIGINAL REF. NO.	Reserved for future use. Any data or other information listed in this field does not/will not adjust, void or otherwise modify any previous payment or denial of a claim. Claim payment adjustments, voids, and refunds must follow previously established processes in policy.
23. PRIOR AUTHORIZATION NUMBER	The prior authorization or benefit extension control number if applicable.
24A. DATE(S) OF SERVICE	The “from” and “to” dates of service for each billed service. Format: MM/DD/YY. 1. On a single claim detail (one charge on one line), bill only for services provided within a single calendar month. 2. Some providers may bill on the same claim detail for two or more sequential dates of service within the same calendar month when the provider furnished equal amounts of the service on each day of the date sequence.
B. PLACE OF SERVICE	Two-digit national standard place of service code.
C. EMG	Enter “Y” for “Yes” or leave blank if “No.” EMG identifies if the services was an emergency.
D. PROCEDURES, SERVICES, OR SUPPLIES	
CPT/HCPCS	One CPT or HCPCS procedure code for each detail.
MODIFIER	Modifier(s) if applicable.

Field Name and Number	Instructions for Completion
E. DIAGNOSIS POINTER	Enter the diagnosis code reference letter (pointer) as shown in Item Number 21 to relate to the date of service and the procedures performed to the primary diagnosis. When multiple services are performed, the primary reference letter for each service should be listed first; other applicable services should follow. The reference letter(s) should be A-L or multiple letters as applicable. The "Diagnosis Pointer" is the line letter from Item Number 21 that relates to the reason the service(s) was performed.
F. $ CHARGES	The full charge for the service(s) totaled in the detail. This charge must be the usual charge to any client, patient, or other recipient of the provider's services.
G. DAYS OR UNITS	The units (in whole numbers) of service(s) provided during the period indicated in Field 24A of the detail.
H. EPSDT/Family Plan	Enter E if the services resulted from a Child Health Services (EPSDT) screening/referral.
I. ID QUAL	Not required.
J. RENDERING PROVIDER ID #	Enter the 9-digit Arkansas Medicaid provider ID number of the individual who furnished the services billed for in the detail or
NPI	Enter NPI of the individual who furnished the services billed for in the detail.
25. FEDERAL TAX I.D. NUMBER	Not required. This information is carried in the provider's Medicaid file. If it changes, please contact Provider Enrollment.
26. PATIENT'S ACCOUNT NO.	Optional entry that may be used for accounting purposes; use up to 16 numeric or alphabetic characters. This number appears on the Remittance Advice as "MRN."
27. ACCEPT ASSIGNMENT?	Not required. Assignment is automatically accepted by the provider when billing Medicaid.
28. TOTAL CHARGE	Total of Column 24F—the sum all charges on the claim.
29. AMOUNT PAID	Enter the total of payments previously received on this claim. Do not include amounts previously paid by Medicaid. *Do **not** include in this total the automatically deducted Medicaid co-payments.
30. RESERVED	Reserved for NUCC use.
31. SIGNATURE OF ~~PHYSICIAN~~ PROVIDER OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS	The provider or designated authorized individual must sign and date the claim certifying that the services were personally rendered by the provider or under the provider's direction. "Provider's signature" is defined as the provider's actual signature, a rubber stamp of the provider's signature, an automated signature, a typewritten signature, or the signature of an individual authorized by the provider rendering the service. The name of a clinic or group is not acceptable.

Field Name and Number	Instructions for Completion
32. SERVICE FACILITY LOCATION INFORMATION	If other than home or office, enter the name and street, city, state, and zip code of the facility where services were performed.
a. (blank)	Not required.
b. (blank)	Not required.
33. BILLING PROVIDER INFO & PH #	Billing provider's name and complete address. Telephone number is requested but not required.
a. (blank)	Enter NPI of the billing provider or
b. (blank)	Enter the 9-digit Arkansas Medicaid provider ID number of the billing provider.

TOC not required

240.000 GLOSSARY

Acute care hospital means a hospital that:

A. Is licensed by the Department of Health under § 20-9- 19 201 et seq., as a general hospital or a surgery and general medical care hospital; and

B. Is enrolled as a provider with the Arkansas Medicaid Program.

Birthing hospital means a hospital in this state or in a border state that:

A. Is licensed as a general hospital;

B. Provides obstetrics services; and

C. Is enrolled as a provider with the Arkansas Medicaid program.

Care coordination coaches mean those individuals who establish relationships with their clients to ensure effective participation in the Rural Life360 program. Coaches may work under various titles including peer specialists, peer counselors, family support workers, and home visitors. They work directly with clients and their families to improve their life skills to be physically, socially, and emotionally healthy to live successfully in their communities.

Community services mean any resource or services provided by public or private organizations to community residents to assist with a particular social need such as mental health or counseling or health-related needs including housing or food or job training and employment. It may also include other general services or programs offered through libraries or other local government funding that benefit the community.

Evidence-based home visitation means a home visitation program that is one of the models recognized by the U.S. Department of Health and Human Services to be effective in improving maternal and child health.

Healthcare coverage means coverage provided under this subchapter through either an individual qualified health plan (QHP), a risk-based provider organization, managed care organization, employer health insurance coverage, or the fee-for-service (FFS) Medicaid program.

High-risk pregnancy means a pregnancy with a diagnostic code of supervision of high-risk pregnancy, as evidenced by a physician, Clinical Nurse Specialist, or Advanced Practice Registered Nurse (APRN) referral. High-risk diagnosis includes medical and/or social risk.

Home-visiting means an evidence-based program that provides direct support and intensive care coordination of services for clients served by Maternal Life360s with the goals of improving maternal and infant health outcomes, promoting child development and school readiness, connecting families to needed community resources and supports, and increasing a family's education and earning potential.

HRSN reimbursable cost means time-limited expenses to enable a client to access services or supports to meet an identified HRSN allowable under Life360. These must be identified through a Health-Related Social Needs (HRSN) screening, or the client's engagement with the care coordinator, and are transitional in nature. Examples include housing safety inspections, pest control, security deposit and first month's rent that is required to obtain a lease on an apartment or home, and nutritional instruction for disease control/prevention.

HRSN screening means a standardized way of capturing a Life360 client's health-related social needs to determine any needs or barriers a client may experience at the time of screening. For

example, an individual may have trouble paying rent on time and be at risk of losing their apartment. A pregnant individual may experience difficulty going to her doctor's appointments due to not having a car and lack resources for food. Information gathered through the screening may be used to help inform care coordination plans or referrals to community services and supports.

Individual Qualified Health Plan (QHP) means an individual health insurance benefit plan offered in the health insurance marketplace to provide coverage in Arkansas that covers only essential health benefits as defined by Arkansas rule and 45 C.F.R. § 156.110 and any federal insurance regulations.

Intensive care coordination is an umbrella term for a collaborative process in which a care coordinator or others assess, plan, implement, coordinate, monitor and evaluate the options, services and supports required to meet the client's health and HRSN needs. It is characterized by advocacy, communication, and resource management, and promotes quality interventions and outcomes. In addition to addressing medical services, care coordination coaches ensure that clients have safe housing, employment, education, financial stability, and emotional/mental wellness.

Mental illness refers to clients with a diagnosis of one or more of the following: neurodevelopmental disorders, schizophrenia spectrum and other psychotic disorders, bipolar and related disorders, depressive disorders, anxiety disorders, obsessive-compulsive and related disorders, trauma- and stressor-related disorders, dissociative disorders, somatic symptom and related disorders, feeding and eating disorders, and personality disorders.

Non-Reimbursable Community Contribution (NRCC) means a payment, including an in-kind payment, for goods or services provided to a client to assist the client with meeting a HRSN identified in the client's person-centered action plan but is not a HRSN-reimbursable cost or reimbursable through other Medicaid funds under the Life360 HOME agreement. NRCC may include rent or utility costs for example, or excluded categories (i.e. job preparation expenses such as clothing or personal care). The identification of sources of NRCC and the types of NRCC provided shall be included in the application and in program reports.

Partner agreement means the sub contractual agreement executed between the Life360 and its partner subrecipients. The subrecipient has its performance measured against whether the objectives of the program as outlined in the Life360 HOME agreement between DHS and the Life360 are met; has responsibility for programmatic decision-making; and uses funds to carry out the program by providing goods or supports to clients. Subrecipients are identified in the application and in programmatic and financial reports. Additional subrecipients can be requested during the program period by contacting the Life360 program manager at DHS. Subrecipients will need to be updated into the Life360 HOME agreement.

Person-Centered Action Plan (PCAP) means a plan completed by the Life360 that identifies a client's strengths, preferences and includes information from the HRSN screen and additional information gathered from the client through meetings and any other tools utilized by the program. The PCAP includes short and longer-term goals and objectives to address the client's HRSN and other personal goals as well as details on how and what services and supports will be obtained, a crisis plan, and documentation of progress on goals and successes and barriers encountered. The PCAP is updated as the client meets goals, circumstances change, or the sets new goals.

Life360 HOME agreement means the administrative instrument to be executed between the Arkansas Department of Human Services (DHS) Division of Medical Services (DMS) and an Arkansas Medicaid enrolled hospital Life360 provider.

Rural area means an Arkansas county where a hospital designated as a critical access hospital or participant in the Small Rural Hospital Improvement Program is located or an Arkansas county with a population of fifty-thousand (50,000) or less.

Small rural hospital means a critical access hospital or a general hospital that:

A. Is located in a rural area;

B. Has fifty (50) or fewer staffed beds; and

C. Is enrolled as a provider in the Arkansas Medicaid program.

Health-Related Social Needs (HRSN) means conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks.

Veteran means a person who served in the active military, naval, or air service and who was discharged or released there from as verified by DD214 documentation.

TOC not required

203.020 Documentation of Services

~~79~~-1-~~17~~24

Home Health providers must maintain the following records for patients of all ages:

A. Signed and dated patient assessments and plans of care, including physical therapy evaluations and treatment plans, when applicable.

B. Signed and dated case notes and progress notes from each visit by nurses, aides, physical therapists and physical therapy assistants.

C. Signed and dated documentation of *pro re nata* (PRN) visits, which must include the following:

1. The medical justification for each such unscheduled visit;~~.~~
2. The patient's vital signs and symptoms;~~.~~
3. The observations of and measures taken by agency staff and reported to the physician~~.~~;
4. The physician's comments, observations and instructions;~~.~~

D. Verification, by means of physician or approved non-physician practitioner documentation that there was a face-to-face encounter with the beneficiary that meets the following requirements:

1. For the initiation of home health services, the face-to-face encounter must be related to the primary reason the beneficiary requires home health services and must occur within the ninety (90) days before or the thirty (30) days after the start of services;~~.~~
2. For the initiation of medical equipment, the face-to-face encounter must be related to the primary reason the beneficiary requires medical equipment and must occur no more than six (6) ~~-~~months prior to the start of services;~~.~~
3. The face-to-face encounter may be conducted by one of the following practitioners:
   a. The primary care ~~physician~~providers~~;~~
   b. A nurse practitioner working in collaboration with the primary care ~~physician~~provider~~;~~
   c. A certified nurse midwife by the scope of practice~~;~~
   d. A physician assistant under the supervision of the primary care physician according to Arkansas Medicaid Physician Policy. Physician assistant services are services furnished according to AR Code § 17-105-101 (2012) and rules and regulations issued by the Arkansas State Medical Board. Physician assistants are dependent medical practitioners practicing under the supervision of the physician, for which the physician takes full responsibility~~. The service is not considered to be separate from the physician's service.~~
   e. For beneficiaries admitted to home health immediately after an acute or post-acute stay, the attending acute or post-acute physician~~.~~
   f. A clinical nurse specialist working in collaboration with the primary care provider, when the PCP is someone other than the clinical nurse specialist
4. The allowed non-physician practitioner performing the face-to-face encounter must communicate the clinical findings of that encounter to the ordering PCP or physician. These clinical findings must be incorporated into a written or electronic document included in the beneficiary's medical record;~~.~~

5. To assure clinical correlation between the face-to-face encounter and the associated home health services, the PCP or physician ordering the services must:
   a. Document that the face-to-face encounter which is related to the primary reason the patient requires home health services occurred within the required timeframes prior to the start of home health services.
   b. Indicate the practitioner who conducted the encounter, and the date of the encounter.
6. The face-to-face encounter may occur through telemedicine when applicable to the program manual of the performing provider of the encounter.

E. No payment may be made for medical equipment, supplies, or appliances to the extent that a face-to-face encounter requirement would apply as durable medical equipment (DME) under the Medicare program unless the primary care ~~physician~~ provider or allowed non-physician practitioner documents a face-to-face encounter with the beneficiary consistent with the requirements. The face-to-face encounter may be performed by any of the practitioners described in D.3. with the exception of nurse-midwives.;

F. Copies of current signed and dated plans of care, including interim and short-term plan-of-care modifications;.

G. Copies of plans of care, PCP referrals, case notes, etc., for all previous episodes of care within the period of required record retention;.

H. The registered nurse's instructions to home health aides, detailing the aide's duties at each visit;.

I. The registered nurse's (or physical therapist's when applicable) notes from supervisory visits.

214.210 Advanced Practice Registered Nurse (APRN) Services Benefit Limits

~~7~~9-1-2~~2~~4

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
8. Clinical nurse specialist services in the office, patient's home, or nursing facility

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.

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.

214.330 Family Planning Coverage Information ~~1~~9-1-24

A. Arkansas Medicaid encourages reproductive health and family planning by reimbursing nurse practitioners and clinical nurse specialists for a comprehensive range of family planning services~~.~~;

1. Family planning services do not require a PCP referral~~.~~
2. Medicaid beneficiaries' family planning services benefits are in addition to their other medical benefits~~,~~ when providers bill the services specifically as family planning services~~.~~
3. Family planning prescriptions are unlimited and do not count toward the benefit limit~~.~~
4. Extension of benefits is not available for family planning services~~.~~
5. Abortion is not a family planning service in the Arkansas Medicaid Program~~.~~

B. Other than full coverage aid categories, Arkansas Medicaid covers one basic family planning examination and three periodic family planning visits per client, per state fiscal year (July 1 through June 30). Refer to Sections 214.321 through 214.333 of this manual for service description and coverage information;~~.~~

C. Nurse practitioners and clinical nurse specialists desiring to participate in the Medicaid Family Planning Services Program may do so by providing the services listed in Sections 214.321 through 241.333 to Medicaid beneficiaries of childbearing age;~~.~~

D. Nurse practitioners and clinical nurse specialists preferring not to provide family planning services may refer their patients to other providers. DHS County Offices maintain listings of local and area providers qualified to provide family planning services. Listed providers include:

1. Arkansas Department of Health local health units
2. Obstetricians and gynecologists
3. Physicians
4. Rural Health Clinics
5. Federally Qualified Health Centers
6. Family planning clinics
7. Physician~~s~~ Assistants
8. Certified Nurse-Midwives
9. Clinical Nurse Specialists
10. Advanced Practice Registered Nurses

E. Effective 1/1/24, providers are allowed to bill for Long-Acting Reversible Contraception (LARC) devices and professional services immediately after childbirth and during post-partum, while the beneficiary remains in an inpatient setting.

Billing guidelines:

1. The Hospital should continue to bill the inpatient stay on an inpatient claim (CMS-1450, formerly UB-04).
2. If the hospital provides the LARC device, the hospital is to bill the LARC device on an outpatient claim (CMS-1450, formerly UB-04), even though the dates fall within an

inpatient stay. On the outpatient claim, **see LARC billing combinations for billing codes**. Ensure the applicable NDC code is submitted on the claim.

3. Physician charges can be billed for insertion and removal on a professional claim (CMS-1500), in addition to their delivery charges. The physician can also charge for the LARC device, if provided by the Physician. **See LARC billing combinations for billing codes**.
4. The 340-B rules and modifiers to the LARC code combinations apply, when applicable.

F. Complete billing instructions for family planning services are in Sections 252.430 through 252.431 of this manual.

SECTION II -PHYSICIAN ASSISTANT

CONTENTS

TOC required

200.000 PHYSICIAN ASSISTANT GENERAL INFORMATION

201.000 Arkansas Medicaid Requirements for Participation in the Physician Assistant Program 9-1-24

The Arkansas Medicaid Program enrolls Physician Assistants for participation in the Physician Assistant Program. Physician Assistant Program providers must meet the Provider Participation and enrollment requirements contained within Section 140.000 of this manual as well as the following criteria to be eligible to participate in the Arkansas Medicaid Program:

A. The provider must be licensed by the state authority in the state in which services are furnished.

B. The following documents must be submitted with the provider application and Medicaid contract:

1. A copy of all certifications and licenses verifying compliance with enrollment criteria for the specialty to be practiced. (See Section 201.300 of this manual.)
2. Providers have the option of enrolling in the Title XVIII (Medicare) Program. If enrolled in Title XVIII, the provider must inform the Medicaid Provider Enrollment Unit of his or her Medicare number. Out-of-state providers must submit a copy of their Title XVIII (Medicare) certification.
3. Providers who have prescriptive authority must furnish documentation of their prescriptive authority certification. Any changes in prescriptive authority must be immediately reported to Arkansas Medicaid.

201.001 Electronic Signatures 9-1-24

Medicaid will accept electronic signatures provided the electronic signatures comply with Arkansas Code § 25-31-103 et seq.

201.100 Group Providers 9-1-24

Group providers of Physician Assistant services must meet the following criteria in order to be eligible for participation in the Arkansas Medicaid Program.

If a Physician Assistant is a member of a group, each individual Physician Assistant and the group must both enroll according to the following criteria:

A. Each individual Physician Assistant within the group must enroll following the criteria established in Section 201.000.

B. All group providers are “pay to” providers only. The service must be performed and billed by a Medicaid-enrolled Physician Assistant within the group.

201.200 Providers in Arkansas and Bordering States 9-1-24

Providers in Arkansas and the six (6) bordering states (Louisiana, Mississippi, Missouri, Oklahoma, Tennessee, and Texas) that satisfy Arkansas Medicaid participation requirements may be enrolled as **routine services providers**.

Routine services providers may furnish and claim reimbursement for services covered by Arkansas Medicaid, subject to benefit limitations and coverage restrictions set forth in this manual.

Services rendered by physician assistants in the six (6) border states must comply with the scope of practice and limitations in privileges specified in Arkansas Law. In addition, physician assistants are only allowed to perform services authorized by their supervising physicians. Their supervising physicians must also be actively enrolled as participating Arkansas Medicaid providers.

201.210 Providers in Non-Bordering States 9-1-24

A. Providers in states not bordering Arkansas may enroll in the Arkansas Medicaid program as limited services providers only after they have provided services to an Arkansas Medicaid eligible beneficiary and have a claim or claims to file with Arkansas Medicaid.

To enroll, a non-bordering state provider must download an Arkansas Medicaid application and contract from the Arkansas Medicaid website and submit the application, contract, and claim to Arkansas Medicaid Provider Enrollment. A provider number will be assigned upon approval of the provider application and the Medicaid contract. **View or print the provider enrollment and contract package (Application Packet). View or print Provider Enrollment Unit Contact information**. In addition, the physician assistant's supervising physicians must be actively enrolled with Arkansas Medicaid.

B. Limited services providers remain enrolled for one (1) year.

1. If a limited services provider provides services to another Arkansas Medicaid beneficiary during the year of enrollment and bills Medicaid, the enrollment may continue for one (1) year past the most recent claim's last date of service, if the enrollment file is kept current.
2. During the enrollment period, the provider may file any subsequent claims directly to the Medicaid fiscal agent.
3. Limited services providers are strongly encouraged to file subsequent claims through the Arkansas Medicaid website because the front-end processing of web-based claims ensures prompt adjudication and facilitates reimbursement.

201.300 Certification for Physician Assistant 9-1-24

The Physician Assistant must be licensed as a Physician Assistant by the state in which services are furnished.

202.000 Medical Records Physician Assistants are Required to Keep 9-1-24

A. Physician Assistants are required to keep the following records and, upon request, to furnish the records to authorized representatives of the Arkansas Division of Medical Services and the state Medicaid Fraud Unit and to representatives of the Centers for Medicare and Medicaid Services (CMS):

1. History and physical examinations.
2. Chief complaint on each visit.
3. Tests and results.
4. Diagnoses.
5. Service or treatment, including prescriptions, or a referral to a physician for prescriptions, and record of physician referral or consultation.
6. Signature or initials of the Physician Assistant after each visit.

7. Copies of records pertinent to any and all services delivered by the Physician Assistant and billed to Medicaid.

8. Records must include the service date of each service billed to Medicaid.

B. Patient records must support the levels of service billed to Medicaid, in accordance with the American Medical Association's Common Procedural Terminology (CPT) standards.

C. All required records must be kept for a period of five (5) years from the ending date of service; or, until all audit questions, appeal hearings, investigations, or court cases are resolved, whichever period is longer.

D. Furnishing patient medical records on request to authorized individuals and agencies listed above in part A is a contractual obligation of providers enrolled in the Medicaid Program. Failure to furnish medical records upon request may result in the imposition of sanctions. (See Section 142.300 for additional information regarding record keeping requirements).

E. All documentation must be made available to representatives of the Division of Medical Services during normal business hours at the time of an audit conducted by the Medicaid Field Audit Unit. All documentation must be available at the provider's place of business. If an audit determines that recoupment is necessary, there will be only thirty (30) days after the date of the recoupment letter in which additional documentation will be accepted. Additional documentation will not be accepted later.

203.000 The Physician Assistant's Role in Home Health Services 9-1-24

203.010 Home Health and the Primary Care Physician (PCP) Case Management Program (ConnectCare) 9-1-24

A. Home health care requires a PCP referral except in the following circumstances:

1. Medicaid does not require Medicare beneficiaries to enroll with PCPs; therefore, a PCP referral is not required for home health services for Medicare/Medicaid dual-eligibles.

2. Obstetricians and Gynecologists may authorize and direct medically necessary home health care for postpartum complications without obtaining a PCP referral.

B. A PCP may refer a beneficiary to a specific home health agency only if he or she ensures the beneficiary's freedom of choice by naming at least one alternative agency.

1. PCPs, authorized attending physicians and home health agencies must maintain all required PCP referral documentation in the beneficiary's clinical records.

2. PCP referrals must be renewed when specified by the PCP or every sixty (60) days, whichever period is shorter.

C. PCP referral is not required to revise a plan of care during a period covered by a current referral, but the agency must forward copies of the signed and dated assessment and the revision to the PCP.

203.020 Documentation of Services 9-1-24

Home Health providers must maintain the following records for patients of all ages:

A. Signed and dated patient assessments and plans of care, including physical therapy evaluations and treatment plans, when applicable.

B. Signed and dated case notes and progress notes from each visit by nurses, aides, physical therapists and physical therapy assistants.

C. Signed and dated documentation of *pro re nata* (PRN) visits, which must include the following:

1. The medical justification for each such unscheduled visit.
2. The patient's vital signs and symptoms.
3. The observations of and measures taken by agency staff and reported to the physician.
4. The physician's comments, observations, and instructions.

D. Verification, by means of physician or approved non-physician practitioner documentation that there was a face-to-face encounter with the beneficiary that meets the following requirements:

1. For the initiation of home health services, the face-to-face encounter must be related to the primary reason the beneficiary requires home health services and must occur within the ninety (90) days before or the thirty (30) days after the start of services.
2. For the initiation of medical equipment, the face-to-face encounter must be related to the primary reason the beneficiary requires medical equipment and must occur no more than 6 months prior to the start of services.
3. The face-to-face encounter may be conducted by one (1) of the following practitioners:
   a. The primary care physician;
   b. A Physician Assistant working in collaboration with the primary care physician;
   c. A certified nurse midwife by the scope of practice;
   d. A physician assistant under the supervision of the primary care physician according to Arkansas Medicaid Physician Policy. Physician assistant services are services furnished according to AR Code § 17-105-101 (2012) and rules and regulations issued by the Arkansas State Medical Board. Physician assistants are dependent medical practitioners practicing under the supervision of the physician, for which the physician takes full responsibility.
   e. For beneficiaries admitted to home health immediately after an acute or post-acute stay, the attending acute or post-acute physician; or
4. The non-physician practitioner performing the face-to-face encounter must communicate the clinical findings of that encounter to the ordering physician. These clinical findings must be incorporated into a written or electronic document included in the beneficiary's medical record.
5. To assure clinical correlation between the face-to-face encounter and the associated home health services, the physician ordering the services must:
   a. Document that the face-to-face encounter which is related to the primary reason the patient requires home health services occurred within the required timeframes prior to the start of home health services.
   b. Indicate the practitioner who conducted the encounter, and the date of the encounter.
6. The face-to-face encounter may occur through telemedicine when applicable to the program manual of the performing provider of the encounter.

E. No payment may be made for medical equipment, supplies, or appliances to the extent that a face-to-face encounter requirement would apply as durable medical equipment (DME) under the Medicare program unless the primary care physician or allowed non-physician practitioner documents a face-to-face encounter with the beneficiary consistent with the requirements. The face-to-face encounter may be performed by any of the practitioners described in D.3. except for nurse-midwives.

F. Copies of current signed and dated plans of care, including interim and short-term plan-of-care modifications.

G. Copies of plans of care, PCP referrals, case notes, or other documents, for all previous episodes of care within the period of required record retention.

H. The registered nurse's instructions to home health aides, detailing the aide's duties at each visit.

I. The registered nurse's (or physical therapist's when applicable) notes from supervisory visits.

203.030 Plan of Care Review **9-1-24**

A. All home health services are at the direction of the patient's PCP or authorized attending physician.

B. The physician, in consultation with the patient and professional staff, is responsible for establishing the plan of care, specifying the type(s), frequency and duration of services.

C. Medicaid requires the PCP or authorized attending physician to review the patient's plan of care as often as necessary to address changes in the patient's condition, but no less often than every 60 days.

1. The physician establishes the start date of each new, renewed, or revised plan of care. A "renewed" plan of care is a plan of care that has been reviewed in accordance with the 60-day requirement and has been authorized by the PCP or authorized attending physician to continue, either with or without revision. A "revised" plan of care is a plan of care developed in response to a change in the patient's condition that necessitates prompt review by the physician and reassessment by the case nurse.

2. The PCP or authorized attending physician must have performed a comprehensive (see Physician's Common Procedural Terminology for guidelines regarding comprehensive evaluation and management procedures) physical examination with medical history or history update within the 12 months preceding the start date of a new plan of care, the first date of service in an extended benefit period or the beginning date of service in a revised or renewed plan of care.

203.040 Program Criteria for Home Health Services **9-1-24**

A. A Medicaid beneficiary is eligible for home health services only if he or she has had a comprehensive physical examination and a medical history or history update by his or her PCP or authorized attending physician within the twelve months preceding the beginning date of a new plan of care, the first date of service in an extended benefit period or the beginning date of service in a revised or renewed plan of care.

B. The appropriateness of home health services is determined by the beneficiary's PCP or authorized attending physician.

1. An individual's PCP or authorized attending physician determines whether the patient needs home health services, the scope and frequency of those services and the duration of the services.

2. The PCP or authorized attending physician is responsible for coordination of the patient's care, both in-home and outside the home.

C. Some examples of individuals for whom home health services may be suitable are those who need the following:

1. Specialized nursing procedures with regard to catheters or feeding tubes.

2. Detailed instructions regarding self-care or diet.

3. Rehabilitative services administered by a physical therapist.

D. Some beneficiaries may require home health services of very short duration while they or their caregivers receive training enabling them to provide particular medical needs with little or no assistance from the home health agency.

E. Some individuals may need only intermittent monitoring or skilled care. When an individual's skilled care is so infrequent that more than 60 days elapse between services, that individual requires a new assessment and a new plan of care for each episode of care, unless the physician documents that the interval without such care is no detriment and appropriate to the treatment of the beneficiary's illness or injury.

203.050 Home Health Place of Service 9-1-24

Home health services may be provided in any normal setting in which normal life activities take place, other than a hospital, nursing facility or intermediate care facility for individuals with intellectual disabilities (ICF/IID) or any setting in which payment is or could be made under Medicaid for inpatient services that include room and board. Home health services cannot be limited to services furnished to beneficiaries who are homebound. The single exception to this policy permits Medicaid to reimburse a home health agency for providing nursing services to an ICF/IID resident on a short-term basis if the only alternative to home health services is inpatient admission to a hospital or a skilled nursing facility. Medicaid supplies, equipment and appliances suitable for use may be provided in any setting in which normal life activities take place.

203.060 Intravenous Therapy in a Patient's Home (Home IV Therapy) 9-1-24

Home IV therapy is a skilled nursing service that is included in coverage of LPN and RN home health visits. Home IV therapy is available to a Medicaid-eligible individual who is stabilized on a course of treatment and requires continued IV therapies in the home for several days or weeks. Medicaid requirements for establishing and maintaining home IV therapy are:

A. **A Medicaid-eligible individual may qualify for home IV therapy only if he or she is trained to perform some or all self-care activities by the home health RN**.

1. The registered nurse must visit and reassess the client before the projected date that the complete or partial self-care is to commence.

2. The home health agency in consultation with the PCP or authorized attending physician must terminate or revise the plan of care, basing its determination on the degree of self-care of which the client has become capable.

B. The Home Health provider or a provider enrolled in the Arkansas Medicaid Prosthetics program may furnish the IV therapy supplies. Regardless of the source of the supplies, the Home Health provider is responsible for the deployment and management of the IV therapy supplies and for the documentation of their medical deployment and management.

C. The Home Health provider must report the patient's status to the PCP or authorized attending physician in accordance with the physician's prescribed schedule in the plan of care.

203.070 Registered Nurse Supervision of Home Health Aide Services 9-1-24

A. The supervising registered nurse must issue written instructions to the home health aide.

1. The instructions must specify the aide's specific duties at each visit.

2. The aide must note that he or she has performed each task and note, with written justification of the omission, which tasks he or she did not perform.

B. If a beneficiary is receiving home health aide services only, the registered nurse must visit the beneficiary at least once every sixty (60) days to assess his or her condition and to evaluate the quality of service provided by the home health aide.

C. If a beneficiary is receiving only physical therapy and home health aide services, with no skilled nursing services, either the registered nurse or the qualified physical therapist may make this required supervisory visit.

203.080 Medical Supplies and Diapers or Underpads 9-1-24

When billing for these services, which are benefit-limited to a maximum number of dollars per month, providers must bill according to the **calendar** month. **Providers may not span calendar months when billing for medical supplies and diapers or underpads.** The date of delivery is the date of service. Providers may not enter different dates for "from" and "through" dates of service.

Supplies are healthcare-related items that are consumable or disposable, or cannot withstand repeated use by more than one (1) individual, and are required to address an individual medical disability, illness or injury.

Equipment and appliances are items that are primarily and customarily used to serve a medical purpose; generally are not useful to an individual in the absence of a disability, illness or injury; can withstand repeated use; and can be reusable or removable. Medical coverage of equipment and appliances is not restricted to items covered as durable medical equipment in the Medicare program.

Arkansas has a list of preapproved medical equipment, supplies and appliances for administrative ease, but the state is prohibited from having absolute exclusions of coverage on medical equipment, supplies or appliances. Items not available on the preapproval list may be requested on a case-by-case basis. When denying a request, the state must inform the beneficiary of the right to a fair hearing.

203.100 The Physician Assistant's Role in the Pharmacy Program 9-1-24

Medicaid covers prescription drugs in accordance with policies and regulations set forth in this section and pursuant to orders (prescriptions) from authorized prescribers. The Arkansas Medicaid Program complies with the Medicaid Prudent Pharmaceutical Purchasing Program (MPPPP) which was enacted as part of the Omnibus Budget Reconciliation Act (OBRA) of 1990. **This law requires Medicaid to limit coverage to drugs manufactured by pharmaceutical companies that have signed rebate agreements.** A numeric listing of approved pharmaceutical companies and their respective labeler codes is located on the Arkansas Division of Medical Services (DMS) Pharmacy website. **View or print numeric listing of approved pharmaceutical companies and their respective labeler codes**. Except for drugs in the categories excluded from coverage, Arkansas Medicaid covers all drug products manufactured by companies with listed labeler codes.

A Physician Assistant with prescriptive authority (verified by the Certificate of Prescriptive Authority Number issued by the licensing authority of the state in which services are furnished) may only prescribe legend drugs and controlled substances identified in the state licensing rules and regulations. Medicaid reimbursement will be limited to prescriptions for drugs in these schedules.

Prescribers must obtain the latest information regarding prescription drug coverage at the website listed in the contact information for DHS or its designated Pharmacy Vendor. **View or print contact information for the DHS designated Pharmacy Vendor.**

203.101 Tamper Resistant Prescription Applications 9-1-24

Section 7002(b), which amends section 1903(i) of the Social Security Act (the Act) (42 U.S.C. section 1936b(i)) by adding new paragraph (23), states that payment shall not be made for ". . . amounts expended for medical assistance for covered outpatient drugs (as defined in section 1927(k)(2) for which the prescription was executed in written (and non-electronic) form unless the prescription was executed on a tamper-resistant pad." This provision becomes effective on October 1, 2007. The tamper-resistant pad requirement of section 7002(b) applies to all outpatient drugs, including over-the-counter drugs in States that reimburse for prescriptions for such items. Section 1927(k)(3) of the Act provides exceptions to section 1927(k)(2) for drugs provided in nursing facilities, intermediate care facilities for individuals with intellectual disabilities, and other specified institutional and clinical settings. Such drugs in these settings (to the extent that they are not separately reimbursed) are exceptions to section 1927(k)(2), and, therefore, are not subject to the tamper-resistant pad requirement of section 7002(b). Section 7002(b) is applicable regardless of whether Medicaid is the primary or secondary payer of the prescription being filled.

See the CMS website for technical information:

https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/FraudAbuseforProfs/TRP.html

Regardless of whether Medicaid is the primary or secondary payer of the prescription being filled, this rule applies to all non-electronic Medicaid-covered outpatient drugs except:

1. Emergency fills of non-controlled or controlled dangerous substances for which a prescriber provides the pharmacy with a verbal, faxed, electronic or compliant written prescription within 72 hours after the date on which the prescription was filled; and

2. Drugs provided in nursing facilities, intermediate care facilities for individuals with intellectual disabilities and other federally specified institutional and clinical settings so long as those drugs are not billed separately to Medicaid, for example, those billed by an individual pharmacy provider.

For purposes of this rule, "electronic prescriptions" include e-prescriptions transmitted to the pharmacy, prescriptions faxed to the pharmacy or prescriptions communicated to the pharmacy by telephone by a prescriber.

203.200 The Physician Assistant's Role in the Child Health Services (EPSDT) Program 9-1-24

The Child Health Services (EPSDT) program is a federally mandated child health component of Medicaid. It is designed to bring comprehensive health care to individuals eligible for medical assistance from birth until their 21st birthday. The purpose of this program is to detect and treat health problems in the early stages and to provide preventive health care, including necessary immunizations. Child Health Services (EPSDT) combines case management and support services with periodic screening, as well as diagnostic and treatment services delivered.

A primary care physician (PCP) may refer a child to a Physician Assistant to administer an EPSDT screen. A provider of Physician Assistant services may recommend to the PCP that an EPSDT screen could be necessary for any child that is thought to need one. If a Physician Assistant discovers a problem as a result of an EPSDT screen, or receives a referral as a result of an EPSDT screen, Physician Assistant services may be provided after consulting with the child's PCP.

A. Treatment means physician, hearing, visual, dental, Physician Assistant services and any other type of medical care and services recognized under State law to prevent or correct disease or abnormalities detected by screening or by diagnostic procedures.

B. Physician Assistants and other health professionals who do Child Health Services (EPSDT) screening may diagnose and treat health problems discovered during the screening or may refer the child to other appropriate sources for treatment.

C. If a condition is diagnosed through a Child Health Services (EPSDT) screen that requires a treatment service not normally covered under the Arkansas Medicaid Program, the service will also be considered for reimbursement if it is medically necessary and permitted under federal Medicaid regulations.

D. Physician Assistants may bill a sick visit and a periodic Child Health Services (EPSDT) screening for a patient on the same date of service. This visit must be billed electronically, or on paper using form CMS-1500. **View a form CMS-1500 sample form.**

Refer to Section I of this manual for additional information. Providers of Child Health Services (EPSDT) should refer to the Child Health Services (EPSDT) provider manual.

203.300 The Physician Assistant's Role in the ARKids First-B Program 9-1-24

The ARKids First-B Program, established by Arkansas Act 407 of 1997, extends health care coverage to Arkansas' uninsured children. The health care delivery network for ARKids First-B Program is ConnectCare. ConnectCare is the Primary Care Physician (PCP) Managed Care Program utilized by the Arkansas Medicaid Program.

Preventive health screens are covered in the ARKids First–B Program for ARKids First-B eligible children from birth through eighteen (18) years of age. Preventive health screens are similar to EPSDT screens. With the exception of routine newborn care, preventive health screens must be performed by the primary care physician (PCP) or referred by the PCP to an appropriate provider for screening. If a Physician Assistant receives a referral from the child's PCP for a screen and a problem is discovered, treatment may be provided with consultation from the PCP.

Physician Assistants enrolled as a Medicaid provider may request an ARKids First-B provider manual for participation in the ARKids First-B Program. Providers should refer to their ARKids First-B provider manual for more information.

203.400 Physician Assistant's Role in Early Intervention Reporting for Children from Birth to Three Years of Age 9-1-24

Part C of the Individuals with Disabilities Education Act (IDEA '97) mandates the provision of early intervention services to infants and toddlers, ages birth to thirty-six months (36) of age. Health care providers offering any early intervention services to an eligible child must refer the child to the Division of Developmental Disabilities Services for possible enrollment in First Connections, the Part C Early Intervention Program in Arkansas. Federal regulations at 34 CFR 303.321.d.2.ii require health care professionals to refer potentially eligible children within two (2) days of identifying them as candidates for early intervention.

A. A child must be referred if he or she is age birth to three (3) years and meets one or more of the following criteria:

1. Developmental delay – a delay of twenty-five percent (25%) or greater in one (1) of the following areas of development:
   a. Physical (gross/fine motor).
   b. Cognitive.
   c. Communication.
   d. Social or emotional.
   e. Adaptive and self-help skills.
2. Diagnosed physical or mental condition – examples of such conditions include but are not limited to:
   a. Down's Syndrome and chromosomal abnormalities associated with mental condition.
   b. Congenital syndromes associated with delays such as Fetal Alcohol Syndrome,

intra-uterine drug exposure, prenatal rubella, severe microcephaly and macrocephaly.

c. Maternal Acquired Immune Deficiency Syndrome (AIDS).

d. Sensory impairments such as visual or hearing disorders.

B. The Division of Developmental Disabilities Services (DDS) within the Department of Human Services is the lead agency for early intervention as required in Part C of IDEA in Arkansas. Referrals to First Connections may be made either through the DDS Service Coordinator for the child's county of residence or directly to a DDS licensed community program.

203.500 The Physician Assistant's Role in Family Planning Services 9-1-24

Arkansas Medicaid encourages reproductive health and family planning by covering a comprehensive range of family planning services provided by Physician Assistants and other providers. Medicaid clients' family planning services are in addition to their other medical benefits. Family planning services do not require PCP referral.

A. Refer to Sections 214.321 through 214.333 of the manual for family planning coverage information.

B. Refer to Sections 252.430 and 252.431 of the manual for family planning services special billing instructions and procedure codes.

203.600 The Physician Assistant's Role in Hospital Services 9-1-24

A. Medicaid covers medically necessary hospital services, within the constraints of the Medicaid Utilization Management Program (MUMP) and applicable benefit limitations. (Refer to Section 214.711.)

B. The care and treatment of a patient must be under the direction of a licensed physician, a licensed Physician Assistant, a certified nurse-midwife or dentist with hospital staff affiliation.

C. DHS or its designated vendor reviews all inpatient hospital transfers and all inpatient stays longer than four (4) days for the Medicaid Utilization Management Program (MUMP).

DHS or its designated vendor also completes post-payment reviews of hospital stays for medical necessity determinations. **View or print contact information to obtain the DHS or designated vendor step-by-step process for requesting extension of inpatient stays.**

D. Hospital claims are also subject to review by the Medicaid Peer Review Committee or the Medical Director for the Medicaid Program.

1. If Medicaid denies a hospital's claim for lack of medical necessity, payments to Physician Assistants for evaluation and management services incidental to the hospitalization are subject to recoupment by the Medicaid agency.

2. Physician Assistants and hospitals may not bill a Medicaid beneficiary for a service Medicaid has declared not medically necessary.

3. Physician Assistants and hospitals may not bill inpatient services previously denied for lack of medical necessity as outpatient services.

203.700 The Physician Assistant's Role in Preventing Program Abuse 9-1-24

A. The Arkansas Medicaid Program has the responsibility for assuring quality medical care for its beneficiaries along with protecting the integrity of the funds supporting the program. The Division of Medical Services is committed to this goal by providing staff and resources

to the prevention, detection and correction of abuse. However, this task can only be accomplished through the cooperation and support of the provider community. The Physician Assistant is many times in a position to detect certain program abuses.

B. A Physician Assistant who has reason to suspect either beneficiary or provider abuse or unacceptable quality of care should contact the Utilization Review Section of Arkansas Division of Medical Services. An investigation will then be made. **View or print the Arkansas Division of Medical Services Utilization Review Section contact information**.

C. Examples of the types of abuse you may detect include:

1. Beneficiary over-utilization of services;
2. Beneficiary misuse or inappropriate utilization of services;
3. Beneficiary misuse of I.D. card;
4. Poor quality of service; or
5. Provider over-utilization or abuse.

204.000 Role of Quality Improvement Organization (QIO) 9-1-24

The Quality Improvement Organization (QIO) reviews all federally and state funded hospital inpatient services. The purpose of such review is the promotion of effective, efficient and economical delivery of health care services of proper quality and assurance that such services conform to appropriate professional standards. QIO reviews are mandated to assure that federal payment for such services will take place only when they are determined to be medically necessary, consistent with professionally recognized health care standards and provided in the most appropriate setting and location.

A pattern of aberrant practice may result in a Physician Assistant having his or her waiver of liability revoked. Once a Physician Assistant has lost his or her waiver of liability, one hundred percent (100%) of his or her admissions are reviewed by QIO. After the appeal process, QIO forwards any denials to the state agency for recoupment of funds.

210.000 PROGRAM COVERAGE

211.000 Introduction 9-1-24

The Medical Assistance (Medicaid) Program is designed to assist eligible Medicaid beneficiaries in obtaining medical care within the guidelines specified in Section I of this manual. All Medicaid benefits are based upon medical necessity. See the Glossary of this manual for “medical necessity” definition.

212.000 Physician Assistant 9-1-24

A Physician Assistant, as applicable to this program, is a licensed professional who meets the participation requirements and enrollment criteria for physician assistant as defined by the state licensing authority.

Physician Assistant services are services furnished according to Arkansas Code 17-105-101 and rules issued by the Arkansas State Medical Board. Physicians Assistants are dependent medical practitioners practicing under the supervision of the physician, for which the physician takes full responsibility.

Note: A physician assistant providing services during a surgical procedure is not covered as an assistant surgeon.

The Physician Assistant provides direct care to individuals, families and other groups in the settings of hospitals, outpatient hospital offices, clinics, and other institutions and health care settings. The service provided by the Physician Assistant is directed toward the delivery of primary, secondary, and tertiary care that focuses on the achievement and maintenance of optimal functions in the population.

The Physician Assistant engages in collaborative decision-making about the health care needs of clients with the physician under which direct supervision is vested. Collaboration with health professionals and others occurs in making decisions about other health care needs. The Physician Assistant plans and initiates health care programs as a member of the health care team. The supervising physician is directly accountable and responsible for the quality of care provided.

213.000 Scope 9-1-24

The scope of the Physician Assistant Program includes Medicaid covered services provided by pediatric, family, obstetric-gynecologic (women's health care), and gerontological Physician Assistants in accordance with state and federal regulations.

Services provided through the Physician Assistant Program include:

A. Assessment and diagnostic services.

B. Development and implementation of treatment plans.

C. Evaluation of client outcomes.

D. Referrals to appropriate providers when the health status of the Medicaid-eligible individual requires additional diagnostic and treatment services based on the health status of the individual.

E. Other services as authorized by the supervising physician or services as defined in the physician assistant's delegation agreement with the supervising physician.

214.000 Coverage 9-1-24

Many Physician Assistant services covered by the Arkansas Medicaid Program have coverage restrictions or are benefit limited. Coverage restrictions are the circumstances under which certain services will be covered. Benefit limits are the limits on the quantity of covered services Medicaid-eligible individuals may receive. Benefit limits for some services may be extended if medically necessary. See Sections 214.000 through 214.800 for information about covered Physician Assistant services with restrictions or benefit limits.

214.100 Exclusions 9-1-24

Exclusions are those services not covered in Arkansas Medicaid Physician Assistant Program and any covered services furnished by a Physician Assistant that are not within the scope of practice of the Physician Assistant as defined by the state licensing authority and by the national certifying body. Services are not covered when provided by an employed or contracted Physician Assistant who is not enrolled as a participant in the Physician Assistant Program.

Medicaid does not cover services that are not medically necessary or are not generally accepted by the medical profession. Medicaid does not cover services that are not properly documented by diagnoses that certify medical necessity.

214.200 General Physician Assistant Services 9-1-24

A. Services provided by a Physician Assistant include initial visits and established patient visits for:

1. Diagnosis and evaluation.
2. Treatment services.
3. Health management services for prevention and early intervention.
4. Appropriate referrals to other health care providers for diagnostic and treatment services.

B. Some services (for example: pelvic exams, prostate massages, and removal of sutures) are not considered a separate service from an office visit.

214.210 Physician Assistant Services Benefit Limits 9-1-24

A. For clients twenty-one (21) years of age or older, PA services provided in a physician office, a PA 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. PA 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;
8. APRN services in the office, patient's home, or nursing facility; and
9. Clinical Nurse Specialist services.

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

Global obstetric fees are not counted against the -visit limit. Itemized obstetric office visits are not counted in the 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.

214.300 Reserved 9-1-24

214.310 Reserved 9-1-24

214.320 Reserved 9-1-24

214.321 Family Planning Services for Women in Aid Category 61, PW 9-1-24

Women in Aid Category 61, Pregnant Women (PW), are eligible for all Medicaid-covered family planning services through the last day of the month in which the 60th day postpartum falls.

Aid Category 61 PW Unborn Child does not include family planning benefits.

214.330 Family Planning Coverage Information 9-1-24

A. Arkansas Medicaid encourages reproductive health and family planning by reimbursing Physician Assistants for a comprehensive range of family planning services.

1. Family planning services do not require a PCP referral.
2. Medicaid beneficiaries' family planning services benefits are in addition to their other medical benefits, when providers bill the services specifically as family planning services.
3. Family planning prescriptions are unlimited and do not count toward the benefit limit.
4. Extension of benefits is not available for family planning services.
5. Abortion is not a family planning service in the Arkansas Medicaid Program.

B. Other than full coverage aid categories, Arkansas Medicaid covers one (1) basic family planning examination and three (3) periodic family planning visits per client, per state fiscal year (July 1 through June 30). Refer to Sections 214.321 through 214.333 of this manual for service description and coverage information.

C. Physician Assistants desiring to participate in the Medicaid Family Planning Services Program may do so by providing the services listed in Sections 214.321 through 241.333 to Medicaid beneficiaries of childbearing age.

D. Physician Assistants preferring not to provide family planning services may refer their patients to other providers. DHS County Offices maintain listings of local and area providers qualified to provide family planning services. Listed providers include:

1. Arkansas Department of Health local health units;
2. Obstetricians and gynecologists;
3. Physicians;
4. Rural Health Clinics;
5. Federally Qualified Health Centers;
6. Family planning clinics;
7. Physicians; and
8. Certified Nurse-Midwives.

E. Complete billing instructions for family planning services are in Sections 252.430 through 252.431 of this manual.

214.331 Physician Assistant Basic Family Planning Visit 9-1-24

Medicaid covers one (1) basic family planning visit per beneficiary per Arkansas state fiscal year (July 1 through June 30). The basic visit comprises the following:

A. Medical history and medical examination, including head, neck, breast, chest, pelvis, abdomen, extremities, weight and blood pressure.

B. Counseling and education regarding:

1. Breast self-exam.
2. The full range of contraceptive methods available.
3. HIV and STD prevention.

C. Prescription for any contraceptives selected by the beneficiary.

D. Laboratory services, including, as necessary:

1. Pregnancy test.
2. Hemoglobin and hematocrit.
3. Sickle cell screening.
4. Urinalysis testing for albumin and glucose.
5. Papanicolaou (PAP) smears for cervical cancer.
6. Testing for sexually transmitted diseases.

214.332 Physician Assistant Periodic Family Planning Visit 9-1-24

Medicaid covers three (3) periodic family planning visits per beneficiary per Arkansas state fiscal year (July 1 through June 30). The periodic visit includes follow-up medical history, weight, blood pressure and counseling regarding contraceptives and possible complications of contraceptives. The purpose of the periodic visit is to evaluate the patient's contraceptive program, renew or change the contraceptive prescription and to provide the patient with additional opportunities for counseling regarding reproductive health and family planning.

214.333 Contraception 9-1-24

A. Prescription and Non-Prescription Contraceptives:

1. Medicaid covers birth control pills and other prescription contraceptives as a family planning prescription benefit.
2. Medicaid covers non-prescription contraceptives as a family planning benefit when a physician or other licensed practitioner with prescriptive authority writes a prescription for them.

B Contraceptive Implant Systems:

1. Medicaid covers the contraceptive implant systems, including implants and supplies.
2. Medicaid covers insertion, removal, and removal with reinsertion.

C. Intrauterine Device (IUD):

1. Medicaid pays for IUDs as a family planning benefit.
2. Alternatively, Medicaid reimburses physicians that supply the IUD at the time of insertion.
3. Medicaid pays physicians for IUD insertion and removal.

D. Medroxyprogesterone Acetate:

Medicaid covers medroxyprogesterone acetate injections for birth control.

E. Sterilization:

1. All adult (twenty-one (21) years of age or older) male or female Medicaid beneficiaries who are mentally competent are eligible for sterilization procedures as long as they remain Medicaid-eligible.
2. Refer to Sections 252.430 through 252.431 of this manual for family planning procedure codes and billing instructions for family planning services.

214.400 Reserved 9-1-24

214.500 Laboratory and X-Ray Services Referral Requirements 9-1-24

A Physician Assistant referring a Medicaid beneficiary for laboratory, radiology or machine testing services must specify an ICD diagnosis code for each test ordered, *and include in the order,* pertinent supplemental diagnosis supporting the need for the test(s).

A. Diagnostic facilities, hospital labs and outpatient departments performing reference diagnostics rely on the referring Physician Assistant to establish medical necessity.

B. The diagnoses provide documentation of medical necessity to the reference diagnostic facilities performing the tests.

C. Physician Assistants must follow the Centers for Medicare and Medicaid Services (CMS) requirements for medical claim diagnosis coding when submitting diagnosis coding with their orders for diagnostic tests.

D. The Medicaid agency will enforce the CMS requirements for diagnosis coding, as those requirements are set forth in the ICD volume concurrent with the referral dates and the claim dates of service.

E. The following ICD diagnosis codes may not be utilized (**View ICD Codes.**).

Medicaid regulations regarding collection, handling, and conveyance of specimens are as follows:

A. Reimbursement will not be made for specimen handling fees.

B. A specimen collection fee may be allowed only in circumstances including:

1 drawing a blood sample through venipuncture (for example: inserting into a vein a needle with syringe or vacutainer to draw the specimen); or,

2 collecting a urine sample by catheterization.

The following procedure codes should be used when billing for specimen collection:

View or print the procedure codes for Physician Assistant services.

NOTE: The P codes listed within the procedure codes hyperlink are the Urinary Collection Codes.

Reimbursement for laboratory procedures requiring a venous blood specimen includes the collection fee when performed by the same provider. If laboratory procedures requiring a venous blood specimen are performed in the office and other laboratory procedures are sent to a reference laboratory on the same date of service, no collection fee may be billed.

Independent laboratories must meet the requirements to participate in Medicare. Independent laboratories may only be paid for laboratory tests they are certified to perform. Laboratory services rendered in a specialty for which an independent laboratory is not certified are not covered and claims for payment of benefits for these services will be denied.

214.510 Diagnostic Laboratory and Radiology/Other Services Benefit Limits 9-1-24

A. The Medicaid Program's diagnostic laboratory services benefit limit and radiology/other services benefit limit each apply to the outpatient setting.

1. Radiology/other services include without limitation diagnostic X-rays, ultrasounds, and electronic monitoring or machine tests, such as electrocardiograms (ECG or EKG).

2. All the benefit limits in this section are calculated per State Fiscal Year (SFY: July 1 through June 30).

3. Diagnostic laboratory services and radiology/other services defined as Essential Health Benefits by the U.S. Preventive Services Task Force (USPSTF) are exempt from counting toward either of the two (2) new annual caps.

View or print the essential health benefit procedure codes.

B. Medicaid established a maximum amount (benefit limit) of five hundred dollar ($500) per SFY for diagnostic laboratory services and five hundred dollars ($500) per SFY for radiology/other services for beneficiaries twenty-one (21) years of age and older. Exceptions are listed below:

1. There is no diagnostic laboratory services benefit limit or radiology/other services benefit limit for beneficiaries under twenty-one (21) years of age.

2. There is no benefit limit on diagnostic laboratory services related to family planning. (Refer to Section 252.431 of this manual for the family planning-related clinical laboratory procedures.)

3. There are no benefit limits on diagnostic laboratory services or radiology/other services that are performed as emergency services and approved by DHS or its designated vendor for payment as emergency services.

View or print contact information to obtain the DHS or designated vendor step-by-step process for requesting extension of benefits.

4. Claims with the following primary diagnoses are exempt from diagnostic laboratory services or radiology/other services benefit limits:

a. Malignant Neoplasm (**View ICD Codes**);

b. HIV disease and AIDS (**View ICD Codes**);

c. Renal failure (**View ICD Codes**);

d. Pregnancy* (**View ICD Codes**); or

e. Opioid Use Disorder (OUD) when treated with Medication Assisted Treatment (MAT). (**View ICD OUD Codes.**) Designated diagnostic laboratory tests will be exempt from the diagnostic laboratory services benefit limit when the diagnosis is OUD. (**View Laboratory and Screening Codes.**)

C. *Obstetric (OB) ultrasounds and fetal non-stress tests have benefit limits and are not exempt from Extension of Benefits request requirements. (See Section 214.630 for additional coverage information.)

D. Extension of benefit requests are considered for clients who require supportive treatment, such as dialysis, radiation therapy, or chemotherapy for maintaining life.

E. Benefits may be extended for other conditions documented as medically necessary.

214.600 Obstetrical Services 9-1-24

The Arkansas Medicaid Program covers obstetrical services for Medicaid-eligible clients in *full* coverage aid categories with a medically verified pregnancy.

Aid category 61, PW clients are eligible for full range Medicaid coverage. Aid category 61, PW pregnant women's eligibility ends on the last day of the month in which the 60th postpartum day falls.

214.610 Covered Physician Assistant Obstetrical Services 9-1-24

Covered Physician Assistant obstetrical services may be provided when medically necessary and are *limited* to antepartum and postpartum care. Appropriate referrals will be made to a physician or a certified nurse-midwife for complete obstetrical services to include delivery.

214.620 Risk Management Services for High Risk Pregnancy 9-1-24

The Physician Assistant may provide risk management services authorized under the agreement with their supervising physician. If a Physician Assistant does not choose to provide high-risk pregnancy services but believes the patient would benefit from such services, he or she may refer the patient to a clinic that offers the services.

Covered risk management services described in parts A through E below are considered as one (1) service with a benefit limit of thirty-two (32) cumulative units. The early discharge home visit described in part F is considered as a separate service.

A. Risk Assessment

Risk assessment is defined as a medical, nutritional and psychosocial assessment by a Physician Assistant or a registered nurse on the Physician's staff, to designate patients as high or low risk.

1. Medical assessment, using the Hollister Maternal and Newborn Record System or equivalent form includes:
   a. Medical history;
   b. Menstrual history; and
   c. Pregnancy history.
2. Nutritional assessment includes:
   a. 24-hour diet recall;
   b. Screening for anemia; and
   c. Weight history.
3. Psychosocial assessment includes criteria for an identification of psychosocial problems that may adversely affect the patient's health status.

Maximum: Two (2) units per pregnancy

B. Case Management Services

Case management services are provided by a Physician Assistant, APRN, Clinical Nurse Specialist, licensed social worker, or registered nurse to assist pregnant women eligible under Medicaid in gaining access to needed medical, social, educational and other services (examples include, but are not limited to, locating a source of services, making an appointment for services, arranging transportation, arranging hospital admission, locating a physician to deliver a newborn, and following up to verify that the patient kept her appointment, rescheduling the appointment).

Maximum: One (1) unit per month. A minimum of two (2) contacts per month must be provided. A case management contact may be with the patient, other professionals, family, and other caregivers.

C. Perinatal Education

Educational classes provided by a health professional (physician, physician assistant, APRN, Clinical Nurse Specialist, public health nurse, nutritionist or health educator) include:

1. Pregnancy;
2. Labor and delivery;
3. Reproductive health;
4. Postpartum care;

5. Nutrition in pregnancy; and

6. Maximum: Six (6) classes (units) per pregnancy.

D. Nutrition Consultation — Individual

Nutrition consultation services provided for high-risk pregnant women by a registered dietitian or a nutritionist eligible for registration by the Commission on Dietetic Registration must include at least one (1) of the following:

1. An evaluation to determine health risks due to nutritional factors with development of a nutritional care plan; and

2. Nutritional care plan follow-up and reassessment as indicated.

Maximum: Nine (9) units per pregnancy

E. Social Work Consultation

Services provided for high-risk pregnant women by a licensed social worker must include at least one (1) of the following:

1. An evaluation to determine health risks due to psychosocial factors with development of a social work care plan

2. Social work plan follow-up, appropriate intervention and referrals

Maximum: Six (6) units per pregnancy

F. Early Discharge Home Visit

If a physician or certified nurse-midwife chooses to discharge a low-risk mother and newborn from the hospital early (less than twenty-four (24) hours after delivery), the physician or certified nurse-midwife may provide a home visit to the mother and baby within seventy-two (72) hours of the hospital discharge. The physician or certified nurse-midwife may request an early discharge home visit from any clinic that provides perinatal services. Visits will be done by the physician or certified nurse-midwife's order (includes a hospital discharge order).

A home visit may be ordered for the mother and infant discharged later than twenty-four (24) hours if there is specific medical reason for home follow-up.

Billing instructions and procedure codes may be found in **Section 252.450**.

214.630 Fetal Non-Stress Test 9-1-24

The fetal non-stress test is *limited to two (2) per pregnancy per beneficiary*. If it is necessary to exceed this limit, the Physician Assistant must request an extension of benefits and submit documentation that establishes medical necessity. Refer to Section 214.900 of this manual for procedures to request extension of benefits. Refer to **Section 252.451** of this manual for billing instructions and the procedure code.

The post-procedural visits are covered within the 10-day period following the fetal non-stress test.

214.700 Reserved 9-1-24

214.710 Inpatient Services 9-1-24

Physician Assistant inpatient services must meet the Medicaid requirement of medical necessity. The Quality Improvement Organization (QIO) will deny payments for inpatient admissions and subsequent inpatient services when they determine that inpatient care was not necessary.

Inpatient services are subject to QIO review for medical necessity whether the Physician Assistant supervising physician admitted the patient, or whether Medicaid deemed the inpatient status criteria in Section 214.711.

The attending Physician Assistant must document the medical necessity of admitting a patient to observation status, whether the patient's condition is emergent or non-emergent. Physician Assistant and hospital claims for hospital observation services are subject to post-payment review to verify medical necessity.

214.711 Medicaid Utilization Management Program (MUMP) 9-1-24

The Medicaid Utilization Management Program (MUMP) determines covered lengths of stay in inpatient acute care and general hospitals, in state and out of state.

Length-of-stay determinations are made by the Quality Improvement Organization (QIO), under contract to the Arkansas Medicaid Program.

Individuals in all Medicaid eligibility categories and all age groups, except beneficiaries under one (1) year of age, are subject to this policy. Medicaid beneficiaries under one (1) year of age at the time of admission are exempt from the MUMP policy for dates of service before their first birthday. Refer to item "E" below for the procedure to follow when a child's first birthday occurs during an inpatient stay.

The procedures for the MUMP are as follows:

A. Medicaid will reimburse hospitals for up to four (4) days of inpatient service with no pre-certification requirement, except for admissions by transfer from another hospital.

B. If the attending Physician Assistant's supervising physician determines the patient should not be discharged by the fifth day of hospitalization, a hospital medical staff member may contact DHS or its designated vendor and request an extension of inpatient days.

View or print contact information to obtain the DHS or designated vendor step-by-step process for requesting extension of inpatient stays.

C. The number of days allowed for an extension will be based on medical judgment utilizing Medicaid guidelines.

D. When a Medicaid beneficiary reaches one (1) year of age during an inpatient stay, the days from the admission date through the day before the patient's birthday are exempt from the MUMP policy. MUMP policy becomes effective on the one-year birthday. The patient's birthday is the first day of the four (4) days not requiring MUMP certification. If the stay continues beyond the fourth day (inclusive) of the patient's first birthday, hospital staff must apply for MUMP certification of the additional days.

E. Additional extensions may be requested as needed.

F. Reconsideration reviews of denied extensions may be requested by sending the medical record to AFMC through regular mail or expedited by overnight express. The hospital will be notified by the next working day of the decision.

G. Calls for extension of days may be made at any point from the fourth day of stay through discharge. However, the provider must accept the financial liability should the stay not meet the necessary medical criteria for inpatient services. If the provider chooses to delay calling for extension verification and the services are denied based on medical necessity, the beneficiary may not be held liable. All calls will be limited to ten (10) minutes to allow equal access to all providers.

H. Inpatient stays for bone marrow, liver, heart, lung, skin, and pancreas and kidney transplant procedures are excluded from this review program.

I. A retrospective or post-payment random sample review will be conducted for all admissions, including inpatient stays of four (4) days or less, to ensure that medical necessity for the services is substantiated.

J. Admissions of retroactive eligible beneficiary: If eligibility is identified while the patient is still an inpatient, the hospital may request retrospective review of those days already used past the original four (4) for a determination of post-authorization and concurrent evaluation of future extended days.

If the retroactive eligible beneficiary is not identified until after discharge, and the hospital files a claim and receives a denial for any days past the original four allowed, the hospital may request post-extension evaluation approval of the denied days. If granted, the claim may be refiled. If the length of stay is more than thirty (30) days, the provider shall submit the entire medical record to DHS or its designated vendor for review.

K. Claims submitted without an extension will result in automatic denials of any days billed beyond the fourth day. The only exceptions are for claims reflecting third party liability and patients with retroactive Medicaid eligibility described in items G and J above.

L. If a patient is transferred from one (1) facility to another, the receiving facility must contact DHS or its designated vendor within twenty-four (24) hours of admitting the patient to qualify the inpatient stay. If an admission falls on a weekend or holiday, the provider may contact DHS or its designated vendor on the first working day following the weekend or holiday.

M. The certification process for extensions of inpatient days described in this section is a separate requirement from the prior authorization process. If a procedure requires prior authorization, the provider must request and receive prior authorization for the procedure code to be reimbursed.

N. If a provider fails to contact DHS or its designated vendor for an extension of inpatient days due to the patient's having private insurance or Medicare Part A and later receives a denial due to non-covered service, lost eligibility, benefits exhausted, or similar, then post-certification of days past the original four (4) days may be obtained by the following procedures:

1. Send a copy of the denial notice received from the third-party payer to DHS or its designated vendor.
2. Include a note requesting post-certification, the full name of the requester, and a phone number where the requester may be reached.

Upon receipt of the denial copy and the provider request, a coordinator will call the provider and obtain certification information.

O. If a third-party insurer pays for an approved number of days, Medicaid will not grant an extension for days beyond the number of days approved by the private insurer.

214.712 Evaluation and Management 9-1-24

A. Medicaid covers Physician Assistant evaluation and management services for hospital inpatients on Medicaid-covered inpatient days only. The single exception to this policy is that Medicaid will cover discharge day management. Medicaid does not remit the hospitals per diem for the day of discharge unless it is also the admission day. Medicaid reimburses Physician Assistants for medically necessary discharge day management unless the Physician Assistant evaluation and management services for that day are included in another service, or unless the Physician Assistant does not customarily bill private-pay patients for discharge day management.

B. The Medicaid Program covers only one (1) evaluation and management service per day, regardless of how many times the Physician Assistant sees the patient.

C. The Medicaid Program covers standby or detention services when requested by a physician that involves prolonged attendance without direct (face-to-face) patient contact. When providing standby services, the Physician Assistant must not be providing care or services to other patients during this period. Service is covered when provided in the inpatient hospital setting and is limited to one (1) unit per date of service.

D. The Medicaid Program will recover payments to Physician Assistants for inpatient evaluation and management services on days for which the hospital's inpatient claims are denied (or would be denied, if filed) for:

1. Exceeding benefit limits;
2. Failure to pre-certify inpatient days, when applicable; or
3. Lack of medical necessity.

214.713 Professional Components of Diagnostic and Therapeutic Procedures 9-1-24

Medicaid reimbursement to hospitals for inpatient services includes the non-professional components (technical components) such as machine tests, laboratory tests, and radiology procedures provided to inpatients.

Reimbursement to Physician Assistants and independent laboratories for laboratory and radiology services for inpatients is solely for the professional component of machine tests, radiology services, and anatomical laboratory services.

Medicaid does not pay for technical components of diagnostic procedures (or complete procedures that include a technical component) or for clinical laboratory procedures performed in the course of diagnosing and treating a hospital inpatient. Hospitals must furnish or purchase those ancillary services.

214.714 Inpatient Hospital Benefit Limits 9-1-24

A. There is an annual benefit limit of twenty-four (24) medically necessary days per state fiscal year (July 1 through June 30) for Medicaid beneficiaries twenty-one (21) years of age and older. Upon the twenty-fifth day, any medically necessary inpatient days will be covered at a lower rate of four hundred dollars ($400) per day.

B. There is no inpatient hospital benefit limit for beneficiaries under twenty-one (21) years of age in the Child Health Services (EPSDT) Program.

214.720 Outpatient Hospital Services 9-1-24

For the purpose of coverage and reimbursement determination, outpatient hospital Physician Assistant services are divided into two (2) types of service.

214.721 Emergency Services 9-1-24

Physician Assistant outpatient hospital visits are covered as an emergency when the beneficiary's medical condition constitutes an emergency medical condition. (Refer to the Glossary of this manual for the definition of emergency services.)

Services not considered as emergency services are covered with primary care physician approval, or the beneficiary may be billed for the services.

214.722 Non-Emergency Services 9-1-24

Coverage of non-emergency Physician Assistant services in an outpatient hospital setting is restricted to a visit charge and the professional component for machine tests, radiology and anatomical laboratory procedures.

214.800 Occupational, Physical, and Speech-Language Therapy 9-1-24

A. Medicaid covers occupational, physical, and speech-language therapy services for eligible beneficiaries under twenty-one (21) years of age in the Child Health Services (EPSDT) Program by qualified occupational, physical, or speech-language therapy providers. Therapy services are not covered as Physician Assistant services. The following is provided for the Physician Assistant's information.

B. Occupational, Physical, and Speech-Language therapies are covered for beneficiaries in the ARKids A and ARKids -B program benefits.

C. Therapy services for individuals twenty-one (21) years of age and older are only covered when provided through the following Medicaid Programs: Adult Developmental Day Treatment (ADDT), Hospital or Critical Access Hospital (CAH), Rehabilitative Hospital, Home Health, Hospice and Physician. Refer to these Medicaid provider manuals for conditions of coverage and benefit limits.

D. All therapy services for beneficiaries under twenty-one (21) years of age require a referral for evaluation utilizing the form DMS-640 and a separate form DMS-640 for the written prescription from the patient's primary care physician (PCP) or attending physician if the beneficiary is exempt from PCP Managed Care Program requirements. A referral for therapy services must be renewed every twelve (12) months. After the initial referral using the form DMS-640 and initial prescription, utilizing a separate form DMS-640, subsequent referrals and prescriptions for continued therapy may be made at the same time using the same DMS-640. The prescription for treatment is valid for one (1) year unless the prescribing physician specifies a shorter period.

E. The PCP or attending physician must complete and sign the DMS-640 for beneficiaries under twenty-one (21) years of age. The PCP or attending physician must initiate a referral and prescription for beneficiaries over twenty-one (21) years of age. An original signature is required when making a referral or prescribing a therapy service. An electronic signature is acceptable on either document, provided it is in compliance with Arkansas Code 25-31-103. A copy of the prescription must be maintained in the beneficiary's records. The original prescription is to be maintained by the physician. **View or print form DMS-640** (for beneficiaries under twenty-one (21) years of age).

F. For range of benefits, see the following procedure codes: **View or print the procedure codes for therapy services**.

Extended therapy services may be provided based on medical necessity, for Medicaid beneficiaries under twenty-one (21) years of age.

Occupational, physical, and speech-language therapies are subject to the benefit limit of twelve (12) outpatient hospital visits per state fiscal year (SFY) for beneficiaries twenty-one (21) years of age and over. Benefit Extensions may be provided for therapy services, based on medical necessity, for Medicaid beneficiaries twenty-one (21) years of age and over when provided within a covered program.

214.810 Occupational Therapy, Physical Therapy, or Speech-Language Pathology Services Guidelines for Retrospective Review 9-1-24

Though Physician Assistants are not reimbursed for occupational therapy, physical therapy, or speech-language pathology services, it is important for the Physician Assistant to be aware of Medicaid's guidelines to document medical necessity. For Arkansas Medicaid guidelines applicable to therapy services, please refer to the Occupational Therapy, Physical Therapy, or Speech-Language Pathology Services provider manual.

214.811 Occupational and Physical Therapy Guidelines 9-1-24

Occupational, physical and speech therapists must adhere to the specific guidelines for retrospective review.

A. Therapy services for individuals must be medically necessary to the treatment of the individual's medical condition as prescribed by the individual's PCP. Physician Assistants are not reimbursed for occupational or physical therapy services.

1. The services must be considered under accepted standards of practice to be a specific and effective treatment for the patient's condition.
2. The services must be of such a level of complexity, or the patient's condition must be such that the services required can be safely and effectively performed only by or under the supervision of a qualified physical therapist.
3. There must be reasonable expectation that therapy will result in a meaningful improvement or a reasonable expectation that therapy will prevent a worsening of the condition (See medical necessity definition in the Glossary of this manual).

A diagnosis alone is not sufficient documentation to support the medical necessity of therapy. Assessment for physical therapy includes a comprehensive evaluation of the patient's physical deficits and functional limitations, treatment planned and goals to address each identified problem.

B. Frequency, Intensity and Duration of Physical Therapy Services:

Frequency, intensity, and duration of therapy services should always be medically necessary and realistic for the age of the child and the severity of the deficit or disorder. Therapy is indicated if improvement will occur as a direct result of these services and if there is a potential for improvement in the form of functional gain.

1. Monitoring: May be used to ensure that the child is maintaining a desired skill level or to assess the effectiveness and fit of equipment such as orthotics and other durable medical equipment. Monitoring frequency should be based on a time interval that is reasonable for the complexity of the problem being addressed.
2. Maintenance Therapy: Services that are performed primarily to maintain range of motion or to provide positioning services for the patient do not qualify for physical therapy services. These services can be provided to the child as part of a home program that can be implemented by the child's caregivers and do not necessarily require the skilled services of a physical therapist to perform safely and effectively.
3. Duration of Services: Therapy services should be provided if reasonable progress is made toward established goals. If reasonable functional progress cannot be expected with continued therapy, then services should be discontinued, and monitoring or establishment of a home program should be implemented.

C. Progress Notes:

1. Child's name.
2. Date of service.

3. Time in and time out of each therapy session.
4. Objectives addressed (should coincide with the plan of care).
5. A description of specific therapy services provided daily, and the activities rendered during each therapy session, along with a form measurement.
6. Progress notes must be legible.
7. Therapists must sign each date of entry with a full signature and credentials.
8. Graduate students must have the supervising physical therapist co-sign progress notes.

214.812 Speech-Language Therapy Retrospective Review Guidelines **9-1-24**

A. Speech-language therapy services must be medically necessary to the treatment of the individual's illness or injury. To be considered medically necessary, the following conditions must be met:

1. The services must be considered under accepted standards of practice to be a specific and effective treatment for the patient's condition.
2. The services must be of such a level of complexity, or the patient's condition must be such that the services required can be safely and effectively performed only by or under the supervision of a qualified speech and language pathologist.
3. There must be reasonable expectation that therapy will result in meaningful improvement or a reasonable expectation that therapy will prevent a worsening of the condition. (See medical necessity in glossary of the Arkansas Medicaid manual.)

A diagnosis alone is not sufficient documentation to support the medical necessity of therapy. Assessment for speech-language therapy includes a comprehensive evaluation of the patient's speech language deficits and functional limitations, treatment plan, and goals to address each identified problem.

B. Evaluations:

To determine that speech-language therapy services are medically necessary, an evaluation must contain the following information:

1. Date of evaluation.
2. Child's name and date of birth.
3. Diagnosis specific to therapy.
4. Background information including pertinent medical history; and, if the child is twelve (12) months of age or younger, gestational age.
5. Standardized test results, including all subtest scores, if applicable. Test results, if applicable, should be adjusted for prematurity (when less than thirty-seven (37) weeks gestation) if the child is twelve (12) months of age or younger this should be noted in the evaluation.
6. An assessment of the results of the evaluation including recommendations for frequency and intensity of treatment.
7. The child should be tested in their native language; if not, an explanation must be provided in the evaluation.
8. Signature and credentials of the therapist performing the evaluation.

The mental measurement yearbook is the standard reference to determine good reliability and validity of the test(s) administered in the evaluation.

C. Birth to Three:

1. — (minus) 1.5 SD (standard score of 77) below the mean in two (2) areas (expressive, receptive) or a — (minus) 2.0 SD (standard score of 70) below the mean in one area to qualify for language therapy.

2. Two (2) language tests must be reported with at least one (1) of these being a global norm-referenced standardized test with good reliability and validity. The second test may be criterion referenced.

214.900 Procedures for Obtaining Extension of Benefits 9-1-24

A. Physician Assistants who perform diagnostic laboratory services, radiology, or other services within their scope of practice may request extension of benefits for those services if the patient has exhausted the benefit limit.

1. Diagnostic laboratory services benefits are limited to five hundred dollars ($500) per State Fiscal Year (SFY: July 1 through June 30) and radiology/other services benefits are limited to five hundred dollars ($500) per SFY.

2. Radiology/other services include without limitation diagnostic X-rays, ultrasounds, and electronic monitoring or machine tests, such as electrocardiograms (ECG or EKG).

3. Diagnostic laboratory services and radiology or other services defined as Essential Health Benefits by the U.S. Preventive Services Task Force (USPSTF) are exempt from counting toward either of the two (2) new annual caps.

B. To request an extension of benefits for diagnostic laboratory services or radiology/other services, use the following procedures.

214.910 Extension of Benefits for Diagnostic Laboratory and Radiology/Other Services 9-1-24

A. The Medicaid Program's diagnostic laboratory services benefit limit and radiology/other services benefit limit each apply to the outpatient setting.

1. Diagnostic laboratory services benefits are limited to five hundred dollars ($500) per State Fiscal Year (SFY: July 1 through June 30), and radiology/other services benefits are limited to five hundred dollars ($500) per SFY.

2. Radiology/other services include without limitation diagnostic X-rays, ultrasounds, and electronic monitoring/machine tests, such as electrocardiograms (ECG or EKG).

B. Requests for extension of benefits for diagnostic laboratory services or radiology/other services must be submitted to DHS or its designated vendor.

View or print contact information to obtain the DHS or designated vendor step-by-step process for requesting extension of benefits.

1. Requests for extension of benefits are considered only after a claim is filed and is denied because the patient's five-hundred-dollar ($500) benefit limit for either diagnostic laboratory services or radiology/other services is exhausted.

2. Submit with the request a copy of the Medical Assistance Remittance and Status Report reflecting the claim's denial for exhausted benefits. Do not send a claim.

3. Diagnostic laboratory services and radiology/other services defined as Essential Health Benefits by the U.S. Preventive Services Task Force (USPSTF) are exempt from counting toward either of the two (2) new annual caps.

C. A request for extension of benefits must be received within ninety (90) calendar days of the date of benefit limit denial.

D. Additional information will be requested, as needed, to process a benefit extension request. Reconsiderations of additional requested information are not available. Failure to provide requested information within the specified time will result in a technical denial.

E. Correspondence regarding benefit extension requests and requests for reconsideration of denied benefit extension requests do not constitute documentation or proof of timely claim filing.

214.920 Completion of Form DMS-671, "Request For Extension of Benefits for Clinical, Outpatient, Diagnostic Laboratory and Radiology/Other Services." 9-1-24

A. The Medicaid Program's diagnostic laboratory services limit and radiology/other services benefit limit each apply to the outpatient setting.

1. Diagnostic laboratory services benefits are limited to five hundred dollars ($500) per State Fiscal Year (SFY: July 1 through June 30), and radiology/other services benefits are limited to five hundred dollars ($500) per SFY.

2. Radiology/other services include without limitation diagnostic X-rays, ultrasounds, and electronic monitoring/machine tests, such as electrocardiograms (ECG or EKG).

3. Diagnostic laboratory services and radiology/other services defined as Essential Health Benefits by the U.S. Preventive Services Task Force (USPSTF) are exempt from counting toward either of the two new annual caps.

B. Requests for extension of benefits for clinical services (such as physician's visits or Physician Assistant visits), outpatient services (meaning, hospital outpatient visits), diagnostic laboratory services (meaning, laboratory tests) and radiology/other services must be submitted to DHS or its designated vendor for consideration.

View or print contact information to obtain the DHS or designated vendor step-by-step process for requesting extension of benefits.

1. Consideration of requests for extension of benefits requires correct completion of all fields on the "Request for Extension of Benefits for Clinical, Outpatient, Diagnostic Laboratory, and Radiology/Other Services" form (Form DMS-671). **View or print Form DMS-671.**

2. Complete instructions for accurate completion of Form DMS-671 (including indication of required attachments) accompany the form. All forms are listed and accessible in **Section V** of each provider manual.

214.930 Documentation Requirements 9-1-24

A. The Medicaid Program's diagnostic laboratory services benefit limit and radiology/other services benefit limit each apply to the outpatient setting.

1. Diagnostic laboratory services benefits are limited to five hundred dollars ($500) per State Fiscal Year (SFY: July 1 through June 30), and radiology/other services benefits are limited to five hundred dollars ($500) per SFY.

2. Radiology/other services include without limitation diagnostic X-rays, ultrasounds, and electronic monitoring/machine tests, such as electrocardiograms (ECG or EKG).

3. Diagnostic laboratory services and radiology/other services defined as Essential Health Benefits by the U.S. Preventive Services Task Force (USPSTF) are exempt from counting toward either of the two new annual caps.

B. To request extension of benefits for any services with benefit limits, all applicable records that support the medical necessity of extended benefits are required.

C. Documentation requirements are as follows.

1. Clinical records *must:*

a. Be legible and include records supporting the specific request;

b. Be signed by the performing provider;

c. Include clinical, outpatient, and emergency room records for dates of service in chronological order;

d. Include related diabetic and blood pressure flow sheets;

e. Include a current medication list for the date of service;

f. Include the obstetrical record related to a current pregnancy when applicable; and

g. Include clinical indication for diagnostic laboratory and radiology/other services ordered with a copy of orders for diagnostic laboratory and radiology/other services signed by the physician

2. Diagnostic laboratory and radiology/other reports *must* include:

a. Clinical indication for diagnostic laboratory and radiology/other services ordered;

b. Signed orders for diagnostic laboratory and radiology/other services;

c. Results signed by the performing provider; and

d. Current and all previous ultrasound reports, including biophysical profiles and fetal non-stress tests when applicable.

214.940 Reconsideration of Extensions of Benefits Denial 9-1-24

A. Any reconsideration request for denial of extension of benefits must be received at AFMC within thirty (30) days of the date of denial notice. The following information is required from providers requesting reconsideration of denial:

1. Return a copy of current NOTICE OF ACTION denial letter with re-submissions.

2. Return all previously submitted documentation as well as additional information for reconsideration.

B. Only one reconsideration is allowed. Any reconsideration request that does not include required documentation will be automatically denied.

C. Further clinical documentation shall be requested when deemed necessary to complete the medical review.

214.950 Reserved 9-1-24

214.951 Appealing an Adverse Decision 9-1-24

When the Division of Medical Services (DMS) denies a benefit extension request for laboratory and x-ray services, and the beneficiary wishes to appeal the denial, the beneficiary may request a fair hearing.

An appeal request must be in writing and received by the Appeals and Hearings Section of the Department of Human Services within 30 days of the date on the letter from DMS explaining the denial. Appeal requests must be submitted to the Department of Human Services Appeals and Hearings Section. View or print the Department of Human Services Appeals and Hearings Section contact information.

214.952 Requesting Initiation or Continuation of Services Pending the Outcome of an Appeal 9-1-24

A. A beneficiary may request that services be continued (or that services begin, in cases where coverage has been denied), pending the outcome of an appeal.

1. Appeals that include a request to begin or continue services must be received by the DHS Appeals and Hearing Section within 10 days of the date on the DMS denial letter.

2. When such requests are made and timely received by the Appeals and Hearings Section, DMS will authorize the services and notify the provider and beneficiary.

3. The provider will be reimbursed for services furnished under these circumstances and for which the provider correctly bills Medicaid.

B. If the beneficiary loses the appeal, DMS will take action to recover from the beneficiary Medicaid's payments for the services that were provided pending the outcome of the appeal.

215.000 Fluoride Varnish Treatment 9-1-24

Arkansas Medicaid covers fluoride varnish application, ADA code, performed by physicians who have completed the online training program approved by the Arkansas Department of Health, Office of Oral Health.

View or print the procedure codes for Physician Assistant services.

Eligible physicians may delegate the application to a nurse or other licensed health care professional under his or her supervision that has also completed the online training. The online training course can be accessed at **http://ar.train.org**. Each provider must maintain documentation to establish his or her successful completion of the training and submit a copy of the certificate of completion to Provider Enrollment.

220.000 PRIOR AUTHORIZATION

221.000 Procedure for Obtaining Prior Authorization 9-1-24

A. Certain medical and surgical procedures are not covered without prior authorization, because of federal requirements or because of the elective nature of the surgery.

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 extension of benefits.**

1. Prior authorization determinations are in accordance with established medical 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 service does not guarantee eligibility for a beneficiary. Payment is subject to verification that the beneficiary is Medicaid-eligible at the time services are provided.

221.100 Post-Procedural Authorization 9-1-24

Post-procedural authorization will be granted only for emergency procedures for beneficiaries twenty-one (21) years of age or older. Requests for post-authorization of an emergency procedure must be applied for on the first working day after the procedure is 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 displayed in the electronic eligibility verification response.

221.110 Post-Procedural Authorization Process for Beneficiaries Under Age 21 9-1-24

A. Providers performing surgical procedures that require prior authorization are allowed sixty (60) days from the date of service to obtain a prior authorization number if the beneficiary is under twenty-one (21) years of age.

B. The following post-procedural authorization process must be followed when obtaining an authorization number.

1. 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.**
2. 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**.
3. The provider must supply the identifying criteria for the beneficiary and provider and all medical data necessary to justify the procedures.
4. Consultants are responsible for DHS or its designated vendor having their required and restricted procedures added to the PA file. They will be given the prior authorization number at the time of contact on cases that are approved.

Providers must obtain prior authorization for procedures requiring authorization to prevent risk of denial due to lack of medical necessity.

221.200 Prescription Prior Authorization 9-1-24

Prescription drugs are available for reimbursement under the Arkansas Medicaid Program when prescribed by a Physician Assistant with prescriptive authority. Certain prescription drugs may require prior authorization. It is the responsibility of the prescriber to request and obtain the prior authorization. Information may be obtained from DHS or its designated vendor. **View or print contact information to obtain the DHS or designated vendor prescription drug information.**

The following information is available:

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.

221.300 Procedures that Require Prior Authorization 9-1-24

Medical or surgical procedures that are generally restricted to the outpatient setting no longer require prior authorization for inpatient services.

222.000 Appeal Process for Medicaid Beneficiaries 9-1-24

When the Division of Medical Services denies coverage of services the beneficiary may request a fair hearing of the reconsideration decision of the denial of services from the Department of Human Services.

The appeal request must be in writing and received by the Appeals and Hearings Section of the Department of Human Services within thirty (30) days of the date on the letter explaining the denial. Appeal requests must be submitted to the Department of Human Services Appeals and Hearings Section. **View or print the Department of Human Services Appeals and Hearings Section contact information**.

230.000 REIMBURSEMENT

231.000 Method of Reimbursement 9-1-24

Medicaid reimbursement for Physician Assistant services is based on the lesser of the amount billed or the Title XIX maximum allowable.

231.010 Fee Schedules 9-1-24

Arkansas Medicaid provides fee schedules on the ~~Arkansas Medicaid~~DMS website**. View t~~The fee schedules~~** ~~link is located at **https://medicaid.mmis.arkansas.gov/** under the provider manual section~~. The fees represent the fee-for-service reimbursement methodology.

Fee schedules do not address coverage limitations or special instructions applied by Arkansas Medicaid before final payment is determined.

Procedure codes and fee schedules do not guarantee payment, coverage or amount allowed. Information may be changed or updated at any time to correct a discrepancy or error. Arkansas Medicaid always reimburses the lesser of the amount billed or the Medicaid maximum.

232.000 Rate Appeal Process 9-1-24

A provider may request reconsideration of a program decision by writing to the Assistant Director, Division of Medical Services. This request must be received within twenty (20) calendar days following the application of policy or procedure or the notification of the provider of its rate. Upon receipt of the request for review, the Assistant Director will determine the need for a program or provider conference and will contact the provider to arrange a conference if needed. Regardless of the program decision, the provider will be afforded the opportunity for a conference, if he or she so wishes, for a full explanation of the factors involved and the program decision. Following review of the matter, the Assistant Director will notify the provider of the action to be taken by the Division within twenty (20) calendar days of receipt of the request for review or the date of the program or provider conference.

If the decision of the Assistant Director, Division of Medical Services is unsatisfactory, the provider may then appeal the question to a standing rate review panel established by the Director of the Division of Medical Services. The rate review panel will include one (1) member of the Division of Medical Services, a representative of the provider association and a member of the Department of Human Services (DHS) management staff, who will serve as chairman.

The request for review by the rate review panel must be postmarked within fifteen (15) calendar days following the notification of the initial decision by the Assistant Director, Division of Medical Services. The rate review panel will meet to consider the question(s) within fifteen (15) calendar days after receipt of a request for such appeal. The question(s) will be heard by the panel and a recommendation will be submitted to the Director of the Division of Medical Services.

250.000 BILLING PROCEDURES

252.000 Introduction to Billing 9-1-24

Physician Assistant providers use the CMS-1500 form to bill the Arkansas Medicaid Program on paper for services provided to eligible Medicaid beneficiaries. Each claim may contain charges for only one (1) beneficiary.

Section III of this manual contains information about available options for electronic claim submission.

252.000 CMS-1500 Billing Procedures

252.100 Reserved 9-1-24

252.110 Billing Protocol for Computed Tomographic Colonography (CT) 9-1-24

A. The following procedure codes are covered for CT colonography for beneficiaries of all ages.

View or print the procedure codes for Physician Assistant services.

B. Billing protocol for CT colonography procedure codes:

1. CT colonography is billable electronically or on paper claims.
2. For the Physician Assistant, the above listed procedure codes are only payable for the technical component.

See Section 252.442 for additional information about the technical component.

252.120 Reserved 9-1-24

252.130 Special Billing Instructions 9-1-24

A. Use the following procedure codes for billing.

View or print the procedure codes for Physician Assistant services.

B. For consideration of any claims with payable CPT or HCPCS unlisted procedure codes, the provider must submit a paper claim that includes a description of the service that is being represented by that unlisted code on the claim form. Documentation that further describes the service provided must be attached and must include justification for medical necessity.

C. If authorized by the supervising physician, a physician assistant shall be:

1. Identified as the rendering provider in billing and claims processes when the physician assistant rendered the medical services to the Medicaid beneficiary; and
2. Allowed to file claims as the billing provider for medical services provided to a Medicaid beneficiary by the physician assistant.

All other billing requirements must be met in order for payment to be approved.

252.131 Molecular Pathology 9-1-24

The following Molecular Pathology codes require prior authorization from the Arkansas Foundation for Medical Care. See Sections 221.000 through 221.300 for prior authorization procedures.

View or print the procedure codes for Physician Assistant services.

252.132 Special Billing Requirements for Lab and X-Ray Services 9-1-24

For consideration of payable unlisted CPT/HCPCS drug procedure codes:

A. The provider must submit a paper claim that includes a description of the drug being represented by the unlisted procedure code on the claim form.

B. Documentation that further describes the drug provided must be attached and must include justification for medical necessity.

C. All other billing requirements must be met in order for payment to be approved.

View or print the procedure codes for Physician Assistant services.

252.200 Reserved 9-1-24

252.210 National Place of Service (POS) Codes 9-1-24

Electronic and paper claims now require the same National Place of Service code.

Place of Service	POS Codes
Inpatient Hospital	21
Off-Campus Outpatient Hospital	19
On-Campus Outpatient Hospital	22
Office	11
Patient's Home	12
Day Care Facility	99
Nursing Facility	32
Skilled Nursing Facility	31
Ambulance	41
Other Locations	99

252.300 Billing Instructions – Paper Claims Only 9-1-24

Bill Medicaid for Physician Assistant services with form CMS-1500. The numbered items in the following instructions correspond to the numbered fields on the claim form. **View a sample form CMS-1500.**

Carefully follow these instructions to help the Arkansas Medicaid fiscal agent efficiently process claims. Accuracy, completeness, and clarity are essential. Claims cannot be processed if necessary information is omitted.

Forward completed claim forms to the Claims Department. **View or print the Claims Department contact information.**

NOTE: A provider delivering services without verifying beneficiary eligibility for each date of service does so at the risk of not being reimbursed for the services.

252.310 Completion of CMS-1500 Claim Form 9-1-24

Field Name and Number	Instructions for Completion
1. (type of coverage)	Not required.
1a. INSURED'S I.D. NUMBER (For Program in Item 1)	Beneficiary's or participant's 10-digit Medicaid or ARKids First-A or ARKids First-B identification number.
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)	Beneficiary's or participant's last name and first name.
3. PATIENT'S BIRTH DATE	Beneficiary's or participant's date of birth as given on the individual's Medicaid or ARKids First-A or ARKids First-B identification card. Format: MM/DD/YY.
SEX	Check M for male or F for female.
4. INSURED'S NAME (Last Name, First Name, Middle Initial)	Required if insurance affects this claim. Insured's last name, first name, and middle initial.
5. PATIENT'S ADDRESS (No., Street)	Optional. Beneficiary's or participant's complete mailing address (street address or post office box).
CITY	Name of the city in which the beneficiary or participant resides.
STATE	Two-letter postal code for the state in which the beneficiary or participant resides.
ZIP CODE	Five-digit zip code; nine digits for post office box.
TELEPHONE (Include Area Code)	The beneficiary's or participant's telephone number or the number of a reliable message, contact, or emergency telephone.
6. PATIENT RELATIONSHIP TO INSURED	If insurance affects this claim, check the box indicating the patient's relationship to the insured.
7. INSURED'S ADDRESS (No., Street)	Required if insured's address is different from the patient's address.
CITY	
STATE	
ZIP CODE	
TELEPHONE (Include Area Code)	
8. RESERVED	Reserved for NUCC use.
9. OTHER INSURED'S NAME (Last name, First Name, Middle Initial)	If patient has other insurance coverage as indicated in Field 11d, the other insured's last name, first name, and middle initial.
a. OTHER INSURED'S POLICY OR GROUP NUMBER	Policy or group number of the insured individual.
b. RESERVED	Reserved for NUCC use.
SEX	Not required.
c. RESERVED	Reserved for NUCC use.

Field Name and Number	Instructions for Completion
d. INSURANCE PLAN NAME OR PROGRAM NAME	Name of the insurance company.
10. IS PATIENT'S CONDITION RELATED TO:	
a. EMPLOYMENT? (Current or Previous)	Check YES or NO.
b. AUTO ACCIDENT?	Required when an auto accident is related to the services. Check YES or NO.
PLACE (State)	If 10b is YES, the two-letter postal abbreviation for the state in which the automobile accident took place.
c. OTHER ACCIDENT?	Required when an accident other than automobile is related to the services. Check YES or NO.
d. CLAIM CODES	The "Claim Codes" identify additional information about the beneficiary's condition or the claim. When applicable, use the Claim Code to report appropriate claim codes as designated by the NUCC. When required to provide the subset of Condition Codes, enter the condition code in this field. The subset of approved Condition Codes is found at **www.nucc.org** under Code Sets.
11. INSURED'S POLICY GROUP OR FECA NUMBER	Not required when Medicaid is the only payer.
a. INSURED'S DATE OF BIRTH	Not required.
SEX	Not required.
b. OTHER CLAIM ID NUMBER	Not required.
c. INSURANCE PLAN NAME OR PROGRAM NAME	Not required.
d. IS THERE ANOTHER HEALTH BENEFIT PLAN?	When private or other insurance may or will cover any of the services, check YES and complete items 9, 9a and 9d. Only one (1) box can be marked.
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE	Enter "Signature on File," "SOF" or legal signature.
13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE	Enter "Signature on File," "SOF" or legal signature.
14. DATE OF CURRENT: ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)	Required when services furnished are related to an accident, whether the accident is recent or in the past. Date of the accident. Enter the qualifier to the right of the vertical dotted line. Use Qualifier 431 Onset of Current Symptoms or Illness; 484 Last Menstrual Period.

Field Name and Number	Instructions for Completion
15. OTHER DATE	Enter another date related to the beneficiary's condition or treatment. Enter the qualifier between the left-hand set of vertical, dotted lines. The "Other Date" identifies additional date information about the beneficiary's condition or treatment. Use qualifiers: 454 Initial Treatment 304 Latest Visit or Consultation 453 Acute Manifestation of a Chronic Condition 439 Accident 455 Last X-Ray 471 Prescription 090 Report Start (Assumed Care Date) 091 Report End (Relinquished Care Date) 444 First Visit or Consultation
16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION	Not required.
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	Name and title of referral source, whether an individual (such as a PCP) or a clinic or other facility.
17a. (blank)	Not required.
17b. NPI	Enter NPI of the referring physician.
18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES	When the serving or billing provider's services charged on this claim are related to a beneficiary's or participant's inpatient hospitalization, enter the individual's admission and discharge dates. Format: MM/DD/YY.
19. ADDITIONAL CLAIM INFORMATION	Identifies additional information about the beneficiary's condition or the claim. Enter the appropriate qualifiers describing the identifier. See **www.nucc.org** for qualifiers.
20. OUTSIDE LAB?	Not required.
$ CHARGES	Not required.

Field Name and Number	Instructions for Completion
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY	Enter the applicable ICD indicator to identify which version of ICD codes is being reported. Use “9” for ICD-9-CM. Use “0” for ICD-10-CM. Enter the indicator between the vertical, dotted lines in the upper right-hand portion of the field. Diagnosis code for the primary medical condition for which services are being billed. Use the appropriate version of the International Classification of Diseases. List no more than 12 ICD diagnosis codes. Relate lines A-L to the lines of service in 24E by the letter of the line. Use the highest level of specificity.
22. RESUBMISSION CODE ORIGINAL REF. NO.	Reserved for future use. Any data or other information listed in this field does not and will not adjust, void, or otherwise modify any previous payment or denial of a claim. Claim payment adjustments, voids, and refunds must follow previously established processes in policy.
23. PRIOR AUTHORIZATION NUMBER	The prior authorization or benefit extension control number if applicable.
24A. DATE(S) OF SERVICE	The “from” and “to” dates of service for each billed service. Format: MM/DD/YY. 1. On a single claim detail (one (1) charge on one (1) line), bill only for services provided within a single calendar month. 2. Some providers may bill on the same claim detail for two (2) or more sequential dates of service within the same calendar month when the provider furnished equal amounts of the service on each day of the date sequence.
B. PLACE OF SERVICE	Enter the appropriate place of service code. See Section 252.200 for codes.
C. EMG	Check “Yes” or leave blank if “No.” EMG identifies if the service was an emergency.
D. PROCEDURES, SERVICES, OR SUPPLIES	
CPT/HCPCS	Enter the correct CPT or HCPCS procedure code from Sections 252.100 through 252.132.
MODIFIER	Modifier(s) if applicable.

Field Name and Number	Instructions for Completion
E. DIAGNOSIS POINTER	Enter the diagnosis code reference letter (pointer) as shown in Item Number 21 to relate to the date of service and the procedures performed to the primary diagnosis. When multiple services are performed, the primary reference letter for each service should be listed first; other applicable services should follow. The reference letter(s) should be A-L or multiple letters as applicable. The "Diagnosis Pointer" is the line letter from Item Number 21 that relates to the reason the service(s) was performed.
F. $ CHARGES	The full charge for the service(s) totaled in the detail. This charge must be the usual charge to any client, patient, or other beneficiary of the provider's services.
G. DAYS OR UNITS	The units (in whole numbers) of service(s) provided during the period indicated in Field 24A of the detail.
H. EPSDT/Family Plan	Enter E if the services resulted from a Child Health Services (EPSDT) screening or referral.
I. ID QUAL	Not required.
J. RENDERING PROVIDER ID #	Enter the 9-digit Arkansas Medicaid provider ID number of the individual who furnished the services billed for in the detail or
NPI	Enter NPI of the individual who furnished the services billed for in the detail.
25. FEDERAL TAX I.D. NUMBER	Not required. This information is carried in the provider's Medicaid file. If it changes, please contact Provider Enrollment.
26. PATIENT'S ACCOUNT N O.	Optional entry that may be used for accounting purposes; use up to sixteen (16) numeric or alphabetic characters. This number appears on the Remittance Advice as "MRN."
27. ACCEPT ASSIGNMENT?	Not required. Assignment is automatically accepted by the provider when billing Medicaid.
28. TOTAL CHARGE	Total of Column 24F—the sum all charges on the claim.
29. AMOUNT PAID	Enter the total of payments previously received on this claim. Do not include amounts previously paid by Medicaid. *Do **not** include in this total the automatically deducted Medicaid or ARKids First-B co-payments.
30. RESERVED	Reserved for NUCC use.

Field Name and Number	Instructions for Completion
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS	The provider or designated authorized individual must sign and date the claim certifying that the services were personally rendered by the provider or under the provider's direction. "Provider's signature" is defined as the provider's actual signature, a rubber stamp of the provider's signature, an automated signature, a typewritten signature, or the signature of an individual authorized by the provider rendering the service. The name of a clinic or group is not acceptable.
32. SERVICE FACILITY LOCATION INFORMATION	If other than home or office, enter the name and street, city, state, and zip code of the facility where services were performed.
a. (blank)	Not required.
b. (blank)	Not required.
33. BILLING PROVIDER INFO & PH #	Billing provider's name and complete address. Telephone number is requested but not required.
a. (blank)	Enter NPI of the billing provider or
b. (blank)	Enter the 9-digit Arkansas Medicaid provider ID number of the billing provider.

252.400 Special Billing Procedures

252.410 Clinic or Group Billing 9-1-24

Providers who wish to have payment made to a group practice or clinic must enroll as a group practice. When billing, enter the Clinic/Group pay-to Provider Identification Number in Field 33 after "GRP#." Enter the performing provider identification number in Field 24K. If more than one (1) Physician Assistant in a group practice provides services for a beneficiary, the clinic may bill for all their services on the same claim limited only by the size of the claim format.

Procedure code is payable when provided in the inpatient hospital setting by a Physician Assistant.

View or print the procedure codes for Physician Assistant services.

252.420 Evaluations and Management

252.421 Initial Visit 9-1-24

The American Medical Association's *Current Procedures Terminology* (CPT) codes should be used only for the first visit of a new patient. Each subsequent visit should be billed using an established patient code. A distinction is made in CPT codes for new or established patients for office visits, home visits, nursing facility visits and emergency room visits. Refer to the latest edition of the CPT.

Providers are allowed to bill one (1) new patient visit procedure code per beneficiary, per attending provider in a three (3) year period.

252.422 Detention Time (Standby Service) 9-1-24

View or print the procedure codes for Physician Assistant services.

Procedure code must be used by Physician Assistants when billing for detention time.

One (1) unit equals thirty (30) minutes. A maximum of one (1) unit per date of service may be billed.

Procedure code is payable when provided in the inpatient hospital setting by a Physician Assistant.

252.423 Inpatient Hospital Visits 9-1-24

Each Physician Assistant is limited to billing one (1) day of care for each inpatient hospital covered day, regardless of the number of hospital visits rendered.

252.424 Hospital Discharge Day Management 9-1-24

View or print the procedure codes for Physician Assistant services.

Procedure code, hospital discharge day management, may not be billed by providers on the same date of service as an initial or subsequent hospital care code, procedures. Initial hospital care codes and subsequent hospital care codes may not be billed on the day of discharge.

252.425 Nursing Home Visits 9-1-24

The appropriate CPT procedure codes should be used when billing for Physician Assistant visits in a nursing facility.

252.426 Specimen Collections 9-1-24

The policy in regard to collection, handling, and conveyance of specimens is:

A. Reimbursement will not be made for specimen handling fees.

B. A specimen collection fee may be allowed only in circumstances including:

1 drawing a blood sample through venipuncture (for example, inserting into a vein a needle with syringe or vacutainer to draw the specimen); or

2 collecting a urine sample by catheterization.

The following codes should be used when billing for specimen collection:

View or print the procedure codes for Physician Assistant services.

252.428 Services Not Considered a Separate Service from an Office Visit 9-1-24

Some services (examples include, but are not limited to, pelvic examinations, prostate massages, and removal of sutures) are not considered a separate service from an office visit. The charge for such services should be included in the office visit charge. Billing should be under the office visit procedure code that reflects the appropriate level of care. Procedure code should never be used for billing routine pelvic examinations, but should be used only when a pelvic examination is done under general anesthesia.

View or print the procedure codes for Physician Assistant services.

252.429 Health Examinations for ARKids First B Beneficiaries and Medicaid Beneficiaries Under Age 21 9-1-24

Providers should refer to the Child Health Services (EPSDT) Provider manual and the ARKids First-B Provider manual for covered services and billing procedures.

252.430 Family Planning Services Program Procedure Codes 9-1-24

A. Family planning services are covered for beneficiaries in full coverage aid categories. For information regarding additional aid categories, see Section 124.000. **All procedure codes in these tables require a primary diagnosis code of family planning in each claim detail. Please note: See the tables below within this section to determine restrictions applicable to some procedures**. Laboratory procedure codes covered for family planning are listed in **Section 252.431**.

B. Sterilization

A copy of the properly completed Sterilization Consent Form (DMS-615), with all items legible, must be attached to each sterilization claim submitted from each provider before payment may be approved. Providers include hospitals, physicians, anesthesiologists and assistant surgeons. It is the responsibility of the physician performing the sterilization procedure to distribute correct legible copies of the signed consent form (DMS-615) to the hospital, anesthesiologist and assistant surgeon.

Though prior authorization is not required, an improperly completed Sterilization Consent Form (DMS-615) results in the delay or denial of payment for the sterilization procedures. The checklist lists the items on the consent form that are reviewed before payment is made for any sterilization procedure. Use this checklist before submitting any consent form and claim for payment to be sure that all criteria have been met. **View or print form DMS-615 (English) and the checklist**. **View or print form DMS-615 (Spanish) and the checklist**.

C. The procedure code table located within the hyperlink below explains the family planning visit services payable to Physician Assistants.

NOTE: The procedure codes with the modifiers indicated in the table denote the Arkansas Medicaid description.

View or print the procedure codes for Physician Assistant services.

D. The procedure code table explains family planning codes payable to Physician Assistants. Use the FP modifier for family planning services.

252.431 Family Planning Laboratory Procedure Codes 9-1-24

Family planning services are covered for beneficiaries in full coverage aid categories. For information regarding additional aid categories, see Section 124.000. For eligible beneficiaries, these codes are payable when used for purposes other than family planning. Claims require modifier FP when the service diagnosis indicates family planning.

A. The procedure code table within the hyperlink contains family planning laboratory procedure codes.*

View or print the procedure codes for Physician Assistant services.

*Procedure codes are limited to one (1) unit per beneficiary per state fiscal year; are payable only to pathologists and independent labs; require FP modifier only.

B. Laboratory codes payable to **non-hospital-based Physician Assistants.**

The procedure code table contains laboratory services payable to non-hospital-based Physician Assistants.

C. Laboratory codes payable to **hospital-based Physician Assistants.**

The procedure code table within the hyperlink describes the **laboratory services payable to hospital-based Physician Assistants**.

252.438 National Drug Codes (NDCs) 9-1-24

Effective for claims with dates of service on or after January 1, 2008, Arkansas Medicaid implemented billing protocol per the Federal Deficit Reduction Act of 2005. This explains policy and billing protocol for providers that submit claims for drug HCPCS/CPT codes with dates of service on and after January 1, 2008.

The Federal Deficit Reduction Act of 2005 mandates that Arkansas Medicaid require the submission of National Drug Codes (NDCs) on claims submitted with Healthcare Common Procedure Coding System, Level II/Current Procedural Terminology, 4th edition (HCPCS/CPT) codes for **drugs** administered. The purpose of this requirement is to assure that the State Medicaid Agencies obtain a rebate from those manufacturers who have signed a rebate agreement with the Centers for Medicare and Medicaid Services (CMS).

A. Covered Labelers

Arkansas Medicaid, by statute, will only pay for a drug procedure billed with an NDC when the pharmaceutical labeler of that drug is a covered labeler with Centers for Medicare and Medicaid Services (CMS). A "covered labeler" is a pharmaceutical manufacturer that has entered into a federal rebate agreement with CMS to provide each state a rebate for products reimbursed by Medicaid Programs. A covered labeler is identified by the first five (5) digits of the NDC. To assure a product is payable for administration to a Medicaid beneficiary, compare the labeler code (the first five (5) digits of the NDC) to the list of covered labelers which is maintained on the **DHS contracted Pharmacy vendor** website.

A complete listing of **"Covered Labelers"** is located on the website. See Diagram 1 for an example of this screen. The effective date is when a manufacturer entered into a rebate agreement with CMS. The *Labeler termination date* indicates that the manufacturer no longer participates in the federal rebate program and therefore the products cannot be reimbursed by Arkansas Medicaid on or after the *termination date*.

Diagram 1

Labeler ID	Labeler Name	Contract Begin Date	Contract End Date
00002	ELI LILLY AND COMPANY	01/01/1991	01/01/3000
00003	E.R. SQUIBB & SONS, LLC.	01/01/1991	01/01/3000
00004	GENENTECH, INC.	01/01/1991	01/01/3000
00006	MERCK SHARP & DOHME CORP.	01/01/1991	01/01/3000
00007	GLAXOSMITHKLINE LLC	01/01/1991	01/01/3000
00008	WYETH PHARMACEUTICALS LLC,	01/01/1991	01/01/3000
00009	PHARMACIA AND UPJOHN COMPANY LLC	01/01/1991	01/01/3000
00013	PFIZER LABORATORIES DIV PFIZER INC	01/01/1991	01/01/3000
00014	PFIZER, INC	01/01/1991	01/01/3000
00015	MEAD JOHNSON AND COMPANY	01/01/1991	01/01/3000
00023	ALLERGAN INC	01/01/1991	01/01/3000
00024	SANOFI-AVENTIS, US LLC	01/01/1991	01/01/3000
00025	PFIZER LABORATORIES DIV PFIZER INC	01/01/1991	01/01/3000
00026	BAYER HEALTHCARE LLC	01/01/1991	01/01/3000
00032	ABBVIE INC.	01/01/1991	01/01/3000

For a claim with drug HCPCS/CPT codes to be eligible for payment, the detail date of service must be prior to the *NDC termination date*. The NDC termination date represents the shelf-life expiration date of the last batch produced, as supplied on the Centers for Medicare and Medicaid Services (CMS) quarterly update. The date is supplied to CMS by the drug manufacturer or distributor.

Arkansas Medicaid will deny claim details with drug HCPCS/CPT codes with a detail date of service equal to or greater than the NDC termination date.

When completing a Medicaid claim for administering a drug, indicate the HIPAA standard 11-digit NDC with no dashes or spaces. The 11-digit NDC is comprised of three (3) segments or codes: a 5-digit labeler code, a 4-digit product code, and a 2-digit package code. The 10-digit NDC assigned by the FDA printed on the drug package must be changed to the 11-digit format by inserting a leading zero (0) in one (1) of the three (3) segments. Below are examples of the FDA assigned NDC on a package changed to the appropriate 11-digit HIPAA standard format. Diagram 2 displays the labeler code as five (5) digits with leading zeros; the product code as four (4) digits with leading zeros; the package code as two (2) digits without leading zeros, using the "5-4-2" format.

Diagram 2

00123	0456	78
LABELER CODE (5 digits)	PRODUCT CODE (4 digits)	PACKAGE CODE (2 digits)

NDCs submitted in any configuration other than the 11-digit format will be rejected and denied. NDCs billed to Medicaid for payment must use the 11-digit format without dashes or spaces between the numbers.

See Diagram 3 for sample NDCs as they might appear on drug packaging and the corresponding format which should be used for billing Arkansas Medicaid:

Diagram 3

10-digit FDA NDC on PACKAGE	Required 11-digit NDC (5-4-2) Billing Format
12345 6789 1	12345678901
1111-2222-33	01111222233
01111 456 71	01111045671

B. Drug Procedure Code (HCPCS/CPT) to NDC Relationship and Billing Principles

HCPCS/CPT codes and any modifiers will continue to be billed per the policy for each procedure code. However, the NDC and NDC quantity of the administered drug is now also required for correct billing of drug HCPCS/CPT codes. To maintain the integrity of the drug rebate program, it is important that the specific NDC from the package used at the time of the procedure be recorded for billing. HCPCS/CPT codes submitted using invalid NDCs or NDCs that were unavailable on the date of service will be rejected and denied. We encourage you to enlist the cooperation of all staff members involved in drug administration to assure collection or notation of the NDC from the actual package used. It is not recommended that billing of NDCs be based on a reference list, as NDCs vary from one (1) labeler to another, from one (1) package size to another, and from one (1) time period to another.

Exception: There is no requirement for an NDC when billing for vaccines, radiopharmaceuticals, and allergen immunotherapy.

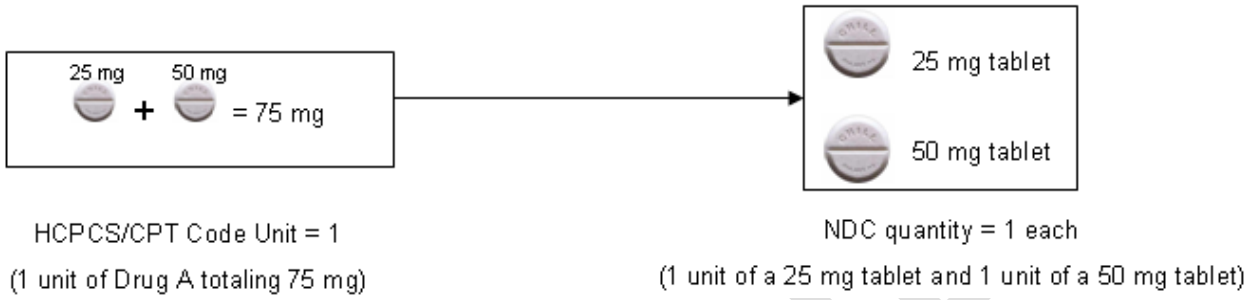
I. Claims Filing

The HCPCS/CPT codes billing units and the NDC quantity do not always have a one-to-one relationship.

Example 1: The HCPCS/CPT code may specify up to seventy-five milligrams (75mg) of the drug whereas the NDC quantity is typically billed in units, milliliters, or grams. If the patient is

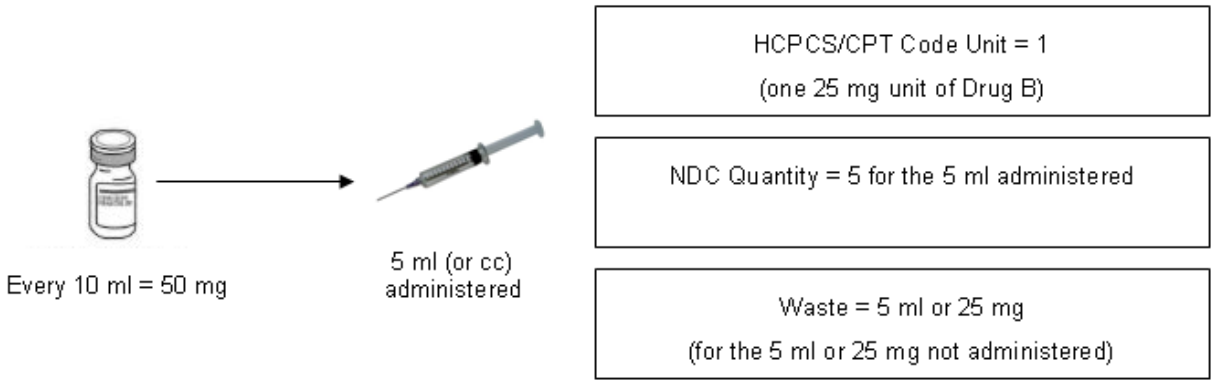
provided two (2) oral tablets, one at twenty-five milligrams (25mg) and one at fifty milligrams (50mg), the HCPCS/CPT code unit would be 1 (one (1) total of seventy-five milligrams (75mg)) in the example whereas the NDC quantity would be 1 each (one (1) unit of the twenty-five milligram (25mg) tablet and one (1) unit of the fifty milligram (50mg) tablet). See Diagram 4.

Diagram 4



Example 2: If the drug in the example is an injection of five milliliters (5ml) or cc of a product that was fifty milligrams (50mg) per ten milliliters (10ml) of a ten milliliter (10ml) single-use vial, the HCPCS/CPT code unit would be 1 (one (1) unit of twenty-five milligrams (25mg)) whereas the NDC quantity would be 5 (five milliliters (5ml)). In this example, five milliliters (5ml) or twenty-five milligrams (25mg) would be documented as wasted. See Diagram 5. For billing wastage, see bullets A (Electronic Claims Filing) and B (Paper Claims Filing) below.

Diagram 5



A. Electronic Claims Filing – 837P (Professional) and 837I (Outpatient)

Providers are instructed to bill as follows:

- One (1) NDC for a procedure – 1st/only detail shall be billed with no modifier
- Two (2) NDCs for same procedure – 1st detail shall be billed with a KP and 2nd gets billed with a KQ modifier
- Three (3) NDCs for same procedure – 1st detail shall be billed with a KP and 2nd & 3rd detail get billed with a KQ modifier
- Four (4) or more NDCs for same procedure – submit via paper claim
- Wastage of each NDC shall be billed on a separate line with a JW modifier.

NOTE: The NDCs listed above are not the same (unless with a JW modifier). Same NDCs shall be billed on a single line with appropriate units.

NOTE: CMS definitions of modifiers:

- KP = First drug of a multiple drug unit dose formulation
- KQ = Second or subsequent drug of a multiple drug unit dose formulation
- JW = Drug wastage

B. Paper Claims Filing – CMS-1500

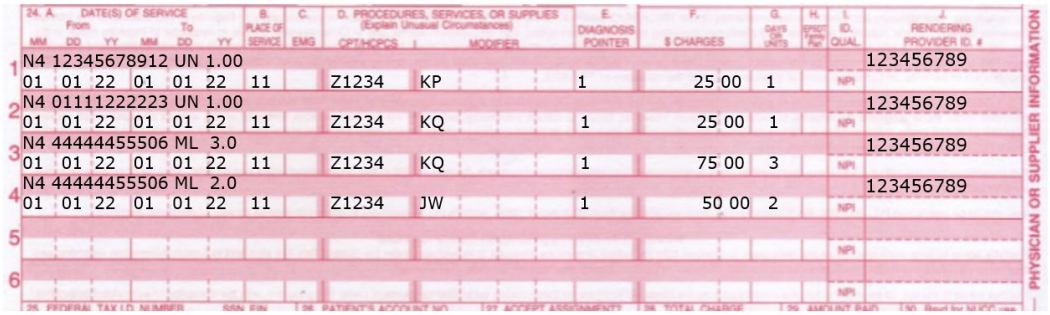
Providers are instructed to bill as follows:

- One (1) NDC for a procedure – 1st/only detail shall be billed with no modifier
- Two (2) NDCs for same procedure – 1st detail shall be billed with a KP and 2nd gets billed with a KQ modifier
- Three (3) NDCs for same procedure – 1st detail shall be billed with a KP and 2nd & 3rd detail get billed with a KQ modifier
- Four (4) or more NDCs for same procedure – 1st detail shall be billed with a KP and 2nd and subsequent details shall be billed with a KQ modifier
- Wastage of each NDC shall be billed on a separate line with a JW modifier.

NOTE: CMS definitions of modifiers:

- KP = First drug of a multiple drug unit dose formulation
- KQ = Second or subsequent drug of a multiple drug unit dose formulation
- JW = Drug wastage

Diagram 6



24. A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1 N4 12345678912 UN 1.00															123456789
01	01	22	01	01	22	11		Z1234	KP	1	25 00	1		NPI	
2 N4 01111222223 UN 1.00															123456789
01	01	22	01	01	22	11		Z1234	KQ	1	25 00	1		NPI	
3 N4 44444455506 ML 3.0															123456789
01	01	22	01	01	22	11		Z1234	KQ	1	75 00	3		NPI	
4 N4 44444455506 ML 2.0															123456789
01	01	22	01	01	22	11		Z1234	JW	1	50 00	2		NPI	
5														NPI	
6														NPI	

PHYSICIAN OR SUPPLIER INFORMATION

II. Adjustments

Paper adjustments for paid claims filed with NDC numbers will not be accepted. Any original claim will have to be voided and a replacement claim will need to be filed. Providers have the option of adjusting a paper or electronic claim electronically.

III. Record Retention

Each provider must retain all records for five (5) years from the date of service or until all audit questions, dispute or review issues, appeal hearings, investigations or administrative/judicial litigation to which the records may relate are concluded, whichever period is longer.

At times, a manufacturer may question the invoiced amount, which results in a drug rebate dispute. If this occurs, you may be contacted requesting a copy of your office records to include documentation pertaining to the billed HCPCS/CPT code. Requested records may include NDC

invoices showing purchase of drugs and documentation showing what drug (name, strength and amount) was administered and on what date, to the beneficiary in question.

252.439 Billing of Multi-Use and Single-Use Vials 9-1-24

Arkansas Medicaid follows the billing protocol per the Federal Deficit Reduction Act of 2005 for drugs.

A. Multiple units may be billed when applicable. Take-home drugs are not covered. Drugs loaded into an infusion pump are not classified as "take-home drugs." Refer to payable CPT code ranges.

View or print the procedure codes for Physician Assistant services.

B. When submitting Arkansas Medicaid drug claims, drug units should be reported in multiples of the dosage included in the HCPCS procedure code description. If the dosage given is not a multiple of the number provided in the HCPCS code description the provider shall round up to the nearest whole number in order to express the HCPCS description number as a multiple.

1. **Single-Use Vials:** If the provider must discard the remainder of a **single-use vial** or other package after administering the prescribed dosage of any given drug, Arkansas Medicaid will cover the amount of the drug discarded along with the amount administered. Discarded drugs shall be billed on a separate detail line with a JW (Drug wastage) modifier.
2. **Multi-Use Vials**: Multi-use vials are not subject to payment for any discarded amounts of the drug. The units billed must correspond with the units administered to the beneficiary.
3. **Documentation:** The provider must clearly document in the patient's medical record the actual dose administered in addition to the exact amount wasted and the total amount the vial is labeled to contain.

Remember to verify the milligrams given to the patient and then convert to the proper units for billing.

Follow the Centers for Disease Control (CDC) requirements for safe practices regarding expiration and sterility of multi-use vials.

252.440 Reserved 9-1-24

252.441 Family/Group Psychotherapy 9-1-24

The following psychotherapy procedure codes are payable by the Arkansas Medicaid Program for family or group psychotherapy:

View or print the procedure codes for Physician Assistant services.

Procedure codes are payable when the place of service is the beneficiary's home, the physician's office, a hospital or a nursing home. Procedure codes are payable when the patient is not present; however, the patient may be present during the session, when appropriate.

252.442 Radiology and Laboratory Procedure Codes 9-1-24

The technical component radiology procedure codes listed on the Physician Assistant fee schedule are payable when performed in the office place of service (11) if the Physician Assistant provider owns the equipment. The technical component must be billed on the claim with modifier TC added to the procedure code on the claim detail.

The payment for laboratory codes listed on the Physician Assistant fee schedule is based on Clinical Laboratory Improvement Amendments (CLIA) certification. CLIA-certified providers are not the only providers who may bill for lab procedures performed in the office place of service (11). Physician Assistant providers that bill CLIA-required laboratory procedure codes must have the current CLIA certification on file with the Provider Enrollment Unit.

252.443 Other Covered Injections 9-1-24

Physician Assistants billing the Arkansas Medicaid Program for injections for treatment or immunization purposes should bill the appropriate CPT or HCPCS procedure code for the specific injection provided. The immunization procedure codes and descriptions may be found in the CPT coding book and in this section of this manual.

Providers may bill the immunization procedure codes on either the Child Health Services (EPSDT) DMS-694 claim form or the CMS-1500 form.

If the patient is scheduled for immunization only, the provider will not be permitted to bill for an office visit, but for the immunization only.

The following is an alphabetized list of injections with special instructions for coverage and billing.

View or print the procedure codes for Physician Assistant services.

* Procedure code requires paper billing.

NOTE: Where both a national code and a local code ("Z code") are available, the local code can be used only for dates of service through October 15, 2003; the national code must be used for both electronic and paper claims for dates of service after October 15, 2003. Where only a local code is available, it can be used indefinitely, but it can be billed only on a paper claim. Where only a national code is available, it can be used indefinitely for both electronic and paper claims.

252.444 Billing Procedures for Rabies Immune Globulin and Rabies Vaccine 9-1-24

The following CPT procedure codes are covered for all ages without diagnosis restrictions.

View or print the procedure codes for Physician Assistant services.

These procedure codes require billing on a paper claim with the dosage entered in the units column of the claim form for each date of service. The manufacturer's invoice must be attached to each claim. Reimbursement for each of these procedure codes includes an administrations fee. Medical policy and billing procedures have not changed for these procedure codes.

252.445 Reserved 9-1-24

252.446 Reserved 9-1-24

252.447 Reserved 9-1-24

252.448 Medication Assisted Treatment and Opioid Use Disorder Treatment Drugs 9-1-24

Medication Assisted Treatment for Opioid Use Disorders is available to all qualifying Medicaid beneficiaries when provided by qualified physicians, physician assistants, or advanced practice registered nurses who are enrolled in an Arkansas Medicaid Program in which MAT services are rendered. All rules and regulations promulgated within the Physician's provider manual for provision of this service must be followed.

Effective for dates of services on and after **October 1, 2018**, the following Healthcare Common Procedure Coding System Level II (HCPCS) procedure codes are payable:

View or print the procedure codes for Physician Assistant services.

To access prior approval of these HCPCS procedure codes when necessary, refer to the Pharmacy Memorandums, Criteria Documents and forms found at the **DHS contracted Pharmacy vendor website**.

252.449 Influenza Virus Vaccine 9-1-24

View or print the procedure codes for Physician Assistant services.

A. Procedure code, influenza virus vaccine, split virus, preservative free, for children six to thirty-five (6-35) months of age, is currently covered through the VFC program. Claims for Medicaid beneficiaries must be filed using modifiers **EP** and **TJ**.

For ARKids First-B beneficiaries, use modifier **TJ**.

B. Effective for dates of service on and after October 1, 2005, Medicaid will cover procedure code, influenza virus vaccine, split virus, and preservative free, for ages three (3) years of age and older.

1. For individuals under nineteen (19) years of age, claims must be filed using modifiers **EP** and **TJ**.
2. For ARKids First-B beneficiaries, use modifier **TJ**.
3. For individuals nineteen (19) years of age and older, no modifier is necessary.

C. Effective for dates of service on and after October 1, 2005, procedure code, influenza virus vaccine, live, for intranasal use, is covered. Coverage is limited to healthy individuals five through forty-nine (5-49) years of age through 49 who are not pregnant.

1. When filing claims for children five through eighteen (5-18) years of age, use modifiers **EP** and **TJ**.
2. For ARKids First-B beneficiaries, the procedure code must be billed using modifier **TJ**.
3. No modifier is required for filing claims for beneficiaries nineteen through forty-nine (19-49) years of age.

D. Procedure code, influenza virus vaccine, split virus, for children six through thirty-five (6-35) months of age, is covered. Modifiers **EP** and **TJ** are required.

For ARKids First-B beneficiaries, use modifier **TJ**.

E. Procedure code, influenza virus vaccine, split virus, for use in individuals three (3) years of age and older, will continue to be covered.

1. When filing paper claims for individuals under nineteen (19) years of age, use modifiers **EP** and **TJ**.
2. For ARKids First-B beneficiaries, use modifier **TJ**.
3. No modifier is required for filing claims for beneficiaries nineteen (19) years of age and older.

252.450 Obstetrical Care and Risk Management Services for Pregnancy 9-1-24

Covered Physician Assistant obstetrical services are limited to antepartum and postpartum care only. Claims for antepartum and postpartum services are filed using the appropriate office visit CPT procedure code.

A Physician Assistant may provide risk management services listed below if he or she receives a referral from the patient's physician or certified nurse-midwife and if the Physician Assistant employs the professional staff required. Complete service descriptions and coverage information may be found in Section 214.620 of this manual. The services in the list below are considered to be one (1) service and are limited to thirty-two (32) cumulative units.

View or print the procedure codes for Physician Assistant services.

For an early discharge home visit, use one (1) of the applicable CPT procedure codes.

252.451 Fetal Non-Stress Test 9-1-24

The Fetal Non-Stress Test (procedure code) is limited to two (2) per pregnancy. If it is necessary to exceed this limit, the Physician Assistant must request an extension of benefits and submit documentation that establishes medical necessity.

View or print the procedure codes for Physician Assistant services.

252.452 Newborn Care 9-1-24

All newborn services must be billed under the newborn's own Medicaid identification number.

The parent(s) of the newborn will be responsible for applying for and meeting eligibility requirements for a newborn to be certified eligible. 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 Physician Assistant services.

For routine newborn care following a vaginal delivery or C-section, procedure codes must be used one (1) time to cover all newborn care visits by the attending physician, certified nurse-midwife or, if applicable, a Physician Assistant.

The newborn care procedure codes represent the initial Child Health Services (EPSDT) newborn care or screen. This screening includes the physical exam of the baby and the conference(s) with the newborn's parent(s). Payment of these codes is considered a global rate, and subsequent visits may not be billed in addition to these codes.

Procedure codes may be billed on the EPSDT screening paper form DMS-694 or on the electronic claim transaction format. These codes may also be filed on the CMS-1500; paper or electronically. For information on the Child Health Service (EPSDT) Program, call the Provider Assistance Center. **View or print Provider Assistance Center contact information.**

For illness care (such as neonatal jaundice), use procedure codes. Do not use procedure codes in addition to these codes.

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.

ARKids A (EPSDT) requires an EPSDT claim form or CMS-1500 claim form and may be billed electronically or on paper.

ARKids First B requires a CMS-1500 claim form and may be billed electronically or on paper.

252.453 Fluoride Varnish Treatment 9-1-24

View or print the procedure codes for Physician Assistant services.

The American Dental Association (ADA) procedure code is covered by the Arkansas Medicaid Program. This code is payable for beneficiaries under twenty-one (21) years of age. Topical

fluoride varnish application benefit is covered every six (6) months plus one (1) day for beneficiaries under twenty-one (21) years of age.

A new specialty code, FC-Fluoride Certification will be tied to provider types 01, 03, 58 and 69. These providers must send proof of their fluoride varnish certification to DHS or its designated vendor before the specialty code will be added to their file in the MMIS. **View or print contact information to obtain the DHS or designated vendor step-by-step process for provider enrollment.** After the specialty code, FC-Fluoride Certification, is added to the provider's file, the provider will be able to bill for procedure code, Topical Application of Fluoride Varnish.

Providers must check the Supplemental Eligibility Screen to verify that the topical fluoride varnish benefit of two (2) per State Fiscal Year (SFY) has not been exhausted. If further treatment is needed due to severe periodontal disease, then the beneficiary must be referred to a Medicaid dental provider.

NOTE: This service is billed on form CMS-1500 with ADA procedure code (Topical application of fluoride varnish (prophylaxis not included) – child (ages 0-20)). View a form CMS-1500 sample form.

252.454 Tobacco Cessation Products and Counseling Services 9-1-24

A. Tobacco cessation counseling and products are covered services to eligible Medicaid beneficiaries. Tobacco cessation products either prescribed or initiated through statewide pharmacist protocol are available without prior authorization (PA) to eligible Medicaid beneficiaries. Additional information can be found on the **DHS Contracted Pharmacy Vendor website** or in the **Prescription Drug Program Prior Authorization Criteria.**

View or print the procedure codes for Physician Assistant services.

*Exempt from PCP referral requirements.

⁂**(…)** This symbol, along with text in parentheses, indicates the Arkansas Medicaid description of the service. When using a procedure code with this symbol, the service must meet the indicated Arkansas Medicaid description.

B. Four (4) Counseling visits per state fiscal year.

C. Health education can include but is not limited to tobacco cessation counseling services to the parent or legal guardian of the child.

D. Can be billed in addition to an office visit or EPSDT.

E. Sessions do not require a PCP referral.

F. If the beneficiary is under eighteen (18) years of age, and the parent or legal guardian smokes, he or she can be counseled as well, and the visit billed under the minor's beneficiary Medicaid number. The provider cannot prescribe meds for the parent under the child's Medicaid number. A parent or legal guardian session will count towards the four (4) counselling sessions limit described in section B above.

The provider must complete the counseling checklist and place in the patient records for audit. A copy of the checklist is available at **Be Well Arkansas Referral Form**.

252.455 Physical Therapy Services Billing 9-1-24

Occupational therapy evaluations and services are payable only to a qualified occupational therapist. Physical therapy evaluations are not payable to the Physician Assistant. Physical therapy may be payable to the physician when directly provided in accordance with the Occupational, Physical, Speech Therapy Services Manual. The following procedure codes must

be used when filing claims for physician provided therapy services. See Glossary - Section IV - for definitions of "group" and "individual" as they relate to therapy services.

View or print the procedure codes for Physician Assistant services.

A provider must furnish a full unit of service to bill Medicaid for a unit of service. Partial units are not reimbursable. Extended therapy services may be requested for physical and speech therapy, if medically necessary, for eligible Medicaid beneficiaries of all ages.

252.456 Laboratory Procedures for Highly Active Antiretroviral Therapy (HAART) 9-1-24

The following CPT procedure codes are covered for Medicaid beneficiaries.

View or print the procedure codes for Physician Assistant services.

252.457 Procedures That Require Prior Authorization 9-1-24

A. The following procedure code requires prior authorization by the Arkansas Foundation for Medical Care (AFMC). (See Section 220.000 of this manual for prior authorization instructions.)

B. The following Molecular Pathology codes require prior authorization from AFMC.

View or print the procedure codes for Physician Assistant services.

252.460 Outpatient Hospital Services

252.461 Emergency Services 9-1-24

The appropriate CPT procedure codes should be used when billing for Physician Assistant visits in an outpatient hospital setting for emergency services.

252.462 Non-Emergency Services 9-1-24

Procedure code should be billed for a non-emergency Physician Assistant visit.

View or print the procedure codes for Physician Assistant services.

252.465 Observation Status 9-1-24

When claims are filed for services provided to a patient in "observation status," Physician Assistants must adhere to Arkansas Medicaid definitions of inpatient and outpatient. Observation status is an outpatient designation. Physician Assistants must also follow the guidelines and definitions in *Current Procedural Terminology* (CPT), under "Hospital Observation Services" and "Evaluation and Management Services Guidelines."

Arkansas Medicaid criteria determining inpatient and outpatient status:

A. If a patient is expected to remain in the hospital for less than twenty-four (24) consecutive hours, and this expectation is realized, the hospital and the Physician Assistant should consider the patient an outpatient meaning, the patient is an outpatient unless the Physician Assistant's supervising physician has admitted him or her as an inpatient).

B. If the Physician Assistant or hospital expects the patient to remain in the hospital for twenty-four (24) hours or more, Medicaid deems the patient admitted at the time the patient's medical record indicates the existence of such an expectation, though the Physician Assistant's supervising physician has not yet formally admitted the patient.

C. Medicaid also deems a patient admitted to inpatient status at the time they have remained in the hospital for twenty-four (24) consecutive hours, even if the Physician Assistant, the supervising physician or hospital had no prior expectation of a stay of that or greater duration.

252.466 Billing Examples **9-1-24**

The following table gives examples of appropriate Physician Assistant claims for several common hospital scenarios. In the table, instructions under the headings "PHYSICIAN ASSISTANT MAY BILL…" do not necessarily include all services that the Physician Assistant may bill. For instance, the provider may bill for interpretation of X-rays or diagnostic tests, though the table below does not indicate this. The purpose of this table is to illustrate Arkansas Medicaid observation status policy and to give guidance for filing claims related to evaluation and management services.

Arkansas Medicaid Observation Status Policy Illustration

PATIENT IS ADMITTED TO OBSERVATION	PATIENT IS	PHYSICIAN ASSISTANT MAY BILL FOR TUESDAY SERVICES:	PHYSICIAN ASSISTANT MAY BILL FOR WEDNESDAY SERVICES:
Tuesday, 3:00 PM	Still in Observation Wednesday, 3:00 PM	Appropriate level of Initial Observation Care	Appropriate level of Initial Hospital Care
Tuesday, 3:00 PM	Discharged Wednesday, 12:00 PM (noon)	Appropriate level of Initial Observation Care	Observation care Discharge Day Management
Tuesday, 3:00 PM	Discharged Wednesday, 4:00 PM	Appropriate level of Initial Observation Care	Appropriate level of Initial Hospital Care
Tuesday, 3:00 PM, after outpatient surgery	Discharged Wednesday, 10:00 AM	Outpatient surgery	No evaluation and Management Services
Tuesday, 3:00 PM, after exam in Emergency Department– emergency or non-emergency	Discharged Tuesday, 7:00 PM	Appropriate level of Initial Observation Care	Not Applicable; Patient was Discharged Tuesday

252.470 Prior Authorization Control Number **9-1-24**

When billing for procedures that have been prior authorized, the 10-digit prior authorization control number must be entered in the CMS-1500 claim format. See Section 220.000 of this manual for additional information on prior authorization.

252.480 Medicare **9-1-24**

When a beneficiary is dually eligible for Medicare and Medicaid and is provided services that are covered by both Medicare and Medicaid, Medicaid will not reimburse for those services if Medicare has not been billed prior to Medicaid billing. The beneficiary cannot be billed for the charges. See Section 142.700 for detailed information regarding Medicare participation and

Sections 332.000 through 332.300 for detailed information regarding Medicare-Medicaid Crossover claims procedures.

252.481 Services Prior to Medicare Entitlement 9-1-24

Services that have been denied by Medicare with the explanation "Services Prior to Medicare Entitlement" may be filed with Medicaid. These services should be filed on the CMS-1500 claim form for processing and forwarded to the Inquiry Unit. **View or print the Inquiry Unit contact information**.

These services usually can be filed electronically unless they are covered by Medicare and the beneficiary was 65 or older on the date of service. It may be necessary to attach a copy of the Medicare denial to the claim.

A note of explanation should accompany these claims in order that they may receive special handling.

252.482 Services Not Medicare Approved 9-1-24

Services that are not Medicare approved for patients with joint Medicare/Medicaid coverage usually are not payable by Medicaid unless they are services that are not covered by Medicare, but are covered by Medicaid. There are exceptions and those may require special handling.

252.483 Drug Treatment for Pediatric PANS and PANDAS 9-1-24

A. Effective for dates of service on and after 6/1/2022 drug treatment will be available to all qualifying Arkansas Medicaid beneficiaries when specified conditions are met for one (1) or both of the following conditions:

   1. Pediatric acute-onset neuropsychiatric syndrome (PANS),
   2. Pediatric autoimmune neuropsychiatric disorders associated with streptococcal infections (PANDAS).

B. The drug treatments include off-label treatments, including without limitation intravenous immunoglobulin (IVIG).

C. Medicaid will cover drug treatment for PANS or PANDAS under the following conditions:

   1. The drug treatment must be authorized under a Treatment Plan; and
   2. The Treatment Plan must be established by the approved PANS/PANDAS provider.

D. A Prior Authorization (PA) must be obtained for each treatment. Providers must submit the current Treatment Plan to the Quality Improvement Organization (QIO) along with the request for Prior Authorization. **View or print contact information for the QIO**.

E. The authorized procedure codes and required modifiers are found in the following link:

View or print the procedure codes for Physician Assistant services, including PANS and PANDAS procedure codes.

252.484 Injections, Therapeutic and/or Diagnostic Agents 9-1-24

Physician Assistants shall administer injections, therapeutic and diagnostic agents in accordance with the rules set forth in the Arkansas Medicaid Physician's policy manual and within the scope of their practice guidelines.

View or print the procedure codes for Physician Assistant services.

TOC not required

213.110 Physician Assistant Services

~~10-15-09~~9-1-24

Physician assistant services are services furnished according to Arkansas Statute 17-105-101 and rules and regulations issued by the Arkansas State Medical Board. Physicians Assistants are dependent medical practitioners practicing under the supervision of the physician, for which the physician takes full responsibility. ~~The service is not considered to be separate from the physician's service.~~

Note: A physician assistant providing services during a surgical procedure is not covered as an assistant surgeon.

241.000 Fluoride Varnish Treatment

~~2-1-22~~9-1-24

Arkansas Medicaid will expand coverage for fluoride varnish application, ADA code, to physicians, physician assistants, clinical nurse specialists, and nurse practitioners who have completed the online training program approved by the Arkansas Department of Health, Office of Oral Health.

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

The online training course can be accessed at **http://ar.train.org**. The provider will need to maintain a copy of the certificate of completion in their files and submit a copy to the Arkansas Medicaid provider enrollment unit.

243.000 Family Planning Coverage Information

~~11-1-10~~9-1-24

A. Arkansas Medicaid encourages reproductive health and family planning by reimbursing physicians, physician assistants, clinical nurse specialists, nurse practitioners, clinics, and hospitals for a comprehensive range of family planning services.

1. Family planning services do not require a PCP referral.
2. Medicaid beneficiaries' family planning services benefits are in addition to their other medical benefits, when providers bill the services specifically as family planning services.
3. Abortion is not a family planning service in the Arkansas Medicaid Program.

B. Physicians, physician assistants, clinical nurse specialists, and advanced practice registered nurses desiring to participate in the Medicaid Family Planning Services Program may do so by providing the services listed in Sections 243.300 through 243.500 to Medicaid beneficiaries of childbearing age.

C. Physicians, physician assistants, clinical nurse specialists, and advanced practice registered nurses preferring not to provide family planning services may refer their patients to other providers. DHS County Offices maintain listings of local and area providers qualified to provide family planning services. Listed providers include:

1. Arkansas Department of Health local health units
2. Obstetricians and gynecologists
3. Nurse practitioners

4. Rural Health Clinics
5. Federally Qualified Health Centers
6. Family planning clinics
7. Physician Assistants
8. Clinical nurse specialists

D. Complete billing instructions for family planning services are in Sections 292.550 through 292.553 of this manual.

292.741 Behavioral Health Screen

~~1-1-23~~9-1-24

A physician, physician's assistant, clinical nurse specialist, or advanced nurse practitioner may administer a brief standardized emotional/behavioral assessment screening to a client along with an office visit. The allowable screening is up to two (2) units per visit and is allowable up to four (4) times per state fiscal year without prior authorization. An extension of benefits may be requested if additional screening is medically necessary. If a client is under the age of eighteen (18), and the parent/legal guardian appears depressed, he or she can be screened as well, and the screening billed under the minor's Medicaid number. The provider cannot prescribe meds for the parent under the child's Medicaid number. A parent/legal guardian session will count towards the four (4) counseling screening limit. The physician must have the capacity to treat or refer the parent/guardian for further treatment if the screening results indicate a need, regardless of payor source.

TOC required

211.000 Scope

~~6-1-09~~9-1-24

The Medical Assistance (Medicaid) Program is designed to assist eligible Medicaid beneficiaries in obtaining medical care within the guidelines specified in this manual. All Medicaid benefits are based on medical necessity. See the Glossary for the definition of medical necessity.

A. A provider-based rural health clinic is one which is an integral part of a hospital, skilled nursing facility or home health agency that participates in Medicare and which is licensed, governed and supervised with other departments of the facility.

B. An independent (free-standing) rural health clinic is one that participates in Medicare and is not provider based.

C. Visit is defined as a face-to-face encounter between a clinic patient and a physician, physician assistant, nurse practitioner, nurse midwife, clinical nurse specialist, or other specialized nurse practitioner whose services are reimbursed under the rural health clinic payment method. Encounters with more than one health care professional and multiple encounters with the same health care professional that take place on the same day and at a single location constitute a single visit, except when the patient, after the first encounter, suffers illness or injury requiring additional diagnosis or treatment.

211.100 Rural Health Clinic Core Services

~~2-1-24~~9-1-24

Rural Health Clinic core services are as follows:

A. Professional services that are performed by a physician at the clinic or are performed away from the clinic by a physician whose agreement with the clinic provides that he or she will be paid by the clinic for such services;

B. Services and supplies furnished “incident to” a physician’s professional services;

C. Services provided by non-physician, services of physician assistants, nurse practitioners, clinical nurse specialists, nurse midwives, and specialized nurse practitioners when the provider is legally:

1. employed by, or receiving compensation from a rural health clinic;
2. under the medical supervision of a physician;
3. acting in accordance with any medical orders for the care and treatment of a patient prepared by a physician; and
4. acting within their scope of practice by providing services they are legally permitted to perform by the state in which the service is provided if the services would be covered if furnished by a physician;

D. Services and supplies that are furnished as an incident to professional services furnished by a nurse practitioner, physician assistant, clinical nurse specialist, nurse midwife, or other specialized nurse practitioner;

E. ~~Visiting nurse services on a part-time or intermittent basis to home-bound patients in areas in which there is a shortage of home health agencies.~~Part-time or intermittent nursing care and related medical supplies (home health) which meets the definition found at 42 CFR 440.70.

~~Note: For purposes of visiting nurse care, a home-bound patient is one who is permanently or temporarily confined to his or her place of residence because of a medical or health condition. Institutions, such as a hospital or nursing care facility, are not considered a patient's residence.~~

~~Note: A patient's place of residence is where he or she lives, unless he or she is in an institution such as a nursing facility, hospital, or intermediate care facility for individuals with intellectual disabilities (ICF/IID); and~~

F. Medication Assisted Treatment (MAT) for Opioid or Alcohol Use Disorders is available to all qualifying Medicaid beneficiaries. All rules and regulations promulgated within the Physician's provider manual for provision of this service must be followed.

211.220 Services and Supplies "Incident To" a Nurse Practitioner's, Clinical Nurse Specialist's, or Physician Assistant's Service

~~10-13-039~~-1-24

Services and supplies "incident to" a nurse practitioner's, clinical nurse specialist's, or physician assistant's services are covered if the service or supply is:

A. Of a type commonly furnished in physicians' offices;

B. Of a type commonly furnished without charge or included in the RHC's bill;

C. Furnished as an incidental, although integral, part of the professional services of a nurse practitioner, clinical nurse specialist, Advanced Practice Registered Nurse (APRN), or physician assistant;

D. Furnished under the direct, personal supervision of a nurse practitioner, clinical nurse specialist, physician assistant, nurse midwife, specialized nurse practitioner or a physician and

E. In the case of a service~~,~~ furnished by a member of the clinic's health care staff who is an employee of the clinic.

The direct personal supervision requirement is met in the case of a nurse practitioner, clinical nurse specialist, physician assistant, nurse midwife or specialized nurse practitioner only if such a person is permitted to supervise such services under the written policies governing the RHC.

Only drugs and biologicals that cannot be self-administered are included within the scope of this benefit.

212.210 Rural Health Clinic (RHC) Non-Core Services

~~10-13-039~~-1-24

A. The following services are not to be Rural Health Clinic (RHC) core services.

1. Emergency and non-emergency outpatient hospital visits,
2. Inpatient hospital visits,
3. Surgeries performed in the inpatient or outpatient hospital or in an ambulatory surgical center,
4. Technical components of radiology procedures and
5. Technical components of electrocardiograms and echocardiography.

B. Inpatient and outpatient hospital visits, home and nursing facility visits and other off-site visits remain core services if the physician, clinical nurse specialist, or nurse practitioner

must, as a condition of his or her employment by or contract with the RHC, see patients at sites away from the RHC and is compensated by the RHC.

C. Physicians, physician assistants, clinical nurse specialists, and nurse practitioners enrolled in the Arkansas Medicaid Program may bill for RHC non-core services according to the guidelines in their respective Medicaid manuals.

D. Rural Health Clinics desiring to bill for RHC non-core physician services must enroll with Arkansas Medicaid as physician group providers, even if they intend to bill for the services of only one physician. See Section II of the Arkansas Medicaid **Physician/Independent Lab/CRNA/Radiation Therapy Center** manual for participation requirements.

E. Rural Health Clinics desiring to bill for RHC non-core physician assistant, clinical nurse specialist, or nurse practitioner services must enroll with Arkansas Medicaid as nurse practitioner and physician assistant group providers, as appropriate, even if they intend to bill for the services of only one (1) physician assistant, clinical nurse specialist, or nurse practitioner. See Section II of the Arkansas Medicaid **Physician Assistant, Clinical Nurse Specialist,** and **Nurse Practitioner** manuals for participation requirements.

213.000 Staff Requirements and Responsibilities

~~1-1-18~~9-1-24

A. The RHC must have a health care staff that includes one or more physicians and one or more physician assistants, clinical nurse specialists, or nurse practitioners. The physicians, physician assistants, clinical nurse specialists, or nurse practitioners may be the owners of the RHC and/or under agreement with the RHC to carry out the responsibilities required.

B. The staff may include ancillary personnel who are supervised by the professional staff.

C. A physician, physician assistant, clinical nurse specialist, or nurse practitioner must be available to furnish patient care services at times the RHC operates. These staff must be available to furnish patient care services at least 50% of the time the RHC operates.

D. The physician must provide medical direction for the RHC activities and consultation for the medical supervision of the health care staff. The physician also must participate in developing, executing, and periodically reviewing policies, services, patient records and must provide medical orders and medical care services to patients of the RHC.

E. The physician assistant, clinical nurse specialist, and nurse practitioner, as members of the RHC staff, must participate in the development, execution and periodic review of the written policies governing the services the RHC furnishes and participate with the physician in a periodic review of patients' health records.

F. The physician assistant, clinical nurse specialist, or nurse practitioner must perform the following functions, to the extent they are not being performed by a physician:

1. Provide services in accordance with RHC policies;
2. Arrange for or refer patient for services that cannot be provided by the RHC; and
3. Assure adequate patient health records are maintained and transferred as required when patients are referred.
4. Some services such as personal care require an Independent Assessment. Please refer to the Independent Assessment Guide for related information.

216.000 Limitations and/or Non-Covered Services

~~10-13-03~~9-1-24

RHC services are subject to the limitation and coverage restrictions that exist for medical services provided in other settings. Services not covered by the Arkansas Medicaid Program include, but are not limited to, the following:

A. The services of nurse practitioners, physician assistants, nurse midwives, clinical nurse specialists, or specialized nurse practitioners if state law or regulations require that the services be performed under a physician's order and no such order was prepared.

B. Services that are not considered medically necessary.

C. Services that are not properly documented.

D. Visits in which a direct relationship does not exist between the patient and a physician, a physician assistant, a clinical nurse specialist, or nurse practitioner (e.g., visit to pick up a prescription, telephone consultation, etc.)

E. Cosmetic surgery performed primarily for aesthetic purposes only (e.g., ear piercing, tattoo removal, etc.)

F. Well child care, routine physical examinations or examinations for school. (See the Child Health Services (EPSDT) Manual, Section II, for coverage of these services and for billing instructions.)

G. Dietary counseling.

H. Most screening-type services unless being used to make a diagnosis (e.g., hypertension H ——screening, diabetes screening, hair analysis, etc.)

I. Literature, booklets, and other educational services.

218.100 RHC Encounter Benefit Limits

~~2-1-24~~9-1-24

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;~~.~~
8. Physician assistant services; and
9. Certified nurse specialist services in the office, client's home, or nursing facility.

Global obstetric fees are not counted against the service encounter limit. Itemized obstetric office visits are not counted in the 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.

TOC required

216.000 Medical Procedures Billable by Optometrists

~~12-1-06~~9-1-24

Optometrists are allowed to bill for certain ~~procedures for~~ office medical services, procedures, and special services previously payable only to physicians.

The office medical services provided by an optometrist will be limited to ~~twelve~~ sixteen (16) visits per state fiscal year (SFY) for individuals ~~age~~twenty-one (21) years of age and over. The benefit limit will be used in conjunction with ~~four~~ other programs. These programs are physicians' services, physician assistant services, medical services provided by dentists, rural health clinic services, federally qualified health center services, clinical nurse specialist services, advanced practice registered nurse services (APRN), and certified nurse-midwife services. Beneficiaries will be allowed ~~twelve~~ sixteen (16) visits per ~~state fiscal year~~SFY ~~for office medical services furnished by an optometrist, medical services furnished by a dentist, physicians' services, rural health clinic services, certified nurse-midwife services~~ for any combination thereof ~~the five~~. Extensions beyond the ~~twelve visit~~ limit may be provided if medically necessary. Office medical services for beneficiaries under ~~age~~twenty-one (21) years of age in the Child Health Services (EPSDT) Program are not benefit limited. Procedure codes, description of services and special billing instructions are located in Section 240.000 of this manual.

All beneficiaries of vision and medical eye care may have direct access to optometrists as primary eye care providers, independent of the primary care provider (e.g., physician, ~~Federally Qualified Health Center (FQHC), etc.)~~ clinical nurse specialist, APRN, etc.).

216.100 Extension of Benefits for Office Medical Services Provided by an Optometrist

~~10-13-03~~9-1-24

Extensions of benefits beyond the ~~twelve~~ sixteen (16) visit limit for individuals ~~age~~twenty-one (21) years of age and over may be provided, if medically necessary~~, for office medical services provided by an optometrist and in conjunction with four other programs. Those programs are physicians' services, medical services provided by dentists, rural health clinic services and certified nurse-midwife services~~.

~~243.150 Office Medical Services~~

~~2-1-22~~

~~The office medical services provided by an optometrist are limited to twelve (12) visits per state fiscal year (July 1 through June 30) for beneficiaries age 21 and older. The benefit limit will be used in conjunction with four other programs: physicians' services, medical services provided by dentists, rural health clinic services and certified nurse-midwife services. Beneficiaries will be allowed twelve visits per state fiscal year for office medical services furnished by an optometrist, medical services furnished by a dentist, physicians' services, rural health clinic services and certified nurse-midwife services or a combination of the five. Extensions beyond the twelve-visit limit may be provided if medically necessary. Office medical services for beneficiaries under age 21 in the Child Health Services (EPSDT) Program are not benefit limited.~~

~~Office medical services covered in the Visual Care Program are limited to the following procedure codes:~~

~~**View or print the procedure codes for Vision services.**~~

2.a. Outpatient Hospital Services (Continued)

Non-Emergency Services

Outpatient hospital services other than those which qualify as emergency, outpatient surgical procedures and treatment, and therapy services are covered as non-emergency services.

Benefit Limit

Outpatient hospital services are limited to a total of twelve (12) visits a year. This yearly limit is based on the State Fiscal Year - July 1 through June 30. Outpatient hospital services include the following:

- non-emergency outpatient hospital and related physician, ~~and~~ nurse practitioner, physician assistant, and clinical nurse specialist services; and
- outpatient hospital therapy and treatment services and related physician and nurse practitioner services.

For services beyond the twelve - (12)-visit limit, an extension of benefits will be provided if medically necessary. The following diagnoses are considered categorically medically necessary and do not require prior authorization for medical necessity: Malignant neoplasm; HIV infection; renal failure; opioid use disorder when the visit is part of a Medication Assisted Treatment Plan; and pregnancy. All other diagnoses are subject to prior authorization before benefits can be extended.

Outpatient hospital services are not benefit--limited for recipients in the Child Health Services, Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Program.

2.b. Rural Health Clinic Services

Rural ~~h~~Health ~~c~~Clinic services are limited to sixteen (16) encounters a year for ~~clients~~beneficiaries twenty-one (21) years of age and older. This yearly limit is based on the State Fiscal Year (July I through June 30). The benefit limit will be considered in conjunction with the benefit limit established for physicians' services, medical services furnished by a dentist, office medical services furnished by an optometrist, certified nurse midwife services, federally qualified health center encounters, **physician assistant services, clinical nurse specialist services,** and advanced practice registered nurse services, or any combination ~~of the seven~~thereof.~~.~~

Extensions of the benefit limit will be available if medically necessary. ~~Certain services, specified in the appropriate provider manual, are not counted toward the limit. Clients~~Beneficiaries under age twenty-one (21) in the Child Health Services, Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Program are not benefit~~-~~limited.

Rural ~~h~~Health ~~c~~Clinic core services are defined as follows:

1. Physicians' services, advanced practice registered nurse's services, clinical nurse specialist, and physician assistant services when properly supervised;

2. Services and supplies furnished as an incident to professional services;

   Services and supplies "incident to" the professional services of physicians, physician assistants, clinical nurse specialist, or advanced practice registered nurses are those which are commonly furnished in connection with these professional services, are generally furnished in the ~~r~~Rural ~~h~~Health ~~center~~Clinic office, and are ordinarily rendered without charge or included in the clinic's bills; e.g., laboratory services, ordinary medications and other services and supplies used in patient primary care services.

3. Clinical psychologist services;

4. Clinical social worker services;

CATEOGORICALLY NEEDY

2.b. **Rural Health Clinic Services**

5. Services of nurse midwives

6. Part-time or intermittent nursing care and related medical supplies (home health) which meets the definition found at 42 C.F.R. § 440.70.

~~Visiting nurse services on a part-time or intermittent basis to home-bound patients (limited to areas in which there is a shortage of home health agencies).~~

Rural ~~h~~Health ~~c~~Clinic ambulatory services are defined as any other ambulatory service included in the Medicaid State Plan if the Rural ~~h~~Health ~~c~~Clinic offers such a service (e.g. dental, visual, etc.). The "other ambulatory services" that are provided by the Rural ~~h~~Health ~~c~~Clinic will count against the limit established in the plan for that service.

Medication Assisted Treatment visits do not count against the Rural Health Clinic encounter benefit limit when the visit is part of a Medication Assisted Treatment plan.

2.c. **Federally qualified health center (FQHC) services and other ambulatory services that are covered under the plan and furnished by a FQHC in accordance with Section 4231 of the State Medicaid Manual (NCFA – Pub. 45-4).**

Federally qualified health center services are limited to sixteen (16) encounters per client, per State Fiscal Year (July 1 through June 30) for clients twenty-one (21) years or older. The applicable benefit limit will be considered in conjunction with the benefit limit established for physicians' services, medical services furnished by a dentist, office medical services furnished by an optometrist, certified nurse midwife services, ~~r~~Rural ~~h~~Health ~~c~~Clinic encounters, physician assistant services, clinical nurse specialist services, and advanced practice registered nurse services, or any combination there~~-~~of~~. the seven.~~

For federally qualified health center core services beyond the benefit limit, extensions will be available if medically necessary. Beneficiaries under age twenty-one (21) in the Child Health Services, Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Program are not benefit~~-~~limited.

FQHC hospital visits are limited to one (1) day of care for inpatient hospital covered days regardless of the number of hospital visits rendered. The hospital visits do not count against the FQHC encounter benefit~~-~~limit.

Medication Assisted Treatment visits do not count against the FQHC encounter benefit limit when the visit is part of a Medication Assisted Treatment plan.

2.c. Federally Qualified Health Center (FQHC) services and other ambulatory services that are covered under the plan and furnished by a FQHC in accordance with Section 4231 of the State Medicaid Manual (HCFA - Pub. 45-4). (Continued)

Covered FQHC core services are defined as follows:

- ~~p~~Physician services;
- ~~s~~Services and supplies incident to physician's services (including drugs and biologicals that cannot be self-administered);
- Immunizations provided based on recommendations of the Advisory Committee on Immunization Practices (ACIP) and their administration;
- ~~p~~Physician assistant services;
- ~~n~~Nurse practitioner services;
- Clinical nurse specialist services;
- ~~c~~Clinical psychologist services;
- ~~c~~Clinical social worker services;
- ~~l~~Licensed certified social worker services;
- ~~l~~Licensed professional counselor services;
- ~~l~~Licensed mental health counselor services;
- ~~l~~Licensed marriage and family therapist services;
- ~~s~~Services and supplies incident to clinical psychologist**,** clinical social worker**,** licensed certified social worker, licensed professional counselor, licensed mental health counselor, and licensed marriage and family therapist services as would otherwise be covered if furnished by or incident to physician services; and
- ~~p~~Part-time or intermittent nursing care and related medical supplies (home health) which meet~~s~~ the definition found at 42 C.F.R. § 440.70.
-

FQHC ambulatory services are defined as any other ambulatory service included in the Medicaid State Plan if the FQHC offers such a service, (e.g. dental, etc.). The "other ambulatory services" that are provided by the FQHC will count against the limit established in the plan for that service.

5. a. Physicians' services, whether furnished in the office, the ~~client's~~beneficiary's home, a hospital, a skilled nursing facility, or elsewhere

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

(a) Benefit Limit Details.

The benefit limit will be considered in conjunction with the benefit limit established for ~~r~~Rural ~~h~~Health ~~c~~Clinic, federally qualified health center, medical services furnished by a dentist, office medical services furnished by an optometrist, certified nurse midwife services, physician assistant services, clinical nurse specialist services, and advanced practice registered nurse or any combination thereof ~~the seven~~. ~~Clients~~Beneficiaries under age twenty-one (21) in the Child Health Services, Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Program are not benefit--limited.

(b) Extension of Benefits

For physicians' services, medical services provided by a dentist, office medical services furnished by an optometrist, certified nurse midwife services, advanced practice registered nurse, physician assistant, clinical nurse specialist, or ~~r~~Rural ~~h~~Health ~~c~~Clinic core services beyond the benefit limit, extensions will be available if medically necessary.

(i) The following diagnoses are considered categorically medically necessary and are exempt from benefit extension requirements: Malignant neoplasm~~;~~, HIV infection, and renal failure.

(ii) Additionally, physicians' visits for pregnancy in the outpatient hospital are exempt from benefit extension requirements.

(c) Special Exceptions

(i) Each attending physician/dentist is limited to billing one day of care for inpatient hospital covered days regardless of the number of hospital visits rendered.

(ii) Surgical procedures which are generally considered to be elective require a prior authorization from the Utilization Review Section.

(iii) Desensitization injections - Refer to Attachment 3.1-A, Item 4.b. (12).

– (iv) Organ transplants are covered as described in Attachment 3.1-E.

5. a. Physicians' Services (Continued)

(6) Consultations, including interactive consultations (telemedicine), are limited to two (2) per recipient per year in a physician's office, beneficiary~~patient~~'s home, hospital or nursing home. This yearly limit is based on the State Fiscal Year (July 1 through June 30). This limit is in addition to the yearly limit described in Item 5.(1). Extensions of the benefit limit will be provided if medically necessary for recipients.

(7) Abortions are covered when the life of the mother would be endangered if the fetus were carried to term or for victims of rape or incest. *Arkansas Code Annotated § 20-16-705(a) states that "no abortion of a viable fetus shall be performed unless necessary to preserve the life or health of the woman." It later goes on to say that the abortion of a viable fetus is not prohibited if "the pregnancy is the result of rape or incest perpetrated on a minor when documentation is presented that states the crime has been reported to law enforcement."* The circumstances must be certified in writing by the woman's attending physician. Prior authorization is required.

5. b. Medical and surgical services furnished by a dentist (in accordance with Section 1905 (a)(5)(B) of the Act).

Medical services furnished by a dentist are limited to ~~twelve (12)~~sixteen (16) visits per State Fiscal Year (July 1 through June 30) for ~~recipients~~ beneficiaries ~~age~~ twenty-one (21) years ~~and~~ older.

The benefit limit will be considered in conjunction with the benefit limit established for physicians' services, ~~r~~Rural ~~h~~Health ~~c~~Clinic services, office medical services furnished by an optometrist, physician assistant services, clinical nurse specialist services, and certified nurse midwife services. ~~Recipients will be allowed twelve (12) visits per State Fiscal Year for medical services furnished by a dentist, physicians' services, rural health clinic services, office medical services furnished by an optometrist, certified nurse midwife services or **advanced practice nurse or registered nurse practitioner services or a combination of the six**.~~ For ~~physicians'~~ services~~, medical services provided by a dentist, office medical services furnished by an optometrist, certified nurse midwife services or rural health clinic core services~~ beyond the ~~12~~ sixteen (16) visit limit, extensions will be provided if medically necessary. ~~Certain services, specified in the appropriate provider manual, are not counted toward the 12 visit limit.~~ Recipients under age 21 in the Child Health Services, Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Program are not benefit limited.

Surgical services furnished by a dentist are not benefit limited.

6. Medical care and any other type of remedial care recognized under State law, furnished by licensed practitioners within the scope of their practice as defined by State law. (Continued)

b. Optometrists' Services (Continued)

(2) One eye exam every twelve (12) months for eligible ~~client~~ beneficiaries under 21 years of age in the Child Health Services, Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Program. Extensions of the benefit limit will be **available** if medically necessary for ~~clients~~ beneficiaries in the Child Health Services (EPSDT) Program.

(3) Office medical services provided by an optometrist are limited to ~~twelve (12)~~sixteen (16) visits per State Fiscal Year (July 1 through June 30) for ~~clients~~ beneficiaries **twenty-one (**21**) years or older**. The benefit limit will be in conjunction with the benefit limit established for physicians' services, medical services furnished by a dentist, ~~rural~~ Rural ~~health~~ Health ~~clinic~~ Clinic services, **Federally Qualified Health Center services**, certified nurse midwife services, physician assistant services, clinical nurse specialist services, and advanced practice **registered** nurse~~s~~ **services**, or any combination ~~of the seven~~thereof. For services beyond the **benefit** limit, extensions will be **available** if medically necessary. ~~Certain services, specified in the appropriate provider manual, are not counted toward the limit.~~

c. Chiropractors' Services

(1) Services are limited to licensed chiropractors meeting minimum standards promulgated by the Secretary of HHS under Title XVIII.

(2) Services are limited to treatment by means of manual manipulation of the spine which the chiropractor is legally authorized by the State to perform.

(3) Effective for dates of service on or after July 1, 1996, chiropractic services will be limited to twelve (12) visits per State Fiscal Year (July 1 through June 30) for eligible Medicaid ~~clients~~beneficiaries twenty-one (21) years or older. Services provided to ~~clients~~beneficiaries under age **twenty-one (**21**)** in the Child Health Services (EPSDT) Program are not benefit limited.

(4) **Effective for dates of service on or after January 1, 2018, c**hiropractic services **do not** require a referral by the ~~client~~beneficiarie**'s** primary care **provider** (PCP).

d. Advanced **Practice Registered** Nurses **(APRN)**

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

The benefit limit will be in conjunction with the benefit limit established for physicians' services, ~~rural~~ Rural H~~h~~ealth C~~e~~linic, medical services furnished by a dentist, **office medical services furnished by an optometrist**, certified nurse midwife services, physician assistant services, clinical nurse specialist services, and ~~federally~~ Federally Q~~q~~ualified ~~health~~ Health ~~center~~Center services, or any combination ~~of the seven~~ thereof. For services beyond the **established benefit** limit, extensions will be **available** if medically necessary. ~~Certain services, specified in the appropriate provider manual, are not counted toward the limit.~~ ~~Clients~~Beneficiaries in

the Child Health Services (EPSDT) Program are not benefit limited.

6. Medical care and any other type of remedial care recognized under State law, furnished by licensed practitioners within the scope of their practice as defined by State law. (Continued)

e. Physician Assistant

For beneficiaries twenty-one (21) years of age or older, services provided by physician assistant in office of practice, a patient's home, or nursing home, if appropriate, are limited to sixteen (16) visits per state fiscal year (July 1 through June 30).
The benefit limit will be in conjunction with the benefit limit established for physicians' services, Rural Health Clinic, medical services furnished by a dentist, office medical services furnished by an optometrist, certified nurse midwife services, clinical nurse specialist services, and federally qualified health center, or any combination thereof. For services beyond the established benefit limit, extensions will be available if medically necessary. ~~Certain services, specified in the appropriate provider manual, are not counted toward the limit.~~ Beneficiaries in the Child Health Services, Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Program are not benefit-limited.

f. Clinical Nurse Specialist

For beneficiaries twenty-one (21) years of age or older, services provided in clinical nurse specialist's office, a patient's home, or nursing home are limited to sixteen (16) visits per state fiscal year (July 1 through June 30).
The benefit limit will be in conjunction with the benefit limit established for physicians' services, Rural Health Clinic, medical services furnished by a dentist, office medical services furnished by an optometrist, certified nurse midwife services, physician assistant services, and federally qualified health center, or any combination thereof. For services beyond the established benefit limit, extensions will be available if medically necessary. ~~Certain services, specified in the appropriate provider manual, are not counted toward the limit.~~ Beneficiaries in the Child Health Services, Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Program are not benefit-limited.

6. Medical Care and any other type of remedial care recognized under State law, furnished by licensed practitioners within the scope of their practice as defined by State law. (Continued)

6.d. Other Practitioners' Services (Continued)

(5) Psychologists

Refer to Attachment 3.1-A, Item 4.b. (13).

(6) Obstetric - Gynecologic and Gerontological Nurse Practitioner

Refer to Attachment 3.1-A, Item 24 for coverage limitations.

(7) Pharmacists

(8) Licensed Registered Nurse Sexual Assault Nurse Examiner-Pediatric/Adolescent (SANE-P) certified by the International Association of Forensic Nurses working under the supervision of a licensed Advanced Practice Registered Nurse (APRN).

(9) Physician Assistant

Refer to Attachment 3.1-A, Page 2e1, Section 6, Item e.

(10) Clinical Nurse Specialists

Refer to Attachment 3.1-A, Page 2e1, Section 6, Item f.

17. Nurse-Midwife Services

Any person possessing the qualifications for a registered nurse in the State of Arkansas who is also certified as a nurse-midwife by the American College of Nurse-Midwives, upon application and payment of the requisite fees to the Arkansas State Board of Nursing, be qualified for licensure as a certified nurse-midwife. A certified nurse-midwife ~~meeting the requirements of Arkansas Act 409 of 1995~~ who meets the requirements set forth by the Board of Nursing is authorized to practice nurse-midwifery.

Services provided by a certified nurse midwife are limited to ~~twelve (12)~~ sixteen (16) visits a year for beneficiaries ~~age~~ twenty-one (21) years and older. This yearly limit is based on the State Fiscal Year (July 1 through June 30). The benefit limit will be considered in conjunction with the benefit limit established for physicians' services, medical services furnished by a dentist, ~~r~~Rural ~~h~~Health ~~c~~Clinic services, office medical services furnished by an optometrist, physician assistant services, clinical nurse specialist services, and advanced practice nurse or registered nurse practitioner services, or any combination ~~of the six~~thereof. For services beyond the ~~twelve~~ visit limit, extensions will be provided if medically necessary. ~~Certain services, specified in the appropriate provider manual, are not counted toward the twelve (12) visit limit.~~ Beneficiaries under age twenty-one (21) in the Child Health Services, Early and Periodic, Diagnostic, and Treatment (EPSDT) program are not benefit-limited.

2.b. Rural Health Clinic Services

Rural ~~h~~Health ~~c~~Clinic services are limited to sixteen (16) visits a year for ~~clients~~beneficiaries twenty-one (21) years or older. This yearly limit is based on the State Fiscal Year (July I through June 30). Rural ~~h~~Health ~~c~~Clinic encounters will be considered in conjunction with the benefit limit established for physician services, medical services furnished by a dentist, office medical services furnished by an optometrist, certified nurse midwife services, physician assistant services, clinical nurse specialist services, federally qualified health center encounters, and advanced practice registered nurse services, or any combination ~~of the seven~~thereof. Benefit limit extensions will be available if medically necessary. Certain services, specified in the appropriate provider manual, are not counted toward the service limit. ~~Clients~~Beneficiaries under age twenty-one (21~~1~~) in the Child Health Services, Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Program are not benefit~~–~~limited.

Rural ~~h~~Health ~~c~~Clinic core services are defined as follows:

1. Physicians' services, advanced practice registered nurses' services, clinical nurse specialists' services, and services of physician assistants when provided under proper supervision;

2. Services and supplies furnished as an incident to professional services;

   Services and supplies "incident to" the professional services of physicians, physician assistants, clinical nurse specialists, or advanced practice registered nurse**s**, are those which are commonly furnished in connection with these professional services, are generally furnished in the ~~r~~Rural ~~h~~Health ~~c~~Clinic office, and are ordinarily rendered without charge or included in the clinic's bills; e.g., laboratory services, ordinary medications and other services and supplies used in patient primary care services.

3. Clinical psychologist services;
4. Clinical social worker services;

2.b. Rural Health Clinic Services

5. Services of nurse midwives; and

~~Visiting nurse services on a part-time or intermittent basis to home-bound patients (limited to areas in which there is a shortage of home health agencies).~~ Part-time or intermittent nursing care and related medical supplies (home health) which meets the definition found at 42 C.F.R. § 440.70.

6.

Rural ~~h~~HealthC~~-~~clinic ambulatory services are defined as any other ambulatory service included in the Medicaid State Plan if the ~~r~~Rural ~~h~~Health ~~c~~Clinic offers such a service (e.g. dental, visual, etc.). The "other ambulatory services" that are provided by the ~~r~~Rural ~~h~~Health ~~c~~Clinic will count against the limit established in the plan for that service.

Medication Assisted Treatment visits do not count against the Rural Health Clinic encounter benefit limit when the diagnosis is for opioid use disorder and is part of a Medication Assisted Treatment plan.

2.c. Federally qualified health center (FQHC) services and other ambulatory services that are covered under the plan and furnished by a FQHC in accordance with Section 4231 of the State Medicaid Manual) NCFA – Pub. 45-4).

Federally qualified health center services are limited to sixteen (16) encounters per ~~client~~beneficiary, per State Fiscal Year (July 1 through June 30) for ~~clients~~beneficiaries twenty-one (21) years or older. The applicable benefit limit will be considered in conjunction with the benefit limit established for physicians' services, medical services furnished by a dentist, office medical services furnished by an optometrist, certified nurse midwife services, physician assistant services, clinical nurse specialist services, ~~r~~Rural ~~h~~Health ~~c~~Clinic encounters, and advanced practice registered nurse services, or a combination of the seven.

Benefit extensions will be available if medically necessary. ~~Clients~~Beneficiaries under age twenty-one (21) in the Child Health Services (EPSDT) Program are not benefit~~-~~-limited.

FQHC hospital visits are limited to one (1) day of care for inpatient hospital covered days regardless of the number of hospital visits rendered. The hospital visits do not count against the FQHC encounter benefit limit.

Medication Assisted Treatment visits do not count against the FQHC encounter benefit limit when the diagnosis is for opioid use disorder and is part of a Medication Assisted Treatment plan.

2.c. Federally Qualified Health Center (FQHC) services and other ambulatory services that are covered under the plan and furnished by a FQHC in accordance with Section 4231 of the State Medicaid Manual (HCFA - Pub. 45-4). (Continued)

Covered FQHC core services are defined as follows:

- ~~p~~Physician services;
- ~~s~~Services and supplies incident to physician's services (including drugs and biologicals that cannot be self-administered);
- ~~pneumococcal vaccine and its administration and influenza vaccine and its administration;~~ Immunizations provided based on recommendations of the Advisory Committee on Immunization Practices (ACIP) and their administration;
- ~~p~~Physician assistant services;
- ~~n~~Nurse practitioner services;
- Clinical nurse specialist services
- ~~c~~Clinical psychologist services;
- ~~c~~Clinical social worker services;
- ~~l~~Licensed certified social worker services;
- ~~l~~Licensed professional counselor services;
- ~~l~~Licensed mental health counselor services;
- ~~l~~Licensed marriage and family therapist services;
- ~~s~~Services and supplies incident to clinical psychologist, clinical social worker service**s,** licensed certified social worker, licensed professional counselor, licensed mental health counselor and licensed marriage and family therapist service**s** as would otherwise be covered if furnished by or incident to physician services; and
- Part-time or intermittent nursing care and related medical supplies (home health) which meets the definition found at 42 C.F.R. § 440.70.
- ~~part-time or intermittent nursing care and related medical supplies to a homebound individual, in the case of those FQHCs that are located in an area in which the Secretary has determined there is a shortage of home health agencies~~.

FQHC ambulatory services are defined as any other ambulatory service included in the Medicaid State Plan if the FQHC offers such a service, (e.g. dental, etc.). The "other ambulatory services" that are provided by the FQHC will count against the limit established in the plan for that service.

5. a. Physicians' services, whether furnished in the office, the beneficiary's home, a hospital, a skilled nursing facility, or elsewhere ~~Physicians' Services~~

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

The benefit limit will be in conjunction with the benefit limit established for advance practice registered nurse services, ~~rural~~ Rural ~~health~~ Health ~~clinic~~clinic, medical services furnished by a dentist, office medical services furnished by an optometrist, certified nurse midwife services, physician assistant services, clinical nurse specialist services, and F~~f~~ederally Q~~q~~ualified ~~health~~ Health ~~center~~Center, or any combination ~~of the seven~~thereof.

For services beyond the established visit limit, extensions will be available if medically necessary. ~~Clients~~ Beneficiaries in the Child Health Services, Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Program are not benefit limited.

(1) The following diagnoses are considered categorically medically necessary and are exempt from benefit extension requirements: Malignant neoplasm; HIV infection and renal failure.

(2) Physicians' visits for pregnancy in the outpatient hospital are exempt from benefit extension requirements.

(3) Each attending physician **or** dentist is limited to billing one day of care for inpatient hospital covered days regardless of the number of hospital visits rendered.

(4) Surgical procedures which are generally considered to be elective require prior authorization from the Utilization Review Section.

(5) Desensitization injections - Refer to Attachment 3.1-A, Item 4.b. (12).

(6) Organ transplants are covered as described in Attachment 3.1-E.

(7) Consultations**, including interactive consultations (telemedicine),** are limited to two (2) per recipient per year in a physician's office, **advanced practice registered nurse's office**, patient's home, hospital, or nursing home. This yearly limit is based on the State Fiscal Year (July 1 through June 30). This limit is in addition to the yearly limit described in Item 5.(1). Extensions of the benefit limit will be **available** if medically necessary.

(8) Abortions are covered when the life of the mother would be endangered if the fetus were carried to term or for victims of rape or incest. *Arkansas Code Annotated § 20-16-705(a) states that "no abortion of a viable fetus shall be performed unless necessary to preserve the life or health of the woman." It later goes on to say that the abortion of a viable fetus is not prohibited if "the pregnancy is the result of rape or incest perpetrated on a minor when documentation is presented that states the crime has been reported to law enforcement."* The circumstances must be certified in writing by the woman's attending physician. Prior authorization is required.

5. b. Medical and surgical services furnished by a dentist (in accordance with Section 1905 (a)(5)(B) of the Act).

Medical services furnished by a dentist are limited to ~~twelve (12)~~sixteen (16) visits per State Fiscal Year (July 1 through June 30) for ~~clients~~ beneficiaries **twenty-one (21) years or** older.

MEDICALLY NEEDY

5. b. Medical and surgical services furnished by a dentist (in accordance with Section 1905 (a)(5)(B) of the Act). (continued)

The benefit limit will be considered in conjunction with the benefit limit established for physicians' services, ~~rural~~ Rural ~~health~~ Health ~~clinic~~ Clinic services, office medical services furnished by an optometrist, physician assistant services, clinical nurse specialist services, certified nurse midwife services, **and services provided by an advanced practice nurse or registered nurse practitioner or any combination ~~of the six~~thereof**. For services beyond the ~~12~~-visit limit, extensions will be provided if medically necessary. ~~Certain services, specified in the appropriate provider manual, are not counted toward the 12 visit limit. Recipients under age 21 in the Child Health Services (EPSDT) Program are not benefit limited.~~

The extension of benefit requirements are exempt for the following diagnoses when it is indicated as the primary diagnosis:

1. Malignant neoplasm (View ICD Codes.).
2. HIV infection or AIDS (View ICD Codes.).
3. Renal failure (View ICD Codes.).
4. Pregnancy* (View ICD Codes.).
5. Opioid Use Disorder when treated with MAT (View ICD OUD Codes.)

Beneficiaries under the age of twenty-one (21) in the Child Health Services, Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Program are not benefit limited.

Surgical services furnished by a dentist are not benefit--limited.

6. Medical care and any other type of remedial care recognized under State law, furnished by licensed practitioners within the scope of their practice as defined by State law. (Continued)

b. Optometrists' Services (Continued)

(2) One eye exam every twelve (12) months for eligible clientsbeneficiaries under twenty-one (21) years of age in the Child Health Services, Early and Periodic Screening, Diangostic, and Treatment (EPSDT) Program. Extensions of the benefit limit will be available if medically necessary for clientsbeneficiaries in the Child Health Services (EPSDT) Program.

(3) Office medical services provided by an optometrist are limited to twelve (12)sixteen (16) visits per State Fiscal Year (July 1 through June 30) for clientsbeneficiaries twenty-one (21) years or overolder. The benefit limit will be in conjunction with the benefit limit established for physicians' services, medical services furnished by a dentist, rRural hHealth cClinic services, federally qualified health center, certified nurse midwife services, physician assistant services, clinical nurse specialist services,, andservices, and services provided by an advanced practice registered nurse, or any combination of the seventhereof. For services beyond the twelve (12) sixteen (16) visit limit, extensions will be provided if medically necessary. Certain services, specified in the appropriate provider manual, are not counted toward the twelve (12) sixteen (16) visit limit. Beneficiaries in the Child Health Services, (EPSDT) Program are not benefit--limited.

c. Chiropractors' Services

(1) Services are limited to licensed chiropractors meeting minimum standards promulgated by the Secretary of HHS under Title XVIII.

(2) Services are limited to treatment by means of manual manipulation of the spine which the chiropractor is legally authorized by the State to perform.

(3) Effective for dates of service on or after July 1, 1996, chiropractic services will be limited to twelve (12) visits per State Fiscal Year (July 1 through June 30) for eligible Medicaid recipients age 21 and older. Services provided to recipients under age 21 in the Child Health Services (EPSDT) Program are not benefit--limited.

(4) Effective for dates of service on or after January 1, 2018, **c**hiropractic services do not require a referral by the beneficiary's primary care physician (PCP).

d. Advanced Practice Registered Nurses

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

The benefit limit will be in conjunction with the benefit limit established for physicians' services, Rrural hHealth cClinic, medical services furnished by a dentist, office medical services furnished by an optometrist, certified nurse midwife services, physician assistant services, clinical nurse specialist services, and federally qualified health center or any combination of the seventhereof. For services beyond the established limit, extensions will be available if medically necessary. Certain services, specified in the appropriate provider manual, are not counted toward the limit. ClientsBeneficiaries in the Child Health Services (EPSDT) Program are not benefit--limited.

6. Medical care and any other type of remedial care recognized under State law, furnished by licensed practitioners within the scope of their practice as defined by State law. (Continued)

e. Physician Assistant

For beneficiaries twenty-one (21) years of age or older, services provided by physician assistant in office of practice, a patient's home, or nursing home, if appropriate, are limited to sixteen (16) visits per state fiscal year (July 1 through June 30).
The benefit limit will be in conjunction with the benefit limit established for physicians' services, Rural Health Clinic, medical services furnished by a dentist, office medical services furnished by an optometrist, certified nurse midwife services, clinical nurse specialist services, and federally qualified health center, or any combination thereof. For services beyond the established benefit limit, extensions will be available if medically necessary. ~~Certain services, specified in the appropriate provider manual, are not counted toward the limit.~~ Beneficiaries in the Child Health Services, Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Program are not benefit-limited.

f. Clinical Nurse Specialist

For beneficiaries twenty-one (21) years of age or older, services provided in clinical nurse specialist's office, a patient's home, or nursing home are limited to sixteen (16) visits per state fiscal year (July 1 through June 30).
The benefit limit will be in conjunction with the benefit limit established for physicians' services, Rural Health Clinic, medical services furnished by a dentist, office medical services furnished by an optometrist, certified nurse midwife services, physician assistant services, and federally qualified health center, or any combination thereof. For services beyond the established benefit limit, extensions will be available if medically necessary. ~~Certain services, specified in the appropriate provider manual, are not counted toward the limit.~~ Beneficiaries in the Child Health Services, Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Program are not benefit-limited.

6. Medical care and any other type of remedial care recognized under State law, furnished by licensed practitioners within the scope of their practice as defined by State law. (Continued)

6.d. Other Practitioners' Services (Continued)

(5) Psychologists

Refer to Attachment 3.1-A, Item 4.b.(13).

(6) Obstetric - Gynecologic and Gerontological Nurse Practitioner

Refer to Attachment 3.1-B, Item 21 for coverage limitations.

(7) Pharmacists

(8) Licensed Registered Nurse Sexual Assault Nurse Examiner- Pediatric/Adolescent (SANE-P) certified by the International Association of Forensic Nurses working under the supervision of a licensed Advanced Practice Registered Nurse (APRN).

(9) Physician Assistant

Refer to Attachment 3.1-B, Page 3b1, Section 6, Item e.

(10) Clinical Nurse Specialists

Refer to Attachment 3.1-B, Page 3b1, Section 6, Item f.

17. Nurse-Midwife Services

Any person possessing the qualifications for a registered nurse in the State of Arkansas who is also certified as a nurse-midwife by the American College of Nurse-Midwives, upon application and payment of the requisite fees to the Arkansas State Board of Nursing, be qualified for licensure as a certified nurse-midwife. A certified nurse-midwife meeting the requirements of Arkansas Act 409 of 1995 is authorized to practice nurse-midwifery.

Services provided by a certified nurse midwife are limited to ~~twelve (12)~~ sixteen (16) visits a year for beneficiaries ~~age~~ twenty-one (21) years and older. This yearly limit is based on the State Fiscal Year (July 1 through June 30). The benefit limit will be considered in conjunction with the benefit limit established for physicians' services, medical services furnished by a dentist, ~~r~~Rural ~~h~~Health ~~c~~Clinic services, office medical services furnished by an optometrist, physician assistant services, clinical nurse specialist services, and services provided by an advanced practice nurse or registered nurse practitioner or any combination ~~of the six~~thereof.- For services beyond the ~~twelve~~ visit limit, extensions will be provided if medically necessary. ~~Certain services, specified in the appropriate provider manual, are not counted toward the 12 visit limit.~~ Beneficiaries under age twenty-one (21) in the Child Health Services, Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) program are not benefit-limited.

5. Physicians' Services (Continued)

Supplemental Payment to Certain Professionals Employed by UAMS

(a) Effective January 1, 2008, certain medical professional providers employed by the University of Arkansas for Medical Sciences (UAMS) shall be eligible for a supplemental payment that equals the difference between the regular, base Medicaid rate and an estimate of the average commercial rate paid for each billing code.

Eligible professionals are:

(i) Physicians, psychiatrists, psychologists, social workers, psychological examiners, speech therapists, advanced practice nurses, physician assistant~~s~~, nurse anesthetists, occupational therapists, physical therapists, podiatrists, audiologists, opticians and nutritionists;

(1) Effective July 1, 2024, clinical nurse specialists are eligible professionals;

(ii) Licensed by the State of Arkansas; and

(iii) Employed by the UAMS College of Medicine.

(b) A supplemental payment will be made for services rendered by eligible professionals equal to the difference between the Medicaid payments otherwise made and payments at the Average Commercial Rate. This supplemental payment will, for the same dates of service, be reduced by any other supplemental payment for eligible professionals found elsewhere in the state plan. Payment will be made quarterly and will not be made prior to the delivery of services.

(c) The supplemental payment to eligible professionals will be determined as follows:

(i) Compute the Average Commercial Fee Schedule: Determine the average commercial allowed amount paid per procedure code by the top five payers with negotiated fee schedules. The State will develop separate Average Commercial Fee Schedules for services billed through UAMS, Area health Education Centers (AHECs) and Children's Hospital. Additionally, if there are any differences in payment on a per billing code basis for services rendered by different types of medical professionals, the State will calculate separate Average Commercial Fee Schedule(s) to reflect these differences. The data used to develop the Average Commercial Fee Schedule will be derived from the most recently completed state fiscal year.

(ii) Calculate the Average Commercial Payment Ceiling: For each quarter of the current fiscal year multiply the Average Commercial Fee Schedule as determined in 5(c)(i) above by the number of times each procedure code was paid in the quarter to eligible professionals on

behalf of Medicaid beneficiaries as reported from the MMIS. The Average Commercial Payment Ceiling will be calculated separately for services billed through UAMS, Arkansas Children's Hospital and AHECs. If applicable, a separate payment ceiling will be set when payment for the same service differs according to the type of professional rendering the service.

(d) The Supplemental Payment shall equal the difference between the Average Commercial Payment Ceiling for the quarter and the total Medicaid payments made for the quarter to eligible professionals for the procedure codes included in the calculation of the Average Commercial Fee Schedule in 5(c)(i) above, as reported from the MMIS.

6.d. Other Practitioner's Services (Continued)

(5) Psychologist Services

Refer to Attachment 4.19-B, Item 4.b. (17).

(a) Additional Reimbursement for Psychologist~~s~~ Services Associated with UAMS – Refer to Attachment 4.19-B, item 5.

(6) Obstetric-Gynecologic and Gerontological Nurse Practitioner Services

Reimbursement is the lower of the amount billed or the Title XIX maximum allowable.

The Title XIX maximum is based on eighty percent (80%) of the physician fee schedule except Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) procedure codes. Medicaid maximum allowables are the same for all EPSDT providers. Immunizations and Rhogam RhoD Immune Globulin are reimbursed at the same rate as the physician rate since the cost and administration of the drug does not vary between the nurse practitioner and physician.

Refer to Attachment 4.19-B, Item 27~~,~~ (Attachment 4.19-B,page 14) for a list of the advanced practice nurse and registered nurse practitioner services.

Except as otherwise noted in the plan, state developed fee schedule rates are the same for both governmental and private providers of services provided by Advanced Practice Nurse. The agency's fee schedule rate was set as of April 1, 2004 and is effective for services provided on or after that date. All rates are published on the agency's fee schedules ~~agency's website@~~ tservices/~~www.medicaid.state.ar.us.~~

(7) Advanced Practice Nurses Services Associated with UAMS – For additional reimbursement refer to Attachment 4.19-B, item 5.

(8) Licensed Clinical Social Workers' Services Associated with UAMS – For additional reimbursement refer to Attachment 4.19-B, item 5.

(9) Physician~~s~~' Assistant Services Associated with UAMS – For additional reimbursement refer to Attachment 4.19-B, item 5.

(10) Registered Nurse Sexual Assault Nurse Examiner-Pediatric (SANE-P) Certified by the Internal Association of Forensic Nurses For additional reimbursement refer to Attachment 4.19-B, item 5 (Attachment 4.19-B, pages 1www2, 2.1, 2a)..

(11) Clinical Nurse Specialists' Services Associated with UAMS – For additional reimbursement refer to Attachment 4.19-B, item 5.

7. Home Health Services

a. Intermittent or part-time nursing services furnished by a home health agency or a registered nurse when no home health agency exists in the area;
b. Home health aide services provided by a home health agency; and
c. Physical therapy.

Reimbursement is based on the lesser of the amount billed or the Title XIX (Medicaid) maximum charge allowed. State developed fee schedule rates are the same for both public and private providers of home health services.

~~The initial computation (effective July 1, 1994) or the Medicaid maximum for home health reimbursement was calculated using audited 1990 Medicare cost reports for three high volume Medicaid providers, Medical Personnel Pool, Arkansas Home Health, W. M. and the Visiting Nurses Association. For each provider, the cost per visit for each home health service listed above in items 7.a., b. and c. was established by dividing total allowable costs by total visits. This figure was then~~

7. Home Health Services (Continued)
a., b.and c. (Continued)

The initial computation (effective July 1, 1994) or the Medicaid maximum for home health reimbursement was calculated using audited 1990 Medicare cost reports for three high volume Medicaid providers, Medical Personnel Pool, Arkansas Home Health, W. M. and the Visiting Nurses Association. For each provider, the cost per visit for each home health service listed above in items 7.a., b. and c. was established by dividing total allowable costs by total visits. This figure was then inflated by the Home Health Market Basket Index in Federal Register #129, Vol. 58 dated July 8, 1993- inflation factors: 1991 - 105.7%, 1992 - 104.1%, 1993 - 104.8%. The inflated cost per visit was then weighted by the total visits per providers' fiscal year (i.e., the visits reported on the 1990 Medicare cost reports) to arrive at a weighted average visit cost.

The physical therapy reimbursement rate calculated under this method will be submitted to the United States District Court for the Eastern District of Arkansas (case of *Arkansas Medical Society v. Reynolds*) for its approval.

For registered nurses (RN) and licensed practical nurses (LPN), the Full Time Equivalent Employees (FTEs) listed on cost report worksheet S-1, Part II, were used to allocate nursing costs and units of service (visits). It was necessary to make these allocations because home health agencies are not required by Medicare to separate their registered nurses and licensed practical nurse costs or visits on the annual cost report.

RN and LPN salaries and fringes were separated using an Office of Personnel Management Survey, which indicated that RNs, on an average, are paid 36% more than licensed practical nurses. Conversely, if RNs are paid 36% more than LPNs, then LPNs are paid, on an average, 73.5% of what RNs earn. Cost report salaries and fringes were allocated based on 100% of RN FTEs and 73.5% of LPN FTEs. Other costs and service units (visits) were allocated based on 100% of RN FTEs and 100% of LPN FTEs. RN and LPN unit service (visit) costs were then inflated and weighted as outlined above.

Since home health reimbursement is based on audited costs, the home health rates will be adjusted annually by the Home Health Market Basket Index. This adjustment will occur at the beginning of the State Fiscal Year, July 1. Every third year, the cost per visit will be rebased utilizing the most current audited cost report from the same three providers and using the same formula described above to arrive at a cost per visit inflated through the rebasing year. ~~(~~The first rebasing will occur in 1996 to be effective July 1, 1997.~~)~~

c. Medical Supplies, Equipment and Appliances Suitable for Use in the Home

(1) Medical Supplies

Effective for dates of service on or after October 1, 1994, medical supplies, for use by patient in their own home - Reimbursement is based on 100% of the Medicare maximum for

medical supplies reflected in the 1993 Arkansas Medicare Pricing File not to exceed the Title XIX coverage limitations as specified in Attachment 3.l-A and Attachment 3.l-B, Item l2.c.7.