Click below to view any of the materials in this quarter's packets. Note: Some links will open a webpage.

WHAT'S NEW

- Arkansas Take Back
  - Permanent sites
- Arkansas Works
- Behavioral Health
  - Informational report
  - OBHS manual
  - Referral change for primary care physicians
  - Webinars – Stakeholder and transformation
- Episodes of Care (EOC)
  - Announcements
  - Performance payment and reconciliation reports
  - URI – AFMC Resources
- Fluoride
  - Codes
  - Manual language
- Medicaid Management Information System (MMIS)
  - https://medicaid.mmis.arkansas.gov/Provider/frontline.html
  - Aid Category to Benefit Plan Crosswalk
  - AFMC MMIS Specialists Map
  - Managed Care Capitation and Administrative Fees
  - Eligibility Job+Aid
  - Submitting and Reviewing a Claim Job+Aid
- New URL for Arkansas Medicaid
  - https://medicaid.mmis.arkansas.gov
- PASSE
  - Independent assessment
  - Updated contact information
  - Webinar (Recorded Oct. 2017)
- PCMH News
  - 6-month activities – due by June 30
  - Asthma metric
  - Webinar (Recorded Oct. 2017)
- QMB and SMB
  - Cost sharing
- Remittance Advice (RA), March 22–29
  - Chiropractic services
- Who May Not Enroll with a PCP

CONTINUED, NEXT PAGE
Click below to view any of the materials in this quarter’s packets. Note: Some links will open a webpage.

Arkansas Health Care Payment Improvement Initiative (AHCPII): paymentinitiative.org

Patient Centered Medical Home (PCMH)
- PCMH 24/7 Best Practices
- PCMH Contacts
- PCMH Manual and Program Policy Addendum
  www.paymentinitiative.org/pcmh-manual-and-additional-resources
  - Health Literacy Tool
  - PCMH Recovery of Practice Support
  - PCMH Research, Reconsideration and Appeal
  - History Button and Medical Neighborhood Report

Practice Transformation (AFMC)

Episodes of Care (Algorithms) and Updates — Performance Period and Final Report Dates

Links
- AFMC Service Center
- Beneficiary Education | afmc.org/ARBeneEd
- Drug Lists/Magellan
  - Cough and Cold Drug List
    https://arkansas.magellanrx.com/provider/docs/rxinfo/candclist.pdf
  - Generic Drug Upper Limit List
    https://arkansas.magellanrx.com/provider/docs/rxinfo/gul.pdf
  - Over the Counter (OTC) Drug List
    https://arkansas.magellanrx.com/provider/docs/rxinfo/otclist.pdf
  - Magellan Pharmacy Call Center
  - Preferred Drug List (PDL)
    https://arkansas.magellanrx.com/provider/docs/rxinfo/PDL.pdf

Emergency Room
- ER Flow Sheets
- ER Billing Sheet

EPSDT
- Billing Sheet
- EPSDT booklet
- Fee Schedule
- Screenings and Sick Visits
- Messages for Remittance Advice

Learn on Demand
https://uams.community360.net/content/uams/LODFlier2015.pdf

Medicaid Policy: PCP selection and enrollment
- DMS-2609
- Voice Response System (VRS)

Quality Improvement Project Updates
- Alcohol Use Disorder
- Flu Prevention
- CT Imaging in the Emergency Department
- LARC
- Opioids
- Diabetes

Review
- AFMC ReviewPoint
- Prior Authorizations
  https://afmc.org/review/prior-authorization/

“What’s New” for Providers
https://medicaid.mmis.arkansas.gov/Provider/newprov.aspx
Refer to the map and the color key below to find your representative.

- **Manager**
  Sheryl Hurt ................. 501-212-8688
  shurt@afmc.org [C] 501-804-3168

- **Supervisor, Outreach Logistics**
  Tonyia Haynes ............ 501-212-8686
  thaynes@afmc.org

- **Outreach Specialists**
  Emily Alexander ......... 501-804-0184
  ealexander@afmc.org

  All Outreach Specialists .......... 501-212-8686

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

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

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

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

  Connie Riley ............. 501-545-7873
  Arkansas Children's Hospital
  Representative
criley@afmc.org

---

**DXC Technology Services (Claims Processing)**

500 President Clinton Avenue, Suite 400 • Little Rock, AR 72201

- **Operator** ............. 501-374-6608

- **Helpline**
  - In state toll free .......... 800-457-4454
  - Local/out of state ....... 501-376-2211

- **Voice Response System**
  - 1-800-805-1512

- **Supervisor, Service Relations**
  Karyette Simmons ........ 501-244-5917

---

**ARKIDS FIRST/ MEDICAID MEDICAL ASSISTANCE**

https://medicaid.mmis.arkansas.gov

- ARKids First Enrollment Information .......... 888-474-8275

**CONNECTCARE**

- Toll free .................. 800-275-1131

**MEDICAID FRAUD CONTROL UNIT (PROVIDERS)**

- Central Arkansas .......... 501-682-8349

**PROVIDER ENROLLMENT**

DXC Technology Services
P.O. Box 8105
Little Rock, AR 72203-8105

- Central Arkansas .......... 501-376-2211
  Fax .......................... 501-374-0746

**ARKANSAS MEDICAL SOCIETY REPRESENTATIVE**

PHYSICIAN OUTREACH SPECIALIST

Gloria Boone ............... 501-352-1443
gboone@arkmed.org
Behavioral Health Informational Report Overview

Report Release: 2018 JAN

Introduction

The following is a new informational report which subtotals the behavioral health Medicaid reimbursements for your practice, grouped by primary behavioral health diagnosis found on claims. This report will enable your practice to profile their Medicaid reimbursements and compare their reimbursements to the average of all BH providers. Reimbursements are graphically displayed based on claims frequency, group cost and patient age. Reimbursements are also detailed by beneficiary across diagnosis groupings. This report will be published quarterly, and future iterations will add quality measures.

Transitional Report

The Behavioral Health Informational Report is currently a transitional report. It will evolve over time as Arkansas Medicaid’s Behavioral Health Transformation efforts come to full fruition. Behavioral Health Transformation has implemented a new procedure coding system that categorizes behavioral health cases into three tiers of service based on their severity. Tiers 2 & 3 are the more severe cases, and will ultimately become the financial responsibility of a provider led managed care hybrid system. Over time, Tier 2 & 3 services will drop from this report leaving only Tier 1 services. Therefore, the reports created during 2018 may contain a combination of all three tiers.

Sections in this Report

- **Behavioral Health Summary** - a cost summary by diagnosis grouping which lists the number of claims, number of patients, total amount reimbursed, average cost per beneficiary, and the average cost comparison across all providers.
- **Distribution of Claims by Primary Diagnosis Category** - a chart displaying the frequency of your claims based on primary diagnosis by diagnosis grouping.
- **Average Cost Per Patient** – a chart displaying your average cost per beneficiary by diagnosis grouping.
- **Distribution of Unique Beneficiaries by Age Category** - a chart displaying the distribution of your behavioral health beneficiaries by their age.
- **Behavioral Health Detailed Cost Information by Provider** - a detailed listing for each performing provider which lists each beneficiary under their care, displaying the frequency of claims and cost by diagnosis grouping.

Where to Find More Information

More information about this report, including diagnosis code grouping details and claims inclusion/exclusion parameters, can be found at [www.paymentinitiative.org](http://www.paymentinitiative.org).
ADULT MEDICAID BH REFERRAL CHANGES UNDERWAY

WHAT IS CHANGING?

The current AR Medicaid program under which Behavioral Health Services are provided (RSPMI) will end June 30th 2018. A new program is being implemented in its place, the Outpatient Behavioral Health (OBH) program. Under the OBH program clients who require a full array of services beyond outpatient counseling and medication management will receive an Independent Assessment through a DHS contractor Optum Health Solutions. Clients who receive an assessment will be given a Tier determination:

TIERS OF SERVICE

Tier 1: Counseling level services provided by a mental health professional.
Tier 2: Rehabilitative level services provided by mental health professionals and paraprofessionals employed by a certified agency provider.
Tier 3: Residential level services provided in residential settings.

Clients who receive a Tier 2 or Tier 3 determination will no longer need a PCP referral for behavioral health services. These clients will receive care coordination through the Provider Led Arkansas Shared Savings Entity (PASSE) programs. All clients who receive a Tier 1 determination and those that do not receive an Independent Assessment will need a PCP referral for counseling services in the OBH program. This population includes children, youth and adults. These services can be provided by certified agency providers, certified counselors in private practice and certified school based providers.

LIMITS AND DOCUMENTATION

Each beneficiary may receive up to three (3) OBH Tier 1 Counselor Level Services without a PCP referral. Following those three (3) OBH visits, the beneficiary will need a referral/approval to continue treatment. The referral must be retained in the beneficiary’s medical file.

The PCMH will be responsible for coordinating care with a beneficiary’s PCP or physician for these OBH Tier 1 Counseling Level Services.

Medical responsibility for beneficiaries shall be vested in an Arkansas-licensed physician.
Verbal referrals from PCPs or PCMHs are acceptable to Medicaid as long as they are documented in the beneficiary’s medical chart as described in section 171.410.
Episodes of Care Announcements

Reports Release: 2018 APR

Reports for April 2018 Will Be on Time

Episodes of Care and Medical Neighborhood reports will be published on April 30, 2018 and will be available on the AHIN provider portal. The only exception to this is the Colon and Tonsil Payment reports, which are being delayed in order to give providers adequate time to review and enter their randomized quality measure data.

Important Information for Tonsillectomy and Colonoscopy Providers

Below are some important dates to keep in mind:

- March 26, 2018 – Randomized quality measure portal entry selections will be available.
- April 30, 2018 – Last day to enter randomized quality measure portal entry.

System Infrastructure and Reports Update

As many providers may know, AR Medicaid has transitioned to a new Medicaid Management Information System (MMIS) called InterChange. Because of this change, we have performed a major transformation of the application programs that drive the Episode of Care analytic engine. Included in this overhaul are a new claims data format, updated procedure and diagnosis codes, algorithm standardization, and countless other changes to accommodate our new data structure and new data source.

Due to the extensive volume of updates, we have assigned a new versioning system for all existing and new reports we produce. With the release of the 2018 APR PAP reports, existing financial EOC’s and Medical Neighborhood Performance Report (MNPR) will be labelled as Version 2.0.0.

Even with rigorous quality assurance, data source changes of this magnitude its possible anomalies may occur. If any oddities occur on your report, please reach out to the Arkansas Medicaid AHCPII call center. The AHCPII contact information is 501.301.8311 or 866.322.4946 or email at ARKPII@dxc.com.

You can find more information about your reports and find the latest announcements at www.paymentinitiative.org.
What are Episodes of Care
PAP Reports?

An Episode of Care (EOC) is the retrospective bundle of Arkansas Medicaid-covered health care services provided to perform a specific procedure or treat an ailment/condition for a given length of time. For each financial EOC, providers submit claims and will continue to be reimbursed per established fee schedules. A Principal Accountable Provider (PAP) is identified for each EOC through claims data. PAPs are defined as providers who have the greatest potential to influence treatment decisions, cost, and quality of care within each type of EOC. PAPs share in savings or excess costs of a financial EOC determined by the average adjusted cost per valid episode and performance on quality/outcome measures as compared to peers.

Who Receives this Report?

The performance period and/or reconciliation period has concluded for at least one episode of care. You have been identified as a Principal Accountable Provider (PAP) and will receive a financial incentive payment, recovery or adjustment. Financial episode incentives, gain or risk sharing, are based on your average episode cost and quality over the 12-month performance period.

PAPs are given incentives after the conclusion of a performance period. A positive incentive (gain share) payment is given for high-quality, cost-effective care. PAPs are assessed a negative incentive (risk share) recovery for unnecessarily high-cost care. Performance reports are reconciled one year later and adjustments to performance incentives are paid or recovered as needed.

For Additional Information

The Arkansas Healthcare Payment Improvement Initiative website at www.paymentinitiative.org provides many resources including: episode-specific information, a PAP Report glossary and a guide to understanding the report.

We appreciate the participation of all providers as we seek to transform health care across Arkansas by improving population health, patients’ experience of care, and clinical cost-effectiveness.

If you have any questions or concerns, please contact the AHCPII help desk at: 866-322-4696, 501-301-8311 or arkipi@dxc.com

Episodes of Care
Performance Payment and Reconciliation Reports

ARKANSAS DEPARTMENT OF HUMAN SERVICES

Health Care Innovation
Division of Medical Services
Arkansas Department of Human Services
Post Office Box 1437, Slot 5425
Little Rock, AR 72203

2018 MAR
Report Types and their possible Financial Consequence

There are two financial episode report types: performance and reconciliation. Principal Accountable Provider (PAP) Performance Reports detail a PAP’s performance in terms of both cost and quality. Reconciliation reports make any necessary adjustments to the initial performance report determination. PAP Reports may be found on the provider portal at: https://secure.a hin-net.com/ahin/logon.jsp.

**Performance Year Payment** – A positive incentive (gain share) determination and payment to the Principal Accountable Provider (PAP). (Performance Year Payments are subject to Reconciliation one year later).

**Performance Year Recovery** – A negative incentive (risk share) determination and recovery of unnecessary costs from the Principal Accountable Provider (PAP). (Performance Year Payments are subject to Reconciliation one year later).

**Reconciliation Payment** – A final positive adjustment determination and payment to the Principal Accountable Provider (PAP). This positive incentive is either an additional gain share or a reduced risk share amount compared to the performance year report.

**Reconciliation Recovery** – A final negative adjustment determination and recovery from the Principal Accountable Provider (PAP). This negative incentive is either a decrease in gain share or an increase in risk share compared to the performance year report.

Performance or Reconciliation Payment

If you are receiving a positive incentive (gain share) payment, DMS payment to you will accompany and appear in the Financial Items section of your next remittance advice.

Performance or Reconciliation Recovery

DMS will recover any funds owed in one of three ways:

1. DMS, by default, will withhold the amount from future remittances until the debt is settled.

2. You may pay by check, made payable to ‘Division of Medical Services’. Please enclose a copy of the enclosed incentive notice and include your billing provider identification number to ensure that DMS properly credits your account. Also, your check must be received within 30 days at the following address:

   DHS Office of Finance and Administration Accounts Receivable Unit
   PO Box 8181 Slot WG2
   Little Rock AR 72203

3. You may request a payment arrangement. If you are interested in making payment arrangements, please contact Dawn Harrell in Accounts Receivable by email at daw n.harrell@dhs.arkansas.gov or by telephone at 501.320.6523.

If you wish to dispute a negative determination, you may request a reconsideration, an appeal or both. You will receive a separate Notice of Recovery letter containing information about the pending automatic recovery. The recovery of a negative incentive (risk share) does not preclude other legal or administrative action which may be taken.

If you want to file an Administrative Reconsideration or Appeal:

Note: Please refer to the Arkansas Medicaid Provider Manual §160 for more information on the Administrative Reconsideration and Appeals process at https://www.medicaid.state.ar.us/Provider/docs/episode.aspx.

To request a reconsideration, please submit, along with the incentive notice, a letter and supporting documentation specifying detailed information and rationale for your request. If you request a reconsideration and/or appeal, payment will not be required until 30 days after you receive a Notice of Determination of your request for reconsideration.

For a reconsideration, please mail notice and supporting documentation to:

**Department of Human Services**
**ATTN: EO C Reconsideration**
**PO Box 1437, Slot 5425**
**Little Rock AR 72203**

For an appeal, please mail notice and supporting documentation to:

**Arkansas Department of Health**
**ATTN: Office of Medicaid Appeals**
**4815 W Markham St Slot 31**
**Little Rock AR 72205**

2018-03-20 - Provider Support Meeting
DIVISION OF MEDICAL SERVICES
Program Development & Quality Assurance

P.O. Box 1437, Slot S295 • Little Rock, AR 72203-1437
501-320-6428 • Fax: 501-404-4619
TDD/TTY: 501-682-6789

REVISED NOTICE OF RULE MAKING

TO: Health Care Providers – All Providers
DATE: August 26, 2016

I. General Information


Procedure codes that are identified as deletions in CPT® 2016 (Appendix B) are non-payable for dates of service on and after August 26, 2016.

For the benefit of those programs impacted by the conversions, the Arkansas Medicaid website fee schedules will be updated soon after the implementation of the 2016 CPT® and Healthcare Common Procedure Coding System Level II (HCPCS) conversions.
II. Process for Obtaining Prior Authorization

When obtaining a Prior Authorization (PA) from the Arkansas Foundation for Medical Care (AFMC), please send your request to the following:

<table>
<thead>
<tr>
<th>Service Description</th>
<th>Contact Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>In-state and out-of-state toll free for inpatient reviews, Prior Authorizations for surgical procedures and assistant surgeons only</td>
<td>1-800-426-2234</td>
</tr>
<tr>
<td>General telephone contact, local or long distance—Fort Smith</td>
<td>(479) 649-8501 1-877-650-2362</td>
</tr>
<tr>
<td>Fax for CHMS only</td>
<td>(479) 649-0776</td>
</tr>
<tr>
<td>Fax for Molecular Pathology only</td>
<td>(479) 649-9413</td>
</tr>
<tr>
<td>Fax</td>
<td>(479) 649-0799</td>
</tr>
<tr>
<td>Web portal</td>
<td><a href="https://afmc.org/review/exchange/">https://afmc.org/review/exchange/</a></td>
</tr>
<tr>
<td>Mailing address</td>
<td>Arkansas Foundation for Medical Care, Inc.</td>
</tr>
<tr>
<td></td>
<td>P.O. Box 180001</td>
</tr>
<tr>
<td></td>
<td>Fort Smith, AR 72918-0001</td>
</tr>
<tr>
<td>Physical site location</td>
<td>5111 Rogers Avenue, Suite 476</td>
</tr>
<tr>
<td></td>
<td>Fort Smith, AR 72903</td>
</tr>
<tr>
<td>Office hours</td>
<td>8:00 a.m. until 4:30 p.m. (Central Time), Monday through Friday, except holidays</td>
</tr>
</tbody>
</table>

III. Non-Covered 2016 CPT® Procedure Codes

A. Effective for dates of service on and after August 26, 2016, the following CPT® procedure codes are non-covered:

<table>
<thead>
<tr>
<th>Procedure Codes</th>
<th>Procedures</th>
</tr>
</thead>
<tbody>
<tr>
<td>43210</td>
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<tr>
<td>50705</td>
<td></td>
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<tr>
<td>61645</td>
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<td>61650</td>
<td></td>
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<td>61651</td>
<td></td>
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<td>65785</td>
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<tr>
<td>77767</td>
<td></td>
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<tr>
<td>77768</td>
<td></td>
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<td>78265</td>
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<td>78266</td>
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<td>81219</td>
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<td>81273</td>
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<td>81311</td>
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<td>81490</td>
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<td>81493</td>
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<td>81525</td>
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<td>81528</td>
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<td>81535</td>
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<td>81536</td>
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<td>81538</td>
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<td>81540</td>
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<td>81545</td>
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<tr>
<td>90625</td>
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<td>90697</td>
<td></td>
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<tr>
<td>93050</td>
<td></td>
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<td>96931</td>
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<td>96932</td>
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<td>96934</td>
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<td>96935</td>
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<tr>
<td>93636</td>
<td></td>
</tr>
<tr>
<td>99177</td>
<td></td>
</tr>
</tbody>
</table>
B. All 2016 CPT® procedure codes listed in Category II (supplemental tracking for performance codes) and Category III (a set of temporary codes for emerging technology) are not recognized by Arkansas Medicaid; therefore, they are non-covered.

C. The following new 2016 CPT® procedure codes are not payable to Outpatient Hospitals because these services are covered by another CPT® procedure code, another HCPCS code or a revenue code:

<table>
<thead>
<tr>
<th></th>
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</tr>
</thead>
<tbody>
<tr>
<td>10036</td>
<td>45742</td>
<td>47543</td>
<td>47544</td>
<td>50606</td>
<td>50706</td>
<td>64462</td>
</tr>
</tbody>
</table>

IV. **CPT® Lab and Molecular Pathology Procedure Codes**

Molecular Pathology procedure codes in this section listed in points A and B below, require Prior Authorization (PA). Providers are to acquire Prior Authorization before a claim for Molecular Pathology is filed for payment. Providers may request the PA from Arkansas Foundation for Medical Care (AFMC) before or after the procedure is performed as long as it is acquired within the 365-day filing deadline. Providers of these procedures may submit Molecular Pathology requests and medical record documentation to AFMC via mail, fax or electronically through a web portal. See additional contact information for AFMC in Section II of this notice.

Molecular Pathology PA requests must be submitted by the performing provider with submission of a completed Arkansas Medicaid Request for Molecular Pathology Laboratory Services (Form DMS-841) and the attachment of all pertinent clinical documentation needed to justify the procedure. If the request is approved, a Prior Authorization number will be assigned and the provider will receive notification of the approval in writing by mail. If the request does not meet the medical necessity criteria and is denied, the requesting provider will receive notification of the denial in writing by mail. Reconsideration is allowed if new or additional information is received by AFMC within 30 days of the initial denial. A sample copy of Form DMS-841 is attached. This form may be found in Section V of the provider manual. Copies may be made of this form. The enclosed form is for informational purposes only. **Please do not complete the enclosed form unless you are submitting a Molecular Pathology PA request.**

Molecular Pathology procedure codes must be submitted on a redline paper claim form with the PA listed on the claim and the itemized invoice attached that supports the charges for the test billed.
A. The following 2016 CPT® Molecular Pathology codes require a Prior Authorization from the Arkansas Foundation for Medical Care (AFMC):

<table>
<thead>
<tr>
<th></th>
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</tr>
</thead>
<tbody>
<tr>
<td>81162</td>
<td>81170</td>
<td>81218</td>
<td>81272</td>
<td>81276</td>
<td>81314</td>
<td>81412</td>
<td>81422*</td>
</tr>
<tr>
<td>81432*</td>
<td>81433*</td>
<td>81434*</td>
<td>81437*</td>
<td>81438*</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Requires paper claim submission.

B. The following 2016 CPT® Laboratory codes with special coverage criteria include the following:

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Age Restriction in Years</th>
<th>Diagnosis</th>
<th>Special Instructions</th>
<th>Requires Prior Authorization</th>
</tr>
</thead>
<tbody>
<tr>
<td>81412</td>
<td>No</td>
<td>No</td>
<td>Panel testing is only covered when the panel would replace and would be of similar or lower cost than individual gene testing including CF carrier testing.</td>
<td>Yes</td>
</tr>
<tr>
<td>81595</td>
<td>No</td>
<td>No</td>
<td>Generic testing for cardiac transplant rejection (CPT 81595) included only for patients at least (1) one year post transplant who are without clinical signs of rejections.</td>
<td>Yes</td>
</tr>
</tbody>
</table>

V. **Hearing Providers**

The following 2016 CPT® procedure codes are payable to **Hearing Providers**:

<table>
<thead>
<tr>
<th>Code</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>92537</td>
<td>92538</td>
</tr>
</tbody>
</table>
VI. **Hospital Providers**

The following 2016 CPT® procedure code is payable to Hospital Providers with special instructions:

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Required Modifiers</th>
<th>Age Restriction in Years</th>
</tr>
</thead>
<tbody>
<tr>
<td>49185</td>
<td>No</td>
<td>No</td>
</tr>
</tbody>
</table>

NOTE: Requires paper billing and documentation attached that describes that sclerotherapy of fluid collections is indicated for the treatment of cysts, seromas or lymphoceles which are causing bleeding, infection, severe pain, organ torsion or organ dysfunction.

VII. **Independent Radiology Providers**

The following 2016 CPT® procedure codes are payable to Independent Radiology Providers:

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Required Modifiers</th>
<th>Age Restriction in Years</th>
</tr>
</thead>
<tbody>
<tr>
<td>72081  72082  72083  72084  73501  73502  73503  73521</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>73522  7353  73551  73552  74712  74713  77770  77771</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>77772</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

NOTE: Fetal MRI is covered when all of the following conditions are met: 1) Abnormalities are found on fetal ultrasound performed by an experienced sonologist which cannot be adequately further evaluated by 2D or 3D ultrasound. 2) The information obtained by fetal MRI is necessary for decisions about fetal or neonatal therapy, delivery planning or to advise a family about prognosis. 3) The fetus is 18 weeks gestational age or older. 4) The MRI is performed and interpreted at a center with technicians and radiologists who are either trained or highly experienced on fetal MRI and which has appropriate MRI equipment.
VIII. Nurse Practitioner

The payment for Laboratory codes listed on the Nurse Practitioner Fee Schedule is based on Clinical Laboratory Improvement Amendments (C.L.I.A.) certification. Note that only C.L.I.A.-certified providers may bill for lab procedures performed in the provider’s office, place of service 11. Nurse Practitioner Providers that bill C.L.I.A.-required Laboratory procedure codes must have the current C.L.I.A. certification on file with the Arkansas Medicaid Provider Enrollment Unit.

*The technical component of Radiology procedure codes listed on the Nurse Practitioner Fee Schedule is payable when performed in the office place of service (11) if the Nurse Practitioner 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.

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Required Modifiers</th>
<th>Age Restriction in Years</th>
</tr>
</thead>
<tbody>
<tr>
<td>74712</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>74713</td>
<td>No</td>
<td>No</td>
</tr>
</tbody>
</table>

NOTE: Fetal MRI is covered when all of the following conditions are met: 1) Abnormalities are found on fetal ultrasound performed by an experienced sonologist which cannot be adequately further evaluated by 2D or 3D ultrasound. 2) The information obtained by fetal MRI is necessary for decisions about fetal or neonatal therapy, delivery planning or to advise a family about prognosis. 3) The fetus is 18 weeks gestational age or older. 4) The MRI is performed and interpreted at a center with technicians and radiologists who are either trained or highly experienced on fetal MRI and which has appropriate MRI equipment.

The following 2016 CPT® procedure codes are payable to Nurse Practitioner Providers:

<table>
<thead>
<tr>
<th>69209</th>
<th>72081</th>
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<th>72083</th>
<th>72084</th>
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<td>81437</td>
<td>81438</td>
<td>81442</td>
<td>88350</td>
</tr>
<tr>
<td>99188</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

IX. Oral Surgeons

The following 2016 CPT® procedure codes are payable to Oral Surgeon Providers:

| 99415 | 99416 |
X. **Physicians**

The 2016 CPT® procedure code 33477 is payable to Physicians with Prior Authorization from the Arkansas Foundation for Medical Care (AFMC).

XI. **Miscellaneous Information**

A. Effective for dates of service on or after August 26, 2016 – sterilization procedure 58565 (hysteroscopy, surgical; with bilateral fallopian tube cannulation to induce occlusion by placement of permanent implants) and the supply of the implant will no longer be covered by Arkansas Medicaid for any provider program.

B. Existing CPT® procedure codes 43775 and 43843 are now payable to Physicians:

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Required Modifiers</th>
<th>Age Restriction in Years</th>
<th>Special Instructions</th>
</tr>
</thead>
<tbody>
<tr>
<td>43775</td>
<td>No</td>
<td>18y - 64y</td>
<td>Requires Prior Authorization</td>
</tr>
<tr>
<td>43843</td>
<td>No</td>
<td>18y - 64y</td>
<td>Requires Prior Authorization</td>
</tr>
</tbody>
</table>

C. Existing CPT® procedure code 99188 is now payable to Physicians and Nurse Practitioners:

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Required Modifier</th>
<th>Age Restriction in Years</th>
</tr>
</thead>
<tbody>
<tr>
<td>99188</td>
<td>No</td>
<td>0 - 20y</td>
</tr>
</tbody>
</table>

**NOTE:** Dental prophylaxis and a fluoride treatment are preventive treatments covered by Medicaid. Prophylaxis, in addition to application of topical fluoride and/or fluoride varnish, is covered every six (6) months plus one (1) day for beneficiaries under age 21. As a result of Act 90 of 2011, Arkansas physicians, nurses and other licensed health care professionals, as well as dentists, dental hygienists and dental assistants, can apply fluoride varnish. Arkansas Medicaid covers fluoride varnish application performed by physicians who have completed the online training program approved by the Arkansas Department of Health, Office of Oral Health. 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. Physicians and nurse practitioners must complete training on dental caries risk and have an approved fluoride varnish certification from the Arkansas Department of Health, Office of Oral Health. Each provider must maintain documentation to establish his or her successful completion of the training and submit a copy of the certificate to HPE Provider Enrollment. The course that meets the requirements outlined by Act 90 of 2011 can be accessed at [http://ar.train.org](http://ar.train.org). If further treatment is needed due to severe periodontal problems, the provider must request Prior Authorization with a brief narrative.

Dental Providers must follow the Dental Program Manual for policy related to this service.
D. Existing CPT® procedure code 77387 is now payable to Nurse Practitioner, Physician, Hospital and Independent Radiology Providers.

E. Diagnosis code Z51.89 is a payable ICD-10 diagnosis and should be used according to ICD protocols.

If you have questions regarding this notice, please contact the Hewlett Packard Enterprise Provider Assistance Center at 1-800-457-4454 (Toll-Free) within Arkansas or locally and Out-of-State at (501) 376-2211.

If you need this material in an alternative format, such as large print, please contact the Program Development and Quality Assurance Unit at (501) 320-6429.

Arkansas Medicaid provider manuals (including update transmittals), official notices, notices of rule making and remittance advice (RA) messages are available for download from the Arkansas Medicaid website: www.medicaid.state.ar.us.

Thank you for your participation in the Arkansas Medicaid Program.

Dawn Stehle
Director
Dental prophylaxis and a fluoride treatment are preventive treatments covered by Medicaid. Prophylaxis, in addition to application of topical fluoride and/or fluoride varnish, is covered every six (6) months plus one (1) day for beneficiaries under age 21. Arkansas Medicaid covers fluoride varnish application, ADA code D1206, performed by physicians who have completed the online training program approved by the Arkansas Department of Health, Office of Oral Health. Eligible physicians may delegate the application to a nurse or other licensed healthcare professional under his or her supervision that has also completed the online training. Physicians and nurse practitioners must complete training on dental caries risk and have an approved fluoride varnish certification from the Arkansas Department of Health, Office of Oral Health. Each provider must maintain documentation to establish his or her successful completion of the training and submit a copy of the certificate to Provider Enrollment. The course that meets the requirements outlined by the ACT can be accessed at http://ar.train.org. If further treatment is needed due to severe periodontal problems, the provider must request prior authorization with a brief narrative.

Prophylaxis and fluoride treatments are each covered once per state fiscal year (July 1 through June 30) for beneficiaries age 21 and over. Topical fluoride treatment or fluoride varnish is covered every six (6) months plus one (1) day for beneficiaries under age 21.

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 Provider Enrollment before the specialty code will be added to their file in the MMIS. After the specialty code, FC-Fluoride Certification, is added to the provider’s file, the provider will be able to bill for procedure code D1206, Topical Application of Fluoride Varnish.

Medicaid does not reimburse for nitrous oxide for examinations, fluorides, oral prophylaxis and sealants unless other procedures are performed at the same time.

A provider may generally perform the following procedures without prior authorization:

A. Periodic EPSDT screening exam (for beneficiaries under age 21).
B. Prophylaxis, topical fluoride and/or fluoride varnish.
C. Periapical X-rays, amalgam-composite restorations (except four or more surfaces).
D. Pulpotomies for deciduous teeth. (Pulpotomies are not a covered service for beneficiaries age 21 and over.)
E. Chrome crowns on deciduous teeth.

See Sections 262.100 and 262.200 for applicable codes.
AFMC/MMIS Outreach Specialists Information Sheet

AFMC/DXC MMIS OUTREACH SPECIALISTS

Manager
Becky Andrews
501-212-8738

Supervisor/Outreach Specialist
Andrea Rowlett-Allen
501-906-7566
pulaskibilling@afmc.org

Outreach Specialists

- Christy Owens
  NW—North West...... 501-906-7566
  northwestbilling@afmc.org

- Rose Bruton
  NE—North East....... 501-906-7566
  northeastbilling@afmc.org

- Mary Riley
  EC—East Central..... 501-906-7566
  eastcentralbilling@afmc.org

- Samantha DeSalvo
  SE—South East........ 501-906-7566
  southeastbilling@afmc.org

- Angie Riggan
  SW—South West...... 501-906-7566
  southwestbilling@afmc.org

- Renee Smith
  WC—West Central.... 501-906-7566
  westcentralbilling@afmc.org

ARKANSAS DEPARTMENT
OF HUMAN SERVICES,
DIVISION OF MEDICAL SERVICES

ARKIDS FIRST/MEDICAID
https://medicaid.mmis.arkansas.gov

CONNECTCARE
Toll free ......................... 888-474-8275

MEDICAID FRAUD CONTROL
UNIT (PROVIDERS)
Central Arkansas ............. 501-682-8349

PHARMACY
Magellan Medicaid Administration
Help Desk ....................... 800-424-7895

ARKANSAS PAYMENT IMPROVEMENT INITIATIVE
501-301-8311
Local and out-of-state
1-866-322-4696
In-state toll-free
arkpii@hpe.com

DXC Technology Services (Claims Processing)
500 President Clinton Avenue, Suite 400 • Little Rock, AR 72201

DXC Provider Assistance Center
800-457-4454 In-state toll-free
501-376-2211 Local and out-of-state
800-805-1512 Voice Response System
Select Option 0 for “Other inquiries” then
Option 1: EDI Support Center
Option 2: Provider Assistance Center
Option 3: Provider Enrollment
Option 4: Arkansas Incentive Payment Team (AIPIT)

DXC Provider Enrollment
Evyvonne Carbage, Supervisor
P.O. Box 8105
Little Rock AR 72203
501-244-5891
Fax 501-374-0746

Karyette Simmons, DXC Provider Relations
Electronic Data Interchange (EDI) Supervisor
501-244-5917 arkedii@hpe.com

Claims
P.O. Box 8034 • Little Rock AR 72203

Special Claims
Attn: Research Analysts
P.O. Box 8036 • Little Rock AR 72203

HOURS OF OPERATION
Monday – Friday
8:30 A.M. – 5 P.M.
If you are a provider or trading partner submitting electronic transactions to Medicaid, you will need to enroll for a *trading partner ID*. Trading partner IDs will replace the submitter ID (formerly known as the MC ID). Users in the following groups must enroll:

- Third-party vendors (clearing houses, billing companies, vendors who perform X12 transaction sets, etc.)
- Medicaid providers who:
  - Would like to use PES after go-live
  - Utilize EDI direct submit
  - Will upload information into the new portal
- Providers who receive capitated fee information (formerly managed care fees) related to the following programs:
  - Independent Choices
  - PACE (Programs for All-Inclusive Care for the Elderly)
  - CPC (Comprehensive Primary Care)
  - Private Option or Arkansas Works
  - Long-Term Care adjusted service fee claims
  - Net service fee claims
  - Assisted living
  - PCMH (Patient-Centered Medical Home)
- **All PCPs must enroll as a trading partner to see the details of their managed care fees**

**NOTE:** Before go-live, this information was sent on your remittance advice. After go-live, this information has been replaced with a summary line that outlines the dollar amount of the capitated fees. You must enroll for a trading partner ID to receive this information.

Detailed instructions can be found at:

[https://medicaid.mmis.arkansas.gov/Download/provider/insider/MMIS_JobAid_TrndPrtnrIDEnroll.pdf](https://medicaid.mmis.arkansas.gov/Download/provider/insider/MMIS_JobAid_TrndPrtnrIDEnroll.pdf)

**MMIS Capitation Report – How to Access**

1. Log in under the Medicaid number used to receive capitation payment
2. Click the File Exchange tab at the top
3. Click Provider Download Link – a drop down box will appear
4. Choose M200 or MCAP200
5. To populate - change the date range for when the capitation payment was provided

If further assistance is needed please call 1-800-457-4454 or email arkeni@hpe.com.
What is an independent assessment?
A standardized questionnaire of high-needs Medicaid enrollees who require services in one or more of the following special needs categories: behavioral health, developmental disabilities, or aging/physically disabled adults.

Why do I need an Independent Assessment?
DHS has a new process for making decisions about the counseling services a person may receive.
It is called an Independent Assessment.

Can I still get services if I don't have the Independent Assessment?
You may still get individual, family and group counseling services from your therapist whether or not you have an independent assessment.
You can still see your doctor and get your medications.
Some services may not be paid for by Medicaid if the Independent Assessment is not completed by July 1, 2018.

What kind of questions will I be asked?
You will be asked questions about how you or your child are able to do things that you might do every day like, talk with friends, finish homework, or go to the store.
It is important that you be as honest as possible when answering the questions.
Don't be afraid, there are no right or wrong answers.

Who will be asking the questions & how long will it take?
The company DHS hired to ask the questions is called OPTUM.
They will contact you or work with your provider to schedule a time at your provider office, home or school to ask you the questions.
It will take about an hour to answers all of the questions.

What happens after the assessment?
A copy of the assessment results will be sent to you by mail.
Your provider will be sent a summary of the assessment results.
If you qualify for Tier 2 or Tier 3 services, expect a call from another person called a Care Coordinator who will be working with you to coordinate all of your health care needs.

What if I disagree with the results of my assessment?
If you disagree with the results of your assessment, you can speak with your provider to assist you with information for an appeal.

Have more questions?
If you have any questions, please contact your service provider or you may call Optum at 844-809-9538 for assistance.

Selected Vendor: Optum
Optum proposed an instrument that is validated to use across the spectrum of special needs populations, which means the Arkansas-based assessment team will be trained to understand the needs of all these populations rather than just one. That will be especially helpful given that many clients have both mental health issues and developmental disabilities. Optum also will provide ongoing provider support and education.
<table>
<thead>
<tr>
<th>Provider Name</th>
<th>Start Date</th>
<th>End Date</th>
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<td>ASCENT ACQUISITION CORPORATION Total</td>
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<td>BIRCH TREE COMMUNITIES INC Total</td>
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<td>BOST INC Total</td>
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<tr>
<td>CENTER FOR YOUTH AND FAMILIES INC Total</td>
<td>5/14/2018</td>
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<td>CONWAY COUNTY COMMUNITY SERVICE I Total</td>
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<td>UNITED FAMILY SERVICES INC Total</td>
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<td>UNITED METHODIST CHILDRENS HOME Total</td>
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<td>YOUTH HOME INC Total</td>
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<td>COUNSELING AND EDUCATION CENTER INC</td>
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<tr>
<td>UAMS Total</td>
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</table>
Contact Information for PASSE Entities

**Empower Healthcare Solutions**
1401 West Capitol Avenue, Suite 330
Little Rock, AR 72201
1-866-261-1286
www.getempowerhealth.com

**Arkansas Advanced Care**
320 West Capitol Avenue, Suite 211
Little Rock, AR 72201
1-855-472-8589
www.arkansasadvancedcare.com

**Arkansas Total Care**
P.O. Box 25010
Little Rock, AR 72221
1-866-282-6280
www.arkansastotalcare.com

**Summit Community Care**
425 W. Capitol Ave. Suite 233
Little Rock, AR 72203
1-844-405-4295
www.summitcommunitycare.com

**Forevercare**
400 West Capitol Avenue, Suite 1700
Little Rock, AR 72201
1-855-544-8744
www.forevercare.com
241.000 Activities Tracked for Practice Support – List of Activities for the 2018 Performance Period. The 2018 PCMH Program Policy Addendum can be found at [www.paymentinitiative.org](http://www.paymentinitiative.org). Attestation is completed via the AHIN portal.

- All PCMHs must meet 3-month activities by 3/31/18; 6-month activities by 6/30/18; and 12-month activities by 12/31/18.
- In order to be eligible for practice support, PCMHs must meet all activities by their specified deadlines.
- For information on remediation, please refer to the PCMH manual.
<table>
<thead>
<tr>
<th>Description</th>
<th>HEDIS 2013</th>
<th>HEDIS 2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>The percentage of members 5-64 years of age during the measurement year who were identified as having persistent asthma and who were appropriately prescribed medication during the measurement year.</td>
<td><strong>Use of Appropriate Medications for People with Asthma (ASM)</strong></td>
<td><strong>Medication Management for People with Asthma (MMA)</strong></td>
</tr>
<tr>
<td>The percentage of members 5-64 years of age during the measurement year who were identified as having persistent asthma and were dispensed appropriate medications that they remained on during the treatment period: ✓ The percentage of members who remained on an asthma controller medication for at least 50% of their treatment period.</td>
<td><strong>Used for 2015 &amp; 2016 Performance Periods</strong></td>
<td><strong>Used for 2017 &amp; 2018 Performance Periods</strong></td>
</tr>
<tr>
<td><strong>Dispensing Event</strong></td>
<td>Three methods to identify a dispensing event:</td>
<td>Three methods to identify a dispensing event:</td>
</tr>
<tr>
<td>✓ If the days supply of a prescription is less than 30, the prescription is equal to 1 dispensing event.</td>
<td>✓ If the days supply of a prescription is less than 30, the prescription is equal to 1 dispensing event.</td>
<td>✓ If the days supply of a prescription is less than 30, the prescription is equal to 1 dispensing event.</td>
</tr>
<tr>
<td>✓ If the days supply of a prescription greater than or equal to 30, the days supply is divided by 30 and rounded down.</td>
<td>✓ If the days supply of a prescription greater than or equal to 30, the days supply is divided by 30 and rounded down.</td>
<td>✓ If the days supply of a prescription greater than or equal to 30, the days supply is divided by 30 and rounded down.</td>
</tr>
<tr>
<td>- Example: 100 days supply / 30 = 3.33 (rounded down to 3 dispensing events)</td>
<td>- Example: 100 days supply / 30 = 3.33 (rounded down to 3 dispensing events)</td>
<td>- Example: 100 days supply / 30 = 3.33 (rounded down to 3 dispensing events)</td>
</tr>
<tr>
<td>- Multiple prescriptions for different medications dispensed on the same day count as separate dispensing events.</td>
<td>- Multiple prescriptions for different medications dispensed on the same day count as separate dispensing events.</td>
<td>- Multiple prescriptions for different medications dispensed on the same day count as separate dispensing events.</td>
</tr>
<tr>
<td>- Multiple prescriptions for the same medication dispensed on the same day will have the days supply summed and divided by 30 to determine the number of dispensing events.</td>
<td>- Multiple prescriptions for the same medication dispensed on the same day will have the days supply summed and divided by 30 to determine the number of dispensing events.</td>
<td>- Multiple prescriptions for the same medication dispensed on the same day will have the days supply summed and divided by 30 to determine the number of dispensing events.</td>
</tr>
<tr>
<td>✓ Inhaler /Injection medications</td>
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</tr>
<tr>
<td>- Every inhaler/injection medication dispensed counts as a unique dispensing event.</td>
<td>- All inhalers of the same medication dispensed on the same day count as one dispensing event. Medications with different Drug IDs dispensed on the same day are counted as different dispensing events.</td>
<td>- All inhalers of the same medication dispensed on the same day count as one dispensing event. Medications with different Drug IDs dispensed on the same day are counted as different dispensing events.</td>
</tr>
</tbody>
</table>
### Denominator Inclusion

<table>
<thead>
<tr>
<th>Age:</th>
<th>5 – 64 (as of the last day of the performance period)</th>
</tr>
</thead>
</table>
| Continuous Enrollment: | ✔ No more than one gap in enrollment of up to 45 days during the performance period.  
✔ No more than one gap in enrollment of up to 45 days during the previous performance period. |
| **Persistent Asthma** *(Beneficiaries must meet at least one of the following in both the performance period and the year prior):* | ✔ At least one ED visit with asthma as the principal diagnosis  
✔ At least one acute inpatient claim/encounter with asthma as the principle diagnosis  
✔ At least four outpatient asthma visits on different dates of service, with asthma as one of the listed diagnoses and at least two asthma medication dispensing events  
✔ At least four asthma medication dispensing events  ➢ If a beneficiary had four asthma medication dispensing events and a leukotriene modifier was the sole asthma medication dispensed during the performance period (or year prior), the beneficiary must also have at least one diagnosis of asthma (any setting) in the same year as the leukotriene modifier. |
| Age: | 5 – 64 (as of the last day of the performance period) |
| Continuous Enrollment: | ✔ No more than one gap in enrollment of up to 45 days during the performance period.  
✔ No more than one gap in enrollment of up to 45 days during the previous performance period. |
| **Persistent Asthma** *(Beneficiaries must meet at least one of the following in both the performance period and the year prior):* | ✔ At least one ED visit with asthma as the principal diagnosis  
✔ At least one acute inpatient claim/encounter with asthma as the principle diagnosis  
✔ At least four outpatient asthma visits on different dates of service, with asthma as one of the listed diagnoses and at least two asthma medication dispensing events  
✔ At least four asthma medication dispensing events  ➢ If a beneficiary had four asthma medication dispensing events and a leukotriene modifier or antibody inhibitors were the sole asthma medication dispensed during the performance period (or year prior), the beneficiary must also have at least one diagnosis of asthma (any setting) in the same year as the leukotriene modifier or antibody inhibitor. |

### Denominator Exclusion

| Exclude any member who had at least one encounter (any setting) with a code to identify the following: | ✔ Emphysema  
✔ COPD |
|-------------------------------------------------|-------------------------------------------------|
| Exclude any member who had at least one encounter (any setting) with a code to identify the following: | ✔ Emphysema  
✔ COPD |
<table>
<thead>
<tr>
<th>Exclusions are counted if they occurred anytime in the beneficiary history back to 2010.</th>
<th>* Exclusions are counted if they occurred anytime in the beneficiary history back to 2010.</th>
</tr>
</thead>
</table>
| ✓ Cystic Fibrosis  
✓ Acute Respiratory Failure | ✓ Obstructive Chronic Bronchitis  
✓ Chronic Respiratory Conditions Due to Fumes/Vapors  
✓ Cystic Fibrosis  
✓ Acute Respiratory Failure |

Exclusions are counted if they occurred anytime in the beneficiary history back to 2010.

Exclude any beneficiary who had no asthma controller medications dispensed during the performance period.

### Numerator Inclusion

| Beneficiary is dispensed at least one prescription for an asthma controller medication during the measurement year. | Number of beneficiaries who achieve a Proportion of Days Covered (PDC) of at least 50% for their asthma controller medications during the performance period. |

- **Identify the Index Prescription Start Date (IPSD)** – The earliest dispensing event for any asthma controller medication during the performance period.
- **Calculate the number of days beginning on the IPSD through the end of the performance period.**
- **Count the days covered by at least one prescription for an asthma controller medication during the treatment period (does not include days supply that extend beyond the end of the performance period)**
- **Calculate the beneficiary’s PDC:**
  - [ ] Total Days Covered by a controller medication in the treatment period  
  - [ ] Total Days in treatment period

*Reproduced with permission from HEDIS Volume 2: Technical Specifications for Health Plans by the National Committee for Quality Assurance (NCQA).  
HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).*
The Qualified Medicare Beneficiary (QMB) group was created by the Medicare Catastrophic Coverage Act and uses Medicaid funds to assist low-income Medicare beneficiaries. QMBs do not receive the full range of Medicaid benefits. For example, QMBs do not receive prescription drug benefits from Medicaid or drugs not covered under Medicare Part D. If a person is eligible for QMB, Medicaid pays the Medicare Part B premium, the Medicare Part B deductible and the Medicare Part B coinsurance, less any Medicaid cost sharing, for Medicare covered medical services. Medicaid also pays the Medicare Part A hospital deductible and the Medicare Part A coinsurance, less any Medicaid cost sharing. Medicaid pays the Medicare Part A premium for QMBs whose employment history is insufficient for Title XVIII to pay it. Certain QMBs may be eligible for other limited Medicaid services. Only individuals considered to be Medicare/Medicaid dually eligible qualify for coverage of Medicaid services that Medicare does not cover.

To be eligible for QMB, individuals must be age 65 or older, blind or an individual with a disability and enrolled in Medicare Part A or conditionally eligible for Medicare Part A. Their countable income may equal but may not exceed 100% of the Federal Poverty Level (FPL). Countable resources may be equal to but not exceed twice the current Supplemental Security Income (SSI) resource limitations.

Generally, individuals may not be certified in a QMB category and in another Medicaid category simultaneously. However, some QMBs may simultaneously receive assistance in the medically needy categories, SOBRA pregnant women (61 and 62). QMB generally do not have Medicaid coverage for any service that is not covered under Medicare; with the exception of the above listed categories and individuals dually eligible.

Individuals eligible for QMB receive a plastic Medicaid ID card. Providers must view the electronic eligibility display to verify the QMB category of service. The category of service for a QMB will reflect QMB-AA, QMB-AB or QMB-AD. The system will display the current eligibility.

Most providers are not federally mandated to accept Medicare assignment (See Section 142.700). However, if a physician (by Medicare’s definition) or non-physician provider desires Medicaid reimbursement for coinsurance or deductible on a Medicare claim, he or she must accept Medicare assignment on that claim (see Section 142.200 D) and enter the information required by Medicare on assigned claims. When a provider accepts Medicare according to Section 142.200 D, the beneficiary is not responsible for the difference between the billed charges and the Medicare allowed amount. Medicaid will pay a QMB’s or Medicare/Medicaid dual eligible’s Medicare cost sharing (less any applicable Medicaid cost sharing) for Medicare covered services.

Interested individuals may be directed to apply for the QMB program at their local Department of Human Services (DHS) county office.
124.160  Qualifying Individuals-1 (QI-1)  7-5-12

The Balanced Budget Act of 1997, Section 4732, (Public law 105-33) created the Qualifying Individuals-1 (QI-1) aid category. Individuals eligible as QI-1 are not eligible for Medicaid benefits. They are eligible only for the payment of their Medicare Part B premium. No other Medicare cost sharing charges will be covered. Individuals eligible for QI-1 do not receive a Medicaid card. Additionally, unlike QMBs and SMBs, they may not be certified in another Medicaid category for simultaneous periods. Individuals who meet the eligibility requirements for both QI-1 and medically needy spend down must choose which coverage they want for a particular period of time.

Eligibility for the QI-1 program is similar to that of the QMB program. The individuals must be age 65 or older, blind or an individual with a disability and entitled to receive Medicare payment Medicare Part A hospital insurance and Medicare Part B medical insurance. Countable income must be at least 120% but less than 135% of the current Federal Poverty Level.

Countable resources may equal but not exceed twice the current SSI resource limitations.

124.170  Specified Low-Income Medicare Beneficiaries (SMB)  7-15-12

The Specified Low-Income Medicare Beneficiaries Program (SMB) was mandated by Section 4501 of the Omnibus Budget Reconciliation Act of 1990.

Individuals eligible as specified low-income Medicare beneficiaries (SMB) are not eligible for the full range of Medicaid benefits. They are eligible only for Medicaid payment of their Medicare Part B premium. No other Medicare cost sharing charges will be covered. SMB individuals do not receive a Medicaid card.

Eligibility criteria for the SMB program are similar to those for QMB program. The individuals must be aged 65 or older, blind or an individual with disabilities and entitled to receive Medicare Part A hospital insurance and Medicare Part B insurance. Their countable income must be greater than, but not equal to, 100% of the current Federal Poverty Level and less than, but not equal to, 120% of the current Federal Poverty Level.

The resource limit may be equal to but not exceed twice the current SSI resource limitations.

Interested individuals may apply for SMB eligibility at their local Department of Human Services (DHS) county office.
133.000  Cost Sharing  9-15-09

The forms of cost sharing in the Medicaid Program are coinsurance, co-payment, deductibles and premiums. Each are detailed in the following Sections 133.100 through 133.500.

133.100  Inpatient Hospital Coinsurance Charge for Medicaid Beneficiaries Without Medicare  6-1-08

For inpatient admissions, the Medicaid coinsurance charge per admission for non-exempt Medicaid beneficiaries aged 18 and older is 10% of the hospital’s interim Medicaid per diem, applied on the first Medicaid covered day. (See Section 124.230 for Working Disabled cost-sharing requirements.)

Example:

A Medicaid beneficiary is an inpatient for 4 days in a hospital whose Arkansas Medicaid interim per diem is $500.00. When the hospital files a claim for 4 days, Medicaid will pay $1950.00; the beneficiary will pay $50.00 (10% Medicaid coinsurance rate).

1. Four (4 days) times $500.00 (the hospital per diem) = $2000.00 (hospital allowed amount).
2. Ten percent (10% Medicaid coinsurance rate) of $500.00 = $50.00 coinsurance.
3. Two thousand dollars ($2000.00 hospital allowed amount) minus $50.00 (coinsurance) = $1950.00 (Medicaid payment).

133.200  Inpatient Hospital Coinsurance Charge to ARKids First-B Beneficiaries  7-1-11

For inpatient admissions, the coinsurance charge per admission for ARKids First-B participants is 10% of the hospital’s Medicaid per diem, applied on the first covered day.

Example:

An ARKids First-B beneficiary is an inpatient for 4 days in a hospital whose Arkansas Medicaid per diem is $500.00. When the hospital files a claim for 4 days, Medicaid will pay $1950.00 and the beneficiary will pay $50.00 (10% Medicaid coinsurance rate).

1. Four (4 days) times $500.00 (the hospital per diem) = $2000.00 (hospital allowed amount).
2. Ten percent (10% Medicaid coinsurance rate) of $500.00 = $50.00 coinsurance.
3. Two thousand dollars ($2000.00 hospital allowed amount) minus $50.00 (coinsurance) = $1950.00 (Medicaid payment).
Inpatient Hospital Coinsurance Charge to Medicare-Medicaid Dually Eligible Beneficiaries

9-15-09

The coinsurance charge per admission for Medicaid beneficiaries, who are also Medicare Part A beneficiaries, is 10% of the hospital’s Arkansas Medicaid per diem amount, applied on the first Medicare covered day only.

Example:

A Medicare beneficiary, also eligible for Medicaid, is an inpatient for 4 days in a hospital whose Arkansas Medicaid per diem amount is $500.00.

1. This is the patient’s first hospitalization for the Medicare benefit year; so the patient has not met their Medicare Part A deductible.

2. Medicare pays the hospital its allowed Part A charges, less the current (federal fiscal year) Medicare deductible, and forwards the payment information to Medicaid.

3. Ten percent (10% Medicaid coinsurance rate) of $500.00 (the Arkansas Medicaid hospital per diem) = $50.00 (Medicaid coinsurance). Medicaid coinsurance is due for the first day only of each admission covered by Medicare Part A.

4. Medicaid’s payment is the current (federal fiscal year) Medicare Part A deductible minus $50.00 Medicaid coinsurance.

If, on a subsequent admission, Medicare Part A assesses coinsurance, Medicaid will deduct from the Medicaid payment an amount equal to 10% of the hospital’s Medicaid per diem for one day. The patient will be responsible for the amount deducted from the Medicaid payment.

Co-payment on Prescription Drugs

6-1-08

Arkansas Medicaid has a beneficiary co-payment requirement in the Pharmacy Program. The payment is applied per prescription. Non-exempt beneficiaries aged 18 and older are responsible for paying the provider a co-payment amount based on the following table: (See Section 124.230 for Working Disabled cost-sharing requirements. See the ARKids First-B provider manual for ARKids-First B cost-sharing requirements.)

<table>
<thead>
<tr>
<th>Medicaid Maximum Amount</th>
<th>Beneficiary Co-pay</th>
</tr>
</thead>
<tbody>
<tr>
<td>$10.00 or less</td>
<td>$0.50</td>
</tr>
<tr>
<td>$10.01 to $25.00</td>
<td>$1.00</td>
</tr>
<tr>
<td>$25.01 to $50.00</td>
<td>$2.00</td>
</tr>
<tr>
<td>$50.01 or more</td>
<td>$3.00</td>
</tr>
</tbody>
</table>

Co-Payment of Eyeglasses for Beneficiaries Aged 21 and Older

6-1-08

Arkansas Medicaid has a beneficiary co-payment requirement in the Visual Care Program. Medicaid beneficiaries 21 years of age and older must pay a $2.00 co-payment for Visual Care prescription services. Nursing home residents are exempt from the co-pay requirement.
TO: CHIROPRACTIC PROVIDERS
RE: PCP REFERRALS NOT REQUIRED FOR CHIROPRACTIC VISITS
For Dates of Service on and after 1/1/18, PCP referrals are no longer needed for chiropractic visits. Providers may see patients, but will hold their claims until amended policy goes into effect on 5/1/18.

When the MMIS claims processing system is updated and promulgation complete, another RA message will be released notifying chiropractic providers that all claims may be submitted directly to DXC via electronic or paper submission.

TO: ALL PROVIDERS
RE: CHANGES TO THE ARKANSAS MEDICAID WEBSITE
The Arkansas Medicaid website URL will soon change from the current https://www.medicaid.state.ar.us/ to the new URL https://medicaid.mmis.arkansas.gov/.
The old Arkansas Medicaid URL will automatically redirect to the updated website URL for a period of time; however, your bookmarks to the website should be updated during this period. Eventually, the current Arkansas Medicaid website URL will no longer exist; you will receive a page not found message when trying to access https://www.medicaid.state.ar.us/.

Although you should expect a different look for the Arkansas Medicaid website that utilizes a new drop-down menu structure, the content on the Arkansas Medicaid website will remain the same. If you have difficulty locating information you need after the URL change, contact the webmaster at ARKWebmaster@hpe.com.

TO: DUALLY ELIGIBLE HOSPITAL (EH) PROVIDERS
RE: GRACE PERIOD EXTENSION
All dually-eligible hospitals who submitted eCQMS on the CMS website have until April 28, 2018 to submit an application/attestation.

A submitted application means that you have registered with the R&A, attested through MAPIR and completed the MAPIR application by clicking the Submit button.

If you have questions or concerns, please contact the Arkansas Incentive Payment Team (AIPT) at aipt@hpe.com.

TO: ALL PROVIDERS
RE: UPDATED DXC TECHNOLOGY CLAIMS DEPARTMENT ADDRESSES
Section V has been corrected to update DXC Technology Claims Department mailing addresses. View changes in Section V of all provider billing manuals — https://www.medicaid.state.ar.us/Download/provider/provdocs/Links/Claims.doc.

If you need this material in an alternative format such as large print, please contact the Program Development and Quality Assurance Unit at (501) 320-6429.

Thank you for your participation in the Arkansas Medicaid Program. If you have questions regarding these messages, please contact the Provider Assistance Center at 1-800-457-4454 (toll-free) within Arkansas or locally and out-of-state at (501) 376-2211.

Remittance Advices cannot be forwarded. Notify the Arkansas Medicaid Program of any address change, indicating all provider numbers affected by the change. This notification must include the provider's original signature (no facsimiles accepted).
All Medicaid-eligible participants must enroll with a PCP unless they:

A. Have Medicare as their primary insurance.
B. Are in a long term care aid category and a resident of a nursing facility.
C. Reside in an intermediate care facility for individuals with intellectual disabilities (ICF/IID).
D. Are in a Medically Needy Spend Down eligibility category.
E. Only have a retroactive eligibility period.

1. Medicaid does not require PCP enrollment for the period between the beginning of the retroactive eligibility segment and the fifth day (inclusive) following the eligibility authorization date.

2. If eligibility extends beyond the fifth day following the authorization date, Medicaid requires PCP enrollment unless the beneficiary is otherwise exempt from PCCM requirements.
Best Practices for Providing After-Hours Care

Providing full continuity of care for patients requires physicians to provide some sort of system to handle patient crises after hours and on weekends. When communication is not available, patients either seek more expensive ER care or deteriorate, leading to more serious complications. Providing 24/7 physician communications is evolving as a professional standard of care and is an integral part of the medical home. Where improved after-hours communications have been implemented, patient satisfaction has increased and ER utilization has declined.

BEST PRACTICES

- PCPs should have an after-hours system in place that ensures that patients can reach the PCP or another on-call medical professional with medical concerns or questions.
- This system should connect callers with a live voice — either an answering service or after-hours personnel — who should either forward patient calls directly to the on-call professional or instruct callers that the professional will return the call within 30 minutes.
- The answering service or after-hours personnel should ask the caller if the situation is an emergency. If so, the caller should be told to call 911 or go straight to the nearest ER.
- If staff or an answering service is not immediately available, the PCP/clinic may use an answering machine with a recorded message that directs callers to call 911 if they have an emergency, and to dial an alternate number (or system prompt) to reach an on-call professional.
- PCPs may provide access to an on-call professional through arranging with other PCPs to rotate call, or by contracting with a triage hotline service staffed by nurses or other clinical personnel.
- Records of after-hours calls should be made and entered into the patient’s chart.

AFTER-HOURS CARE PRACTICE ASSESSMENT

To gauge your practice’s performance in providing after-hours care, answer the following questions:

- Does your clinic provide access to a medical professional — either an on-call provider or a telephone triage service staffed by clinical personnel — to give callers voice-to-voice medical advice and guidance 24 hours, seven days a week?
- Does your clinic use an answering service or clinic staff to answer after-hours calls?
- If not, does your clinic use an answering machine that directs callers to dial an alternate number or system prompt to reach a live voice?
- If your clinic uses an answering machine, do you check it regularly to make sure it’s working properly and the recorded message is current?
- Are non-emergency calls returned by a medical professional within 30 minutes?
- Are after-hours calls and their results documented and entered into patient records?
Example answering machine greeting

1. “You have reached [clinic name].”
2. “If this is an emergency, please hang up and dial 911 or go to the nearest hospital emergency room.”
3. “If this is not an emergency and you would like to speak to an on-call doctor or nurse, please dial [answering service, on-call pager number, triage hotline number, etc.].”
4. If the alternate number is to an on-call pager, add: “A medical professional will return your call within 30 minutes.”

PROCESS FOR RECORDING AFTER-HOURS CALLS INTO A PATIENT’S CHART

- Check answering machine
- Retrieve messages
- Retrieve patient’s chart
- Document call in chart

FOLLOW UP:
- Contact patient and set appointment
- Contact patient and give referral
- Contact patient and counsel

For more information, contact your AFMC Provider Relations Outreach Specialist.
PCMH Contacts

Arkansas Foundation for Medical Care (AFMC) – Provider Outreach Specialists

- Phone: 501.212.8686
- Email: PCMH@afmc.org
- Website: www.afmc.org

AFMC Provider Outreach ensures that practices have knowledge of the benefits and requirements to become a successful PCMH assisting with enrollment applications, reading of reports and portal navigation. Provider Outreach Specialists act as the gatekeeper between providers and vendors facilitating providers in getting what they need.

DXC Technology (formerly Hewlett Packard Enterprise Services)

- APII Help Desk: 501.301.8311 or 866.322.4696
- Fax: 501.374.0549
- General Inquiries: ARKPII@DXC.com
- Enrollment applications only: ARKPCMH@DXC.com

DXC assists with processing of enrollment applications and researching specific report metrics upon request. DXC assist with any payment issues related to the PCMH program.

Arkansas Foundation for Medical Care, Practice Transformation

Rhelinda McFadden, RN, CPHIT, CPEHR
Manager, PCMHPT/Quality Consultant
1020 West 4th Street, Suite 200
Little Rock, Arkansas 72201

- Phone: 501.212.8733
- Fax: 501.375.0705
- Email: rmcfadden@afmc.org
- Email: pcmhpt@afmc.org
- Website: www.afmc.org

AFMC PT works directly with providers / PCMHs to educate on and implement PCMH Activities and Metrics through customized support to actively address barriers, manage change and improve outcomes of the PCMH.
The UAMS Center for Health Literacy developed this resource to guide Patient Centered Medical Homes in selecting a tool to screen patients for health literacy. This list is based on strength of evidence in the cited literature, along with professional expertise. The list is in ranked priority order; we consider the first tool the most appropriate for PCMH use based on the tools' properties, purposes, administration demands, and utility in the context of patient-centered care. While many of these tools are available in Spanish, this list is recommended for English administration only.

### 1. Single Health Literacy Screening Question

**Description**

*A single health literacy screening question intended to identify adults with inadequate health literacy:*

“How confident are you filling out medical forms by yourself?”


**Measurement**

Scores 3 or greater indicate inadequate health literacy.

**Administration Time**

Approx. 1 minute

**Strengths**

- Shortest and therefore practical for use in clinical setting
- Validated with the STOFHLA, REALM and NVS
  - Performed better than other screening questions with Spanish speaking patients
  - Performed better than other screening questions across age, race, ethnicity, language, and education
- Currently implemented in large health systems, including over 40,000 patients screened to date at UAMS

**Limitations**

As with all self-reported questions, false negatives are possible; however, this question is estimated to identify with the highest level of accuracy of all screening questions.

**References**


### 2. Brief (Three) Screening Questions for Health Literacy

**Description**

Two studies investigated the utility of three questions to detect limited health literacy:

1. How often do you have problems learning about your medical condition because of difficulty understanding written information? Responses are: 1-Never 2-Occasionally 3-Sometimes 4-Often 5-Always
2. How often do you have someone help you read hospital materials? Responses are: 1-Never 2-Occasionally 3-Sometimes 4-Often 5-Always
3. *How confident are you filling out medical forms by yourself?* Responses are: 1-Extremely 2-Quite a bit 3-Somewhat 4-A little 5-Not at all

**Measurement**

Any response that is 3 or greater on any question indicates inadequate health literacy.

**Administration Time**

Approx. 3 minutes

**Strengths**

Brief and therefore practical for use in clinical practice.

**Limitations**

*Recent research suggests that the “how confident” question is sufficient alone.*

**References**

3. Newest Vital Sign (NVS)

**Description**
This 6-item assessment measures reading and comprehension of a nutrition label.

**Measurement**
- 0-1 questions answered correctly: Patients highly likely to have low literacy
- 2-3 questions answered correctly: Patients possibly have low literacy
- 4-6 questions answered correctly: Patients unlikely to have low literacy

May dichotomize as limited (0-3) and adequate (4-6)\(^1\)

**Administration Time**
Approx. 3 minutes

**Strengths**
- Tests for numeracy, reading ability and comprehension skills\(^1\)
- Available in English and Spanish\(^1\)
- Correlates with TOFHLA\(^1\)
- May be more sensitive to patients with marginal health literacy than other functional health literacy assessments\(^1\)

**Limitations**
- May overestimate the percentage of patients with low literacy\(^1\)
- Takes longer to administer than single question and score must be tallied
- May seem like a math test to patients

**References**


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4. Rapid Estimate of Adult Literacy in Medicine - Revised (REALM-SF)

**Description**
The word-recognition REALM test was shortened from 66 items to 7 items.\(^1\)

**Measurement**
- Words read correctly
  - 0: Third grade and below; will not be able to read most low-literacy materials; will need repeated oral instructions, materials composed primarily of illustrations, or audio or video tapes.
  - 1-3: Fourth to sixth grade; will need low-literacy materials, may not be able to read prescription labels.
  - 4-6: Seventh to eighth grade; will struggle with most patient education materials; will not be offended by low-literacy materials.
  - 7: High school; will be able to read most patient education materials.

**Administration Time**
Approx. 2 minutes

**Strengths**
- Has been used in health literacy research for almost 20 years
- Short administration time

**Limitations**
- Assesses a narrow scope of skills (reading aloud)
- Poor literacy skills are thought to disproportionately affect the elderly and minorities, 2 groups underrepresented in the study validating the REALM-R\(^1\)
- Utility in clinical settings less known

**References**
1. Health literacy measurement tools (Revised): Content last reviewed February 2016. Agency for Healthcare Research and Quality, Rockville, MD.

### 5. Short Test of Functional Health Literacy in Adults (S-TOFHLA)

<table>
<thead>
<tr>
<th>Description</th>
<th>The TOFHLA is reduced to 2 reading passages with missing words, based on the Cloze method. The first passage is at the 4th grade reading level and the second passage is at the 10th grade reading level.¹</th>
</tr>
</thead>
</table>
| Measurement | 0-16: Inadequate functional health literacy  
17-22: Marginal functional health literacy  
23-36: Adequate functional health literacy |
| Administration Time | Approx. 7 minutes |
| Strengths | • Indicator of a patient’s ability to read health-related prose passages  
• Tested on a variety of populations (young, elderly) |
| Limitations | • Numeracy not tested  
• Longer administration time than other tools  
• Assesses sentence completion rather than functional understanding  
• May not be free to use |
PCMH Recovery of Practice Support

Practice support is suspended or terminated if the practice fails to remediate within the required time. When a practice files an appeal because they feel that they were improperly suspended, the practice is treated like an enrolled practice during the appeal process. Quality Assurance (QA) will continue to validate, and the practice will continue to receive reports and payments.

However, if the judge agrees with DMS decision to suspend, the suspension date is retroactively applied. Any financial incentive received after the suspension date is recouped as the practice was not enrolled in the program.

241.000 Activities Tracked for Practice Support 1-1-18

Using the provider portal, participating PCMHs must complete and document the activities as announced by DMS on the APII website at http://www.paymentinitiative.org/pcmh-manualand-additional-resources. The reference point for the deadlines is the first day of the calendar year.

242.000 Accountability for Practice Support 1-1-16

If a PCMH does not meet deadlines and targets for activities tracked for practice support as described in Section 241.000, then the practice must remediate its performance to avoid suspension or termination of practice support.

DMS will verify whether attestation and required documentation was submitted as required by the PCMH program. Failure to comply with this requirement will result in a Notice of Attestation Failure.

DMS will also validate whether attested activities met the PCMH program requirements. Failure to pass validation will result in a Notice of Validation Failure.

PCMHs which received a Notice of Attestation Failure and/or PCMHs which received a Notice of Validation Failure will have 15 calendar days to submit sufficient QIP. Failure to submit sufficient QIP within 15 days of receiving a Notice of Attestation Failure and/or a Notice of Validation Failure will result in suspension or termination of practice support. PCMHs which receive a Notice of Attestation Failure will have 90 days to remediate their performance from the date of the Notice of Attestation Failure.

PCMHs which received a Notice of Validation Failure will have 45 days to remediate their performance from the date of the Notice of Validation Failure.

If a PCMH fails to meet the deadlines or targets for activities within the specified remediation time, then DMS will suspend or terminate practice support.
PCMH Research, Reconsideration and Appeal

244,000 Provider Reports

1-1-18

DMS provides participating PCMH provider reports containing information about their PCMH performance on activities tracked for practice support, quality metrics tracked for shared savings incentive payments and their per beneficiary cost of care via the provider portal.

Failing to submit any updated license, address changes or changes to the Provider Id number, may result in provider reports with no beneficiary attribution. Providers may update at any time their licenses, address changes, or changes to their Provider ID number by submitting documentation to the Provider Enrollment unit via fax at (501) 374-0746.

Providers who have concerns about information included in their reports should send an email to PCMH@AFMC.org. The PCMH Quality Assurance Manager will respond to the provider/practice with a review of their inquiry. If the review leads to a discovery that the provider report is inaccurate or does not reflect actual performance, DMS will take the necessary steps to correct the inaccuracies including those that are a result of a systems and/or algorithm error. Providers can also call the APII help desk at 501-301-8311 or 866-322-4698 and by email at ARKPII@DXC.com.

Appeals

If you disagree with DMS’ decision regarding program participation, payment or other adverse action, you have the right to request reconsideration and you have the right to request an administrative appeal. During the remediation period, and prior to the notice of adverse action, practices continue receiving practice support payments.

However, DMS will not pay practice support payments after the notice of adverse action. If the practice prevails during the appeal, or reconsideration, the practice support payments will resume retroactively from the date of the adverse action notice.

A. Request Reconsideration

The Division of Medical Services must receive written request for reconsideration within (30) calendar days of the Date of the adverse action, notice. Send your request to the Arkansas Department of Human Services, Division of Medical Services, Health Care Innovation P.O. Box 1437, Slot S425, Little Rock, AR 72203.

B. Request an Administrative Appeal

The Arkansas Department of Health must receive a written appeals request within (30) calendar days of the date of the adverse action notice, or within (10) calendar days of receiving a reconsideration decision. Send your request to Arkansas Department of Health: Attention: Medicaid Provider Appeals Office, 4815 West Markham Street, Slot 31, Little Rock, AR 72205.
History Button and Medical Neighborhood Report

Medical Neighborhood Report: Report provides PCMH providers a data analysis of other providers – currently URI in emergency rooms.
Medical Neighborhood Report

Health Care Payment Improvement Initiative
Building a Healthier Future for all Arkansans

Medical Neighborhood Performance Reports

As the Arkansas Payment Improvement Initiative (APII) finishes its fifth year of activities, the DHS Division of Medical Services (Arkansas Medicaid) is preparing a data transparency initiative for 2017 called the Medical Neighborhood.

The Patient Centered Medical Home (PCMH) program has grown substantially since 2014 and provides services for over 80% of eligible Medicaid beneficiaries, administered by 900 physicians in 180 clinical sites. To facilitate PCMH stewardship of health-system resources and manage per beneficiary per year costs, Arkansas Medicaid has been providing quarterly data profiles on a web portal. Primary care providers highly value this information and have requested even more detailed information to manage their practices. Providers are increasingly interested in knowing the performance of their “medical neighborhood” to guide referrals and provide feedback to their consultants and local acute-care facilities.

Below is the first Medical Neighborhood Performance Report for PCMH providers. Data analysis from the Episode of Care for upper respiratory tract infections (URI) has created a spreadsheet documenting antibiotic prescribing rates for emergency departments. This report will allow performance comparisons of all emergency departments in the state.

URI is the first of several planned reports to be given the PCMH community in the near future. Fully transparent information will include hospital performance as well as that of clinical consultants on a variety of topics.

If you have questions about this report please contact the Arkansas Medicaid APII Help Desk at 1-866-322-4090, locally at 501-301-8311 or via email APIII@hpe.com.

Current Reports

- URI ED Antibiotic Metrics
History Button:
The history button can be found on the AHIN portal under your High Priority Beneficiary Tab. It allows you to see the beneficiaries that have been added and/or removed from your PCP’s caseload. It will update on the AHIN portal quarterly with your caseload listing.
AFMC Service Center

AFMC provides an Arkansas Medicaid and Arkansas Works service center to assist beneficiaries with a variety of functions related to their health insurance coverages as well as Arkansas Medicaid and other stakeholders. Services include:

• Serving as the information hub for beneficiaries
• Directing callers where they need to go (dental unit, Magellan for prescriptions, etc.)
• Offering information on general eligibility requirements
• Verifying information regarding current benefits and effective date
• Ordering Medicaid cards
• Managing opt out requests (cancelling coverage)
• Editing demographic information (date of birth, address, etc.)
• Providing onsite Spanish representative for the Spanish-speaking Population

Beneficiaries can call toll-free at 1-888-987-1200, option 3.
The AFMC Service Center’s hours of operation are 8AM – 4:30PM Monday–Friday.
Magellan Pharmacy Call Center

Magellan Pharmacy Call Center - 800-424-7895
- Pharmacy support – option 1
- Prescriber support – option 2
- Beneficiary support – option 3
- Web support – option 4, then option 1

Magellan Fax Number – 800-424-7976

PDL Call Center – 800-424-7895
- Pharmacy support – option 1
- Prescriber support – option 2
- Beneficiary support – option 3
- Web support – option 4, then option 1

PDL Fax Number – 800-424-5739

Call center hours are Monday – Friday 8am – 5pm CST excluding state holidays

Web support hours are Monday – Friday 7am – 7pm CST
Arkansas Medicaid
Emergency Room
Flow Chart

PATIENT PRESENTS AT THE ER

TRIAGE

MEDICAL ASSESSMENT*

NON-EMERGENCY

Determine if the patient has Medicaid

Enrolled with PCP?

ENROLL

Treat

Refer to PCP

Submit non-emergency claim to Medicaid (Rev. code 459) and enrollment fee (Rev. code 960)

EMERGENCY

Treat

Submit emergency claim to Medicaid (Rev. code 450)

CONTACT PCP FOR INSTRUCTIONS AND/OR REFERRAL

PCP gives referral for treatment

Treat

Submit non-emergency claim to Medicaid (Rev. code 459)

PCP refuses referral for treatment

Patient asked for treatment

Bill patient

Refer patient to PCP

Submit assessment claim (Rev. code 451)

*Medical assessment performed by qualified medical personnel.

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### Arkansas Medicaid Emergency Room Visits

<table>
<thead>
<tr>
<th>EXPLANATION</th>
<th>SERVICE</th>
<th>HOSPITAL BILLS:</th>
<th>MEDICAID PAYS:</th>
<th>PHYSICIAN BILLS:</th>
<th>MEDICAID PAYS:</th>
</tr>
</thead>
<tbody>
<tr>
<td>REFERRAL NOT REQUIRED</td>
<td>Assess and screen (1)</td>
<td>451</td>
<td>$15.00 plus ancillary charges</td>
<td>T1015 (3)</td>
<td>$24.20</td>
</tr>
<tr>
<td></td>
<td>Note: You cannot bill if any form of treatment has already been provided</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>REFERRAL REQUIRED</td>
<td>Non-emergency (2)</td>
<td>459</td>
<td>$12.00 plus ancillary charges</td>
<td>T1015 (3)</td>
<td>$31.90</td>
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<td></td>
<td></td>
<td></td>
<td>No drugs or supplies</td>
<td>Modifier U1</td>
<td></td>
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<tr>
<td>REFERRAL NOT REQUIRED</td>
<td>Emergency (1)</td>
<td>450</td>
<td>$51.00 plus ancillary charges</td>
<td>99281</td>
<td>$22.00</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>99282</td>
<td>$35.00</td>
</tr>
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<td></td>
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<td></td>
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<td>99283</td>
<td>$53.90</td>
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<td></td>
<td></td>
<td>99284</td>
<td>$71.50</td>
</tr>
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<td></td>
<td>99285</td>
<td>$83.75</td>
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<tr>
<td></td>
<td></td>
<td>622</td>
<td>Supplies</td>
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<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>250</td>
<td>Drugs and supplies paid</td>
<td></td>
<td></td>
</tr>
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</table>

### NOTES:
- Section 272.130 hospital manual: Patients under age 21 are not limited to 12 visits.
- You cannot bill a combination of codes 450, 451 or 459. Bill only the appropriate code.
- Outpatient Hospital PCP Enrollment fee — 960.
- No limit on ancillary professional component.

(1) Does not count as one of 12 visits for patients over age 21
(2) Counts as one of 12 visits
(3) Physician Type of Service 1
### ARKIDS Full Preventive Health Screen Billing Procedures

#### ARKIDS A: EPSDT SCREEN*

<table>
<thead>
<tr>
<th></th>
<th>PROCEDURE CODE BY AGE</th>
<th>MODIFIERS</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>NEWBORN</td>
<td>&lt; 1 YEAR</td>
</tr>
<tr>
<td>Newborn in hospital</td>
<td>99460: Initial hospital/birthing center care/normal newborn</td>
<td>EP</td>
</tr>
<tr>
<td>Newborn in other setting</td>
<td>99461: Initial care normal newborn other than hospital/birthing center</td>
<td>EP</td>
</tr>
</tbody>
</table>

*ARKids A must choose Special Program Code 01

#### ARKIDS B: PREVENTIVE HEALTH SCREEN*

<table>
<thead>
<tr>
<th></th>
<th>PROCEDURE CODE BY AGE</th>
<th>MODIFIERS</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>NEWBORN</td>
<td>&lt; 1 YEAR</td>
</tr>
<tr>
<td>Newborn in hospital</td>
<td>99460: Initial hospital/birthing center care/normal newborn</td>
<td>(Newborn only)</td>
</tr>
<tr>
<td>Newborn in other setting</td>
<td>99461: Initial care normal newborn other than hospital/birthing center</td>
<td>(Newborn only)</td>
</tr>
</tbody>
</table>

*Ages 7 and 9 are not eligible

Newborn procedure codes pay $108.16 while all other listed codes pay $56.41.

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## ICD-10-CM Diagnosis Codes for Wellness Exams

### ICD-10-CM Diagnosis Codes (Newborn)

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
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</thead>
<tbody>
<tr>
<td>Z38.00</td>
<td>Single liveborn infant, delivered vaginally</td>
</tr>
<tr>
<td>Z38.01</td>
<td>Single liveborn infant, delivered cesarean</td>
</tr>
<tr>
<td>Z38.1</td>
<td>Single liveborn infant, born outside hospital</td>
</tr>
<tr>
<td>Z38.2</td>
<td>Single liveborn infant, unspecified as to place of birth</td>
</tr>
<tr>
<td>Z38.30</td>
<td>Twin liveborn infant, delivered vaginally</td>
</tr>
<tr>
<td>Z38.31</td>
<td>Twin liveborn infant, delivered by cesarean</td>
</tr>
<tr>
<td>Z38.4</td>
<td>Twin liveborn infant, born outside hospital</td>
</tr>
<tr>
<td>Z38.5</td>
<td>Twin liveborn infant, unspecified as to place of birth</td>
</tr>
<tr>
<td>Z38.61</td>
<td>Triplet liveborn infant, delivered vaginally</td>
</tr>
<tr>
<td>Z38.62</td>
<td>Triplet liveborn infant, delivered by cesarean</td>
</tr>
<tr>
<td>Z38.63</td>
<td>Quadruplet liveborn infant, delivered vaginally</td>
</tr>
<tr>
<td>Z38.64</td>
<td>Quadruplet liveborn infant, delivered by cesarean</td>
</tr>
<tr>
<td>Z38.65</td>
<td>Quintuplet liveborn infant, delivered vaginally</td>
</tr>
<tr>
<td>Z38.66</td>
<td>Quintuplet liveborn infant, delivered by cesarean</td>
</tr>
<tr>
<td>Z38.68</td>
<td>Other multiple liveborn infant, delivered vaginally</td>
</tr>
<tr>
<td>Z38.69</td>
<td>Other multiple liveborn infant, delivered by cesarean</td>
</tr>
<tr>
<td>Z38.7</td>
<td>Other multiple liveborn infant, born outside hospital</td>
</tr>
<tr>
<td>Z38.8</td>
<td>Other multiple liveborn infant, unspecified as to place of birth</td>
</tr>
</tbody>
</table>

### ICD-10-CM Diagnosis Codes

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Z00.121</td>
<td>Encounter for routine child health exam with abnormal findings</td>
</tr>
<tr>
<td>Z00.129</td>
<td>Encounter for routine child health exam without abnormal findings</td>
</tr>
<tr>
<td>Z13.4</td>
<td>Encounter for screening for certain childhood developmental disorders in childhood</td>
</tr>
<tr>
<td>Z76.1</td>
<td>Encounter for health supervision and care of foundling</td>
</tr>
<tr>
<td>Z76.2</td>
<td>Encounter for health supervision and care of other healthy infant and child</td>
</tr>
</tbody>
</table>

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Keeping your child healthy!

ARKIDS
WELL CHILD CARE
EPSDT is often called “well-child checkup” because it means that you and your child’s primary care provider (PCP) are working to keep your child healthy and well.

Who can get a well-child checkup?

Any child or young adult under the age of 21 who is on ARKids A, or any child under the age of 19 who is on ARKids B.

What well-child checkup services are available?

- Physical exam
- Vision/hearing tests
- Growth and development screening
- Nutrition
- Immunizations (shots)
- Dental exam (starting in toddler years)

How often should your child get a well-child checkup?

Infants need a well-child checkup several times a year until they are two years old. Your child will need regular well-child checkups after age two. (See immunization schedule on pages 3–4.)
Where do you go for your child’s well-child checkup?

Call your child’s PCP to make an appointment. If you do not have a PCP, call ConnectCare at 1-800-275-1131. They will help you select a PCP. Be sure to tell the PCP’s office that this is a well-child checkup so they can schedule enough time. If you have to cancel, call the PCP’s office as soon as possible.

If you need non-emergency transportation to see your child’s PCP

If your child is on ARKids A and does not have a ride to see the PCP, call 1-888-987-1200 to schedule a ride. Take your child’s ARKids card with you. (ARKids B children do not receive Medicaid transportation.)

What to do to prepare for your child’s well-child checkup

• Make sure you have a ride to and from your child’s checkup.
• Bring a list of any medications or pills your child takes.
• Bring your child’s immunization or “shot” record, if you have one.
• Make a list of any questions or concerns you want to discuss with your PCP about your child’s health, growth and development. Bring the list with you.

After-hours care

Your PCP’s clinic should have access for urgent or sick care after the office has closed. Ask your child’s PCP what number to call when the clinic is closed.
When to Take Your Child for an EPSDT/Well-Child Checkup

<table>
<thead>
<tr>
<th>Age for Visit</th>
<th>Immunizations/Well-Child Checkup</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Month</td>
<td>HepB</td>
</tr>
<tr>
<td>2 Months</td>
<td>DTaP</td>
</tr>
<tr>
<td>4 Months</td>
<td>DTaP</td>
</tr>
<tr>
<td>6 Months</td>
<td>DTaP</td>
</tr>
<tr>
<td>9 Months</td>
<td>Well-child checkup</td>
</tr>
<tr>
<td>12 Months</td>
<td>HepA</td>
</tr>
<tr>
<td>15 Months</td>
<td>DTaP</td>
</tr>
<tr>
<td>18 Months</td>
<td>HepA</td>
</tr>
<tr>
<td>2 Years</td>
<td>Well-child checkup</td>
</tr>
<tr>
<td>3 Years</td>
<td>Well-child checkup</td>
</tr>
<tr>
<td>4 Years</td>
<td>DTaP</td>
</tr>
<tr>
<td>5 Years</td>
<td>Well-child checkup</td>
</tr>
</tbody>
</table>

Your child’s PCP may give these shots in a different order. Talk to your child’s PCP.

<table>
<thead>
<tr>
<th>Age for Visit</th>
<th>Immunizations/Well-Child Checkup</th>
</tr>
</thead>
<tbody>
<tr>
<td>6 Years</td>
<td>Well-child checkup</td>
</tr>
<tr>
<td>8 Years</td>
<td>Well-child checkup</td>
</tr>
<tr>
<td>10 Years</td>
<td>Well-child checkup</td>
</tr>
<tr>
<td>11 Years</td>
<td>HPV*</td>
</tr>
<tr>
<td>12 Years</td>
<td>Well-child checkup</td>
</tr>
<tr>
<td>13 Years</td>
<td>Well-child checkup</td>
</tr>
<tr>
<td>14 Years</td>
<td>Well-child checkup</td>
</tr>
<tr>
<td>15 Years</td>
<td>HPV*</td>
</tr>
<tr>
<td>16 Years</td>
<td>Meningococcal</td>
</tr>
<tr>
<td>17 Years</td>
<td>Well-child checkup</td>
</tr>
<tr>
<td>18 Years</td>
<td>Well-child checkup</td>
</tr>
<tr>
<td>19 &amp; 20 Years</td>
<td>Well-child checkup (ARKids First A only)</td>
</tr>
</tbody>
</table>

**DTaP:** Diphtheria, Tetanus and Pertussis (Whooping Cough)  
**HepA:** Hepatitis A *(Doses should be given at least 6 months apart.)*  
**HepB:** Hepatitis B  
**Hib:** Haemophilus Influenza Type B  
**HPV:** Human Papillomavirus *(if first dose given at 11 years old, two dose series; if first dose given at 15 years old, three dose series)*  
**IPV:** Polio  
**MMR:** Measles, Mumps and Rubella  
**PCV:** Pneumococcal  
**RV:** Rotovirus  
**Tdap:** Tetanus, Diphtheria and Acellular Pertussis  
**Varicella:** Chickenpox

*Influenza given every year after 6 months*
“E” is for “Early”
If your child is seen early by a PCP, he or she can be treated sooner and receive the care needed to stay healthy.

“P” is for “Periodic”
You should take your child to see a PCP at regular times. This will make sure any new health problems are found and treated.

“S” is for “Screening”
Screenings, exams and tests for your child can be done to find any health problems.

“D” is for “Diagnosis”
When a well-child checkup or exam by your PCP shows any health problems, testing is provided for your child.

“T” is for “Treatment”
“Treatment” is the care your child gets from the PCP. The PCP uses treatments like medicine to prevent, help or cure a health problem.
# Helpful Numbers

<table>
<thead>
<tr>
<th>If you have questions, call the Medicaid Service Center</th>
<th>1-888-987-1200, Option 3 (Mon.-Fri., 8 A.M. – 5 P.M.)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>ConnectCare</strong>  Find or be assigned a primary care physician (PCP)</td>
<td>1-800-275-1131 (TDD) 1-800-322-5580</td>
</tr>
<tr>
<td><strong>Medicaid Resolution Center</strong>  For problem solving or other resources</td>
<td>1-888-474-8275</td>
</tr>
<tr>
<td><strong>Non-Emergency Transportation (NET) Help Line</strong>  To schedule a ride to or from the doctor’s office or pharmacy</td>
<td>1-888-987-1200, Option 1</td>
</tr>
<tr>
<td><strong>Medicaid Complaint Hotline</strong>  For concerns or complaints</td>
<td>1-888-987-1200, Option 2 (TDD) 1-800-322-5580</td>
</tr>
</tbody>
</table>

To contact or visit your local DHS office, log on to [humanservices.arkansas.gov](http://humanservices.arkansas.gov)

For a full range of EPSDT services, see the Arkansas Medicaid Handbook at [https://afmc.org/individuals/arkansans-on-medicaid/](https://afmc.org/individuals/arkansans-on-medicaid/)
ARKANSAS MEDICAID CHILD HEALTH SERVICES (EPSDT) FEE SCHEDULE

This fee schedule does not address the various coverage limitations routinely applied by Arkansas Medicaid before final payment is determined (e.g., beneficiary and provider eligibility, benefit limits, billing instructions, frequency of services, third party liability, age restrictions, prior authorization, co-payments/coinsurance where applicable). Procedure codes and/or fee schedule amounts listed do not guarantee payment, coverage or amount allowed.

Although every effort is made to ensure the accuracy of this information, discrepancies may occur. This fee schedule may be changed or updated at any time to correct such discrepancies. The reimbursement rates reflected in this fee schedule are in effect as of the date of this report. The reimbursement rate applied to a claim depends on the claim’s date of service because Arkansas Medicaid’s reimbursement rates are date-of-service effective. This fee schedule reflects only procedure codes that are currently payable. Any procedure code reflecting a Medicaid maximum of $0.00 is manually priced.

This fee schedule only reflects the EPSDT screenings and the Vaccines for Children immunizations. You will need to access the applicable fee schedule for all other services covered for the EPSDT program.

Please note that Arkansas Medicaid will reimburse the lesser of the amount billed or the Medicaid maximum. For a full explanation of the procedure codes and modifiers listed here, refer to your Arkansas Medicaid provider manual.

Current Dental Terminology (including procedure codes, nomenclature, descriptors and other data contained therein) is copyright © 2009 American Dental Association. All rights reserved. Applicable FARS/DFARS apply.

Run Date 7/19/17

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Type of Service</th>
<th>Mod 1</th>
<th>Mod 2</th>
<th>Mod 3</th>
<th>Mod 4</th>
<th>Plan Code</th>
<th>Medicaid Maximum Allowed Amount</th>
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</thead>
<tbody>
<tr>
<td>90620</td>
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<td>TJ</td>
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<td>ZZZ</td>
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Screenings and Sick Visits

292.575 Child Health Services (EPSDT) Screenings and Sick Visits 1-15-11

Screenings performed on the same date of service as an office visit for treatment of an acute or chronic condition may be billed as a periodic Child Health Services (EPSDT) screening, electronically or on paper using the CMS-1500 claim form.

Effective for dates of service on and after May 1, 2006, a Child Health Services (EPSDT) screening performed during an office visit for treatment of an acute or chronic condition may be billed as a separate visit for the same date of service using a CPT evaluation and management procedure code. Do not use modifiers on the sick visit procedure code. The visit must be billed electronically, or on paper using a separate CMS-1500 form. View a CMS-1500 sample form.

242.310 Completion of the CMS-1500 Claim Form

Required Reason Code location: 24H

H. EPSDT/Family Plan

EPSDT Reason Codes are required for EPSDT services. Please enter the appropriate 2 byte reason code in the upper shaded part of the detail line.

AV – Available – Not Used (patient refused referral)

NU – Not Used (used when no EPSDT patient referral was given)

S2 – Under Treatment (patient is currently under treatment for referred diagnostic or corrective health problem)

ST – New Service Requested (Referral to another provider for diagnostic or corrective treatment/scheduled for another appointment with screening provider for diagnostic or corrective treatment for at least one health problem identified during an initial or periodic screening service, not including dental referrals.)

Family Planning Indicator is not applicable for this claim type.

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

PLEASE REFER TO OFFICIAL NOTICE DATED: Dec. 1, 2010……..CMS-1500 Replaces DMS-694 for EPSDT Screenings or Services
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<td><strong>RE: PROCEDURE CODE 77417</strong></td>
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<td>Arkansas Medicaid will continue to cover CPT procedure code 77417, based on its national description. HCPCS Level II “U1 through U4” modifiers are no longer utilized for reimbursement of 77417. NCCI protocols apply to 77417.</td>
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| **TO: ALL PROVIDERS**                                      |
| **RE: NCCI AUDITING OF EPSDT/SICK VISIT RENDERED SAME DATE OF SERVICE** |
| Due to a change in CMS NCCI (National Correct Coding Initiative) auditing, Arkansas Medicaid is no longer able to process both a sick visit and EPSDT/ARKids-First B preventative screening when performed on the same date of service without the appropriate NCCI modifier (Modifier 25). Modifier 25 must be indicated in the first position of the second billed service. This NCCI 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/ARKids-First B preventative screening. Medicaid policy will be corrected to reflect this change in a provider manual update. Please resubmit the denied claims with the required modifiers along with Modifier 25 in the first modifier position. |

If you need this material in an alternative format such as large print, please contact the Program Development and Quality Assurance Unit at 501-320-6429.

**Thank you for your participation in the Arkansas Medicaid Program. If you have questions regarding these messages, please contact the HP Provider Assistance Center at 1-800-457-4454 (toll-free) within Arkansas or locally and out-of-state at (501) 376-2211.**

**Remittance Advices cannot be forwarded. Notify the Arkansas Medicaid Program of any address change, indicating all provider numbers affected by the change. This notification must include the provider’s original signature (no facsimiles accepted).**
1. Go to learnondemand.org
2. Login

4. Complete Registration Form

5. Select Passwords, Security Questions, and accept Privacy Statement

*Use password AFMC2017

6. You Are Now a Registered User

7. Search for and Launch Course

8. Complete Course
   You may exit and resume at any time

9. Logout
Medicaid Policy – PCP Selection and Enrollment For:

- Local DHS Offices
- PCP Offices and Clinics
- ConnectCare Help Line
- Participating Hospitals
- Supplemental Security Income (SSI) Beneficiaries
- PCP Transfer by Enrollee Request
- PCP Transfer by PCP Request
- PCP Enrollment Transfers Initiated by the State

173.000 PCCM Selection, Enrollment and Transfer 7-1-05

A. A Medicaid beneficiary or ARKids First-B participant must be enrolled with a PCP in order to obtain a PCP referral for medical services.
   1. All newly eligible individuals are given opportunities to enroll.
   2. Medicaid beneficiaries and ARKids First-B participants receive regular reminders from ConnectCare of the advantages of PCP enrollment.

B. An individual must select a PCP that is located near his or her residence.
   1. A PCP may be in the beneficiary’s county of residence, a county adjacent to the county of residence or a county that adjoins a county adjacent to the county of residence.
   2. When the county of residence is an Arkansas county bordering another state, the individual may select a PCP in the state bordering the county of residence.

173.100 PCP Selection and Enrollment at Local County DHS Offices 9-15-09

A. Medicaid applicants receive from DHS county office staff, a description and explanation of ConnectCare.
   1. By means of a Primary Care Physician Selection and Change form (DMS-2609 or DCO-2609,) an applicant indicates the first, second and third choice for PCPs of each family member included in the Medicaid case.
   2. Individuals applying for ARKids First-A and B indicate their PCP preferences on the mail-in application (form DCO-995).
   3. Family members may choose the same PCP whenever there is a PCP available that can serve all eligible family members.

B. When eligibility is determined, a DHS worker uses a web-based program or a telephonic voice response system to enroll the beneficiary with a PCP, beginning with each beneficiary/participant’s first choice.
   1. If the first choice has a full caseload, the worker tries the second choice and so on.
   2. The county office forwards confirmation of PCP enrollment to each new enrollee.
Physician and single-entity PCPs may enroll Medicaid beneficiaries and ARKids First-B participants by means of the telephonic voice response system (VRS.)

A. Enrollees must document their PCP choice on a Primary Care Physician Selection and Change form (DMS 2609 or DCO-2609.)
   1. The form must be completed, dated and signed by the enrollee.
   2. The enrollee may request and receive a copy of the form.
   3. The PCP office must retain a copy of the form in the enrollee’s file.

B. Enrolling the beneficiary is performed by accessing the VRS and following the instructions. View or print Voice Response System (VRS) contact information.

C. When a PCP wants to add a new enrollee but the PCP’s Medicaid caseload is full or when a PCP wants to increase or decrease his or her caseload limit:
   1. The PCP may increase or decrease his or her maximum desired caseload by any amount, at any time, up to the default maximum by submitting a signed request to their Medicaid Managed Care Services (MMCS) Provider Relations Representative or, on-line through the Medicaid website https://medicaid.mmis.arkansas.gov/ Provider Enrollment Information, Access to the Provider Information Portal.
   1. Prior to making the request for an increase of a caseload that is already at maximum, the PCP is encouraged to review their caseload using the AMII (Arkansas Medicaid Information Interchange) web portal for inactive patients, to determine if those patients should be removed from their caseload. An increase in PCP caseload above the default maximum requires a written request to the Provider Relations Representative. View or print Provider Relations Representative contact information.
173.300  PCP Selection and Enrollment Through the ConnectCare HelpLine  7-1-05

A. PCP enrollment through the ConnectCare HelpLine is recommended.

B. ConnectCare HelpLine is operated by Medicaid Outreach and Education for ConnectCare.
   1. ConnectCare HelpLine staff is available for PCP enrollments and transfers 24 hours a day, Monday through Thursday, and Friday until midnight.
   2. The HelpLine number (1-800-275-1131) is prominently displayed in ConnectCare publications, frequently in more than one place. View or print ConnectCare contact information.
   3. HelpLine staff members help Medicaid beneficiaries and ARKids First-B participants locate PCPs in their area.
   4. HelpLine staff can help non-English-speaking individuals locate PCP offices or clinics where they can communicate in their native language.

173.400  PCP Selection and Enrollment at Participating Hospitals  7-1-05

Arkansas Medicaid pays acute care hospitals for helping Medicaid beneficiaries enroll with PCPs.

A. Enrollment is by means of a Primary Care Physician Selection and Change form (DMS-2609 or DCO-2609) and the voice response system (VRS).
   1. Hospital personnel enter the PCP selection via the VRS.
   2. The enrollment is effective immediately upon its acceptance by the online transaction processor (OLTP) that interfaces with the VRS.
   3. The OLTP automatically updates the Medicaid Management Information System (MMIS) within 24 hours, but in the meantime, the enrollment information is part of the Medicaid eligibility file in the system.

B. The effective date of the PCP enrollment is the date the enrollment is electronically accepted.

C. The enrollee may request and receive a copy of the completed selection form.

D. Hospital staff must forward a copy of the selection form to the PCP accepted by the VRS.
Individuals that are eligible for Medicaid because they are Supplemental Security Income (SSI) beneficiaries do not have an opportunity to select a PCP when they apply for SSI, because SSI application is made in a federal government office.

A. When an SSI beneficiary’s Medicaid eligibility determination is made, the Arkansas Medicaid fiscal agent generates a letter describing ConnectCare.
   1. It includes instructions for selecting and enrolling with a PCP.
   2. A Primary Care Physician Selection and Change form (DCO-2609) is enclosed in the mailing.

B. SSI beneficiaries may enroll with PCPs by any of the methods used by other Medicaid beneficiaries.

ConnectCare enrollees may transfer their PCP enrollment at any time, for any stated reason.

A. Enrollees are encouraged to use the ConnectCare HelpLine when transferring their enrollment from one PCP to another. Enrollees may change their PCP by calling ConnectCare at 1-800-275-1311 or by completing the PCP Change Request form online at www.seeyourdoc.org.

B. Enrollees may also change their PCP at the local DHS county office in the enrollee’s county of residence but the enrollee or the enrollee’s parent or guardian must request the transfer in writing by means of an Arkansas Medicaid Primary Care Physician Selection and Change form (DMS-2609 or DCO-2609).
A PCP may request that an individual transfer his or her PCP enrollment to another PCP because the arrangement with that individual is not acceptable to the PCP.

A. Examples of unacceptable arrangements include, but are not limited to, the following.
   1. The enrollee fails to appear for 2 or more appointments without contacting the PCP before the scheduled appointment time.
   2. The enrollee is abusive to the PCP.
   3. The enrollee does not comply with the PCP’s medical instruction.

B. At least 30 days in advance of the effective date of the termination, the PCP must give the enrollee written notice to transfer his or her enrollment to another PCP.
   1. The notice must state that the enrollee has 30 days in which to enroll with a different PCP.
   2. The PCP must forward a copy to the enrollee and to the local DHS office in the enrollee’s county of residence.

C. The PCP continues as the enrollee’s primary care physician during the 30 days or until the individual transfers to another PCP, whichever comes first.

The state may initiate PCP enrollment transfers whenever they are necessary. State-initiated enrollment transfers come about because DMS, in exercising its regulatory function, sometimes must sanction, suspend or terminate a provider.

A. For instance, a provider may lose his or her PCP or Medicaid contract for:
   1. Failure to meet PCP or Medicaid contractual obligations
   2. Proven and consistent excessive utilization
   3. Unnecessarily limited utilization of medically necessary services

B. When the State terminates a PCP’s contract, DMS contacts the PCP’s enrollees with instructions for transferring their PCP enrollment.
SELECTIONS:

I have picked the three (3) physicians named below in order of my preference to be my primary care physician. I understand only one (1) of them will be my primary care physician.

1. ________________________________
   PHYSICIAN NAME

2. ________________________________
   PHYSICIAN NAME

3. ________________________________
   PHYSICIAN NAME

CHANGES:

I want to change my primary care physician because:

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

________________________________
BENEFICIARY SIGNATURE

______________________________
MEDICAID I.D. NUMBER

______________________________
DATE

DMS-2609 (Rev. 4/07)
Voice Response System (VRS) Update

Providers may use the Voice Response System (VRS) to assign a primary care provider (PCP) if the patient doesn't have a PCP already assigned. This system can be reached by calling 1-800-805-1512.

It is important to follow the process provided in section 173.200 of the Arkansas Medicaid manual. Be sure to have on file a copy of the PCP change form signed by the beneficiary. The PCP change form is in section V of the Arkansas Medicaid manual.

Download PCP change form
Caseload information has also been updated on the Provider Portal. This allows providers to update their caseload information. Job aids are available to assist providers with this process.

Download job aid
If you have questions, please contact your AFMC Provider Relations representative.
AND REMEMBER — ALWAYS ...

WASH YOUR HANDS!

WASH YOUR HANDS!

WASH YOUR HANDS!

The Centers for Disease Control and Prevention (CDC) recommends these everyday actions:

avoid people who are sick, cover your coughs and sneezes, and wash your hands frequently.

Talk to your health care provider or pharmacist about when to schedule your annual flu shot.
Submitting requests for review has never been easier, faster or more secure.

No paper submissions, no phone calls, no fax machines. With AFMC ReviewPoint, you can submit requests securely in seconds at no cost to you.

Quickly check the status of your submitted reviews and request reconsiderations immediately with AFMC ReviewPoint’s streamlined user interface. Adding notes and attaching documents is a breeze.

It’s a quick and simple registration process, and a training video can be accessed once you log in.

Registration for AFMC ReviewPoint is open now and access is available at afmc.org/reviewpoint. Call the helpdesk at 479-573-7777 or email ReviewPointHelp@afmc.org with questions or problems.

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There are certain medical, diagnostic and surgical procedures that are not covered without prior authorization, either because of federal requirements or because of the elective nature of a procedure. Arkansas Foundation for Medical Care, Inc. (AFMC), under contract with Arkansas Medicaid, makes prior authorization (PA) determinations for most Medicaid-covered surgical procedures that require PA, and for some lab procedures that require PA.

Please refer to Section 244.000 of this manual for a list of procedures requiring prior authorization.

Prior authorization determinations are made utilizing established medical or administrative criteria combined with the professional judgment of AFMC’s physician advisors.

Written documentation is not required. However, the oral information given to AFMC when requesting prior authorization must be substantiated by medical record documentation and reports upon AFMC and/or State retrospective reviews.

It is the responsibility of the physician who will perform the procedure to initiate the prior authorization request. When requesting prior authorization, the physician or the physician’s office nurse must contact AFMC. View or print AFMC contact information. The physician or the physician’s office nurse must furnish the following specific information to AFMC: (All calls are tape recorded.)

A. Patient Name and Address
B. Recipient Medicaid Identification Number
C. Physician Name and License Number
D. Physician provider identification number
E. Hospital Name
F. Date of Service for Requested Procedure
G. Card Issuance Date for Retroactive Eligibility Authorizations

When you call, please provide all patient identification information and medical information related to the necessity of the procedure you need authorized.

AFMC will give approval or denial of the request by phone with follow-up in writing. If approval is granted, AFMC will assign a prior authorization control number that must be entered in the appropriate field of the claim when billing for the procedure. If surgery is involved, a copy of the authorization will be mailed to the hospital where the service will be performed. If the hospital has not received a copy of the authorization before the time of admission, the hospital will contact the admitting physician or AFMC to verify that prior authorization has been granted.

It is the responsibility of the primary surgeon to distribute a copy of the authorization to the assistant surgeon if the assistant has been requested and approved.

Prior authorization of service does not guarantee eligibility for a beneficiary. Coverage is contingent on the beneficiary’s eligibility on the date(s) of service.

Post-authorization will be granted only for emergency procedures and/or retroactively eligible recipients.

A. Requests for emergency procedures must be applied for on the first working day after the procedure has been performed.
B. In cases of retroactive eligibility, AFMC must be contacted for post-authorization within 60 days of the eligibility card issuance date.

C. In cases involving a hysterectomy, documentation must be provided that reflects the acknowledgement statement was signed prior to surgery or the attending physician must certify in writing: (Use form DMS-2606. View or print form DMS-2606.)

1. That the individual was already sterile, stating the cause of sterility; or
2. That the hysterectomy was performed under a life threatening emergency situation in which the physician determined prior acknowledgement was not possible. The physician must also include a description of the nature of the emergency.

**FORM DMS-2606 MUST BE ATTACHED TO THE CLAIM FOR PAYMENT.**

The document must be reviewed and approved by the Medicaid Program before payment will be considered. It should be stressed that all guidelines must be met in order for payment to be made.

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**Providers performing surgical procedures that require prior authorization are allowed 60 days from the date of service to obtain prior authorization if the recipient is under age 21.**

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

AFMC must be provided the recipient and provider identifying criteria and all of the medical data necessary to justify the procedures.

As medical information will be exchanged for this procedure, these calls must be made by the physician or a member of his or her nursing staff.

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

Consulting physicians are responsible for calling AFMC to have procedures added to the PA file. They will be given the prior authorization number at the time of the call on cases that are approved. A letter verifying the PA number will be sent to the consultant upon request. When calling, all patient identification information and medical information related to the necessity of the procedure needing authorization must be provided.

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

This policy applies only to those Medicaid recipients under age 21. This policy does not alter prior authorization procedures applicable to retroactive eligible recipients.
The procedures represented by the CPT and HCPCS codes in the following table require prior authorization (PA). The performing physician or dentist (or the referring physician or dentist, when lab work is ordered or injections are given by non-physician staff) is responsible for obtaining required PA and forwarding the PA control number to appropriate hospital staff for documentation and billing purposes. A claim for any hospital services that involve a PA-required procedure must contain the assigned PA control number or Medicaid will deny it. (See Sections 241.000 through 244.000 of this manual for instructions for obtaining prior authorization.)

See Section 272.449 for billing instructions for Molecular Pathology codes

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A. Organ transplants in Arkansas and in states that border Arkansas require prior approval from Arkansas Medicaid.

B. In states that do not border Arkansas, organ transplants and organ transplant evaluations require prior approval from Arkansas Medicaid.

The attending physician is responsible for obtaining prior approval for organ transplants.
A. The attending physician submits his or her transplant evaluation (workup) results to the Utilization Review (UR) Section, requesting approval of the transplant. View or print the UR Section contact information.

B. UR forwards the request and its supporting documentation to Arkansas Foundation for Medical Care, Inc. (AFMC) for a determination of approval or denial.

C. AFMC advises the requesting physician and the beneficiary of its decision.

245.020 Organ Transplant and Evaluation Prior Approval in Non-Bordering States 3-15-05

A. In states that do not border Arkansas, prior approval is required for organ transplant evaluations and organ transplants.

B. The attending physician is responsible for obtaining prior approval for organ transplant evaluations and organ transplants.

1. The attending physician must request from the UR Section prior approval of a transplant evaluation, identifying the facility at which the evaluation is to take place and the physician who will conduct the evaluation. View or print the UR Section contact information.

2. UR reviews the physician’s request for transplant evaluation and forwards its approval to the facility at which the referring physician has indicated the evaluation will take place.

3. The evaluation results must be forwarded to UR with a request for approval of the transplant procedure.

4. UR forwards the request and the supporting documentation to AFMC for a determination of approval or denial.

5. AFMC advises the requesting physician and the beneficiary of its decision.

245.030 Hyperbaric Oxygen Therapy (HBOT) Prior Authorization 10-1-09

All hyperbaric oxygen therapy will require prior authorization, except in emergency cases such as for air embolism or carbon monoxide poisoning, in which post-authorization will be allowed per protocol. See Section 242.000. Prior authorization will be for a certain number of treatments. Further treatments will require reapplication for a prior authorization. In order to request a prior authorization for HBOT, the provider must call the AFMC prior authorization number, (800) 426-2234.

Refer to Sections 217.130, 242.000, 252.119, and 272.404 for additional information on HBOT.
Prior authorization is required for coverage of the Hyaluronon (sodium hyaluronate) injection. Providers must specify the brand name of Hyaluronon (sodium hyaluronate) or derivative when requesting prior authorization for the following procedure codes:

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A written request must be submitted to Division of Medical Services Utilization Review Section. View or print the Division of Medical Services Utilization Review Section address.

The request must include the patient's name, Medicaid ID number, physician's name, physician's provider identification number, patient's age, and medical records that document the severity of osteoarthritis, previous treatments and site of injection. Hyaluronon is limited to one series of injections per knee, per beneficiary, per lifetime.