ARMedicaid

# PCP Update

FOR MORE INFORMATION, CONTACT:
Tonyia Long, *Supervisor, Outreach Logistics*
501-212-8686 • tonyia.long@afmc.org

*On the web:*

- afmc.org/PCPUpdatePackets
- AFMC Provider Relations Outreach Specialists Contact Information

**2ND QUARTER, SFY 2020 • OCT. 1–DEC. 31, 2019**

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

## AHIN Updates

- **Enhanced AHIN Portal**

## Episodes of Care

- **SFY 2020 second quarter reports**
  - SFY 2020 second quarter episode of care reports can be viewed on AHIN on or after Oct. 31, 2019

## EPSDT Reason Codes

- **Primary care physicians (PCPs) are required to enter** the applicable EPSDT reason code when submitting a claim for an EPSDT screening
- **Specialists and providers delivering service as a result of a referral** from an EPSDT screening should check the EPSDT box in the Medicaid portal, or choose "yes" under the EPSDT tab if billing through PES or an individual vendor

## Exhausted Benefits

- **Responsible provider for requesting extension of benefits: Medicaid Physician Manual, Section 220.000**

## Flu Vaccines

- **Injections, therapeutic and/or diagnostic agents: Medicaid Physician Manual, Section 292.950**

## Hospital Emergency Department

- **Non-emergent emergency department visits: PCP referral requirements**

## MMIS

- **Creating a Prior Authorization Request**
  https://medicaid.mmis.arkansas.gov/Download/provider/insider/MMIS_JobAid_PriorAuthorization.pdf

## PASSE

- **Beneficiary open enrollment dates: Oct. 1–31**
  - PASSE Beneficiary Support Line: 1-833-402-0672
- **DMS-640 PCP Referral requirement for PASSE beneficiaries receiving school-based therapy services**
- **DHS Provider Call Center**
  - Contact Information: 1-888-889-6451 or passe.provider.questions@dhs.arkansas.gov

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ARKANSAS DEPARTMENT OF HUMAN SERVICES

ARMedicaid

# PCP Update

**FOR MORE INFORMATION, CONTACT:**
**Tonyia Long,** *Supervisor, Outreach Logistics*
**501-212-8686 • tonyia.long@afmc.org**

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## 2ND QUARTER, SFY 2020 • OCT. 1–DEC. 31, 2019

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

### Patient Centered Medical Home (PCMH)

- **2020 PCMH Enrollment dates: Oct. 1–Nov. 12**
- **Quarterly reports**
- **Activities due by Dec. 31**

  https://www.paymentinitiative.org/Websites/paymentinitiative/images/PCMH%20Documents/2019%20PCMH%20Program%20Policy%20Addendum_6.25.19.pdf — Pages 6, 11–16

  - Care plans for high priority patients
  - Patient literacy assessment tool
  - Ability to receive patient feedback
  - Care instructions for high priority patients
  - 10-day follow up after an acute inpatient
  - Developmental/behavior health assessment for children and adolescents
- **Questions:** pcmh@afmc.org

### PCP Caseloads

- **ConnectCare Caseload Maximum and PCP Caseload Limits: All Medicaid Manuals, Section 171.210**
- **PCP Patient Termination**
  - PCP patient transfers by PCP request – All Medicaid Manuals, Section 173.620
  - Deceased patient removal process

### Upcoming Conferences

*Registration information will be sent to providers closer to the conference dates.*

- **Arkansas Medicaid Educational Conference: Dec. 17, Embassy Suites Little Rock**
- **Division of Provider Services and Quality Assurance (DPSQA) Educational Conference: Dec. 18, Embassy Suites Little Rock**

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# Provider Relations Outreach Specialists Information Sheet

1020 W. 4th St., Suite 300 • Little Rock, AR 72201 • **Toll free: 1-877-650-2362** • **Transportation Helpline: 1-888-987-1200**

## AFMC OUTREACH SPECIALISTS

Refer to the map and the color key below to find your representative.

### *Manager*

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

### *Supervisor, Outreach Logistics*

**Tonya Long** ................... **501-212-8686**
tlong@afmc.org

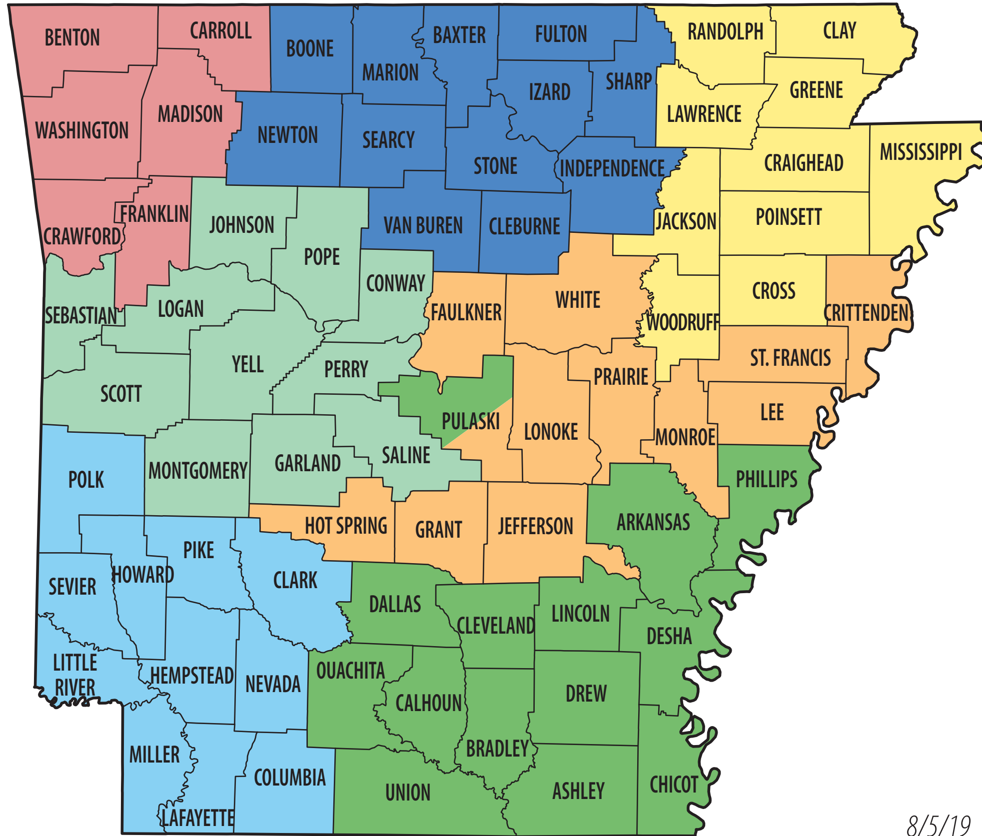
### *Outreach Specialists*

- **Emily Alexander**......... **501-804-0184**
  ealexander@afmc.org
- **Shawna Branscum**...... **501-804-2373**
  sbranscum@afmc.org
- **Kimberly Breedlove** ... **501-553-7642**
  kbreedlove@afmc.org
- **Jackie Clarkson**............ **501-553-7665**
  jclarkson@afmc.org
- **Kellie Cornelius** ........... **501-804-2501**
  kcornelius@afmc.org
- **Carla Hestir**.................. **501-804-2901**
  chestir@afmc.org
- **Connie Riley**................. **501-545-7873**
  criley@afmc.org

## ARKANSAS MEDICAL SOCIETY REPRESENTATIVE

### PHYSICIAN OUTREACH SPECIALIST

**Tereasa Holmes**.............. **501-545-6919**
tholmes@arkmed.org




## DXC Technology Services *(Claims Processing)*

500 President Clinton Ave., Suite 400 • Little Rock, AR 72201

- **Provider Assistance Center (PAC)**
  - In-state toll free ......... **800-457-4454**
  - Local / out-of-state... **501-376-2211**
- **Provider Enrollment**

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

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

## ARKANSAS DEPARTMENT OF HUMAN SERVICES, DIVISION OF MEDICAL SERVICES

### 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**

### VOICE RESPONSE SYSTEM

- Toll free .......................... **800-805-1512**

### AFMC SERVICE CENTER (BENEFICIARIES)

- Toll free .......................... **888-987-1200**

### PCMH QUESTIONS...... **PCMH@afmc.org**

### MAGELLAN MEDICAID ADMINISTRATION

- Pharmacy Help Desk.. **800-424-7895**
  *Prescribers, Option 2*

### THIRD PARTY LIABILITY

- Local.................................. **501-537-1070**
- Fax .................................... **501-682-1644**

DHS Division of Medical Services,
TPL Unit • P.O. Box 1437, Slot S296
Little Rock, AR 72203-1437

# Provider Relations Outreach Specialist

## Register today to see the new enhancements to the aHIN PCMH Portal!

Arkansas Blue Cross and Blue Shield will have new enhancements to the aHIN portal. There are new features for Arkansas Blue Cross and Arkansas Medicaid PCMH providers. The targeted date for implementation is Monday, Oct. 14. Training began Oct. 7, continuing through Friday, Oct. 25.

A registration link is available on the AHIN homepage under Provider News.

**Here is the list of online training dates specific to Arkansas Medicaid PCMH providers:**

9 – 10:30 a.m. Thursday, Oct. 10
1 – 2:30 p.m. Thursday, Oct. 10
11 a.m. – 12:30 p.m. Friday, Oct. 11
3 – 4:30 p.m., Friday Oct. 11
11 a.m. – 12:30 p.m. Monday, Oct. 14
3 – 4:30 p.m. Monday, Oct. 14
9 – 10:30 a.m. Tuesday, Oct. 15
1 – 2:30 p.m. Tuesday, Oct. 15
11 a.m. – 12:30 p.m. Wednesday, Oct. 16
1 – 2:30 p.m. Wednesday, Oct. 16
9 – 10:30 a.m. Thursday, Oct. 17
1 – 2:30 p.m. Thursday, Oct. 17
1 – 2:30 p.m. Friday, Oct. 18
11 a.m. – 12:30 p.m. Monday, Oct. 21
3 – 4:30 p.m. Monday, Oct. 21
11a.m. – 12:30 p.m. Wednesday, Oct. 23
3 – 4:30 p.m. Wednesday, Oct. 23
9 – 10:30 a.m. Thursday, Oct. 24
11 a.m. – 12:30 p.m. Friday, Oct. 25
3 – 4:30 p.m. Friday, Oct. 25

The Portal menu will be removed from the AHIN Home page and be replaced with Programs for all APII Episodes, CPC+, PCMH and Care Management Access.

# EPSDT Reason Codes

Primary Care Physicians (PCP) - PCPs are required to enter a reason code when submitting a claim for an EPSDT screening. PCPs should use only the applicable reason code when submitting their claims. Do not check the EPSDT box or choose “yes” in the EPSDT dropdown box (options depend on billing system).

Supporting manual language can be found in the following manuals:

- Child Health Services/Early and Periodic Screening, Diagnosis and Treatment
    - 212.200 EPSDT Minimum Documentation Requirements
    - 213.000 Provider’s Role in the Child Health Services (EPSDT) Program
    - 242.310 Completion of the CMS-1500 Claim Form

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.

Specialist/provider delivering service – If a provider delivers services as a result of a referral from an EPSDT screening, the EPSDT box should be checked in the Medicaid portal, or choose “yes” under the EPSDT tab if billing through PES or an individual vendor.

- Physician Manual
    - 203.120 Physician’s Role in the Child Health Services (EPSDT) Program
    - 292.310 Completion of the CMS-1500 Claim Form

Please contact your AFMC Provider Relations Outreach specialist if you have questions. We are always happy to assist you.

1020 W. 4TH ST., SUITE 300 | LITTLE ROCK, AR 72201 | 501-212-8600 | FAX: 501-375-0705

## Specialist/Provider Delivering Service

If a provider delivers services as a result of a referral from an EPSDT screening, the EPSDT box should be checked in the Medicaid portal, or choose “yes” under the EPSDT tab if billing through PES or an individual vendor.

- Physician Manual
    - 203.120 Physician’s Role in the Child Health Services (EPSDT) Program
    - 292.310 Completion of the CMS-1500 Claim Form

Please contact your AFMC Provider Relations Outreach specialist if you have questions. We are always happy to assist you.

Provider Relations Outreach Specialist

# Exhausted Benefits

**Physician Medicaid Manual – Section 220.000**

- **220.000 Benefit Limits** **7-1-15**

Benefit limits are the limits on the *quantity* of covered services Medicaid-eligible beneficiaries may receive. Medicaid-eligible beneficiaries are responsible for payment for services beyond the established benefit limits, unless the Division of Medical Services (DMS) authorizes an extension of a particular benefit

If a service is denied for exceeding the benefit limit, and the Medicaid beneficiary had elected to receive the service by written informed consent prior to the delivery of the service, the Medicaid beneficiary is responsible for the payment, unless that service has been deemed not medically necessary.

Benefit extensions are considered after the service has been rendered and the provider has received a denial for "benefits exhausted." DMS considers requests for benefit extensions based on the medical necessity of the service. If a Medicaid provider chooses to file for an extension of benefits and is denied due to the service not being medically necessary, the beneficiary is not responsible for the payment. Once the extension of benefits request has been initiated on a particular service, the provider cannot abort the process before a final decision is rendered.

Please see Section 229.000 through Section 229.120 and Section 131.000 points A and C for benefit extension request procedures. DMS reviews extension of benefits requests for Home Health, personal care, diapers and medical supplies. AFMC reviews extension of benefits requests for physician, lab, radiology and machine tests, using form DMS-671. All personal care services for beneficiaries under age 21 are reviewed by the contracted Quality Improvement Organization (QIO). **View or print AFMC contact information.**

# Flu Vaccines

**292.950 Injections, Therapeutic and/or Diagnostic Agents 5-1-17**

A. Providers billing the Arkansas Medicaid Program for covered injections should bill the appropriate CPT or HCPCS procedure code for the specific injection administered. The procedure codes and their descriptions may be found in the Current Procedure Terminology (CPT) and in the Healthcare Common Procedural Coding System Level II (HCPCS) coding books.

**Injection administration code, T1502** is payable for beneficiaries of all ages. **T1502** may be used for billing the administration of subcutaneous and/or intramuscular injections only. This procedure code cannot be billed when the medication is administered "ORALLY." No fee is billable for drugs administered orally.

**T1502** cannot be billed separately for Influenza Virus vaccines or Vaccines for Children (VFC) vaccines.

**T1502** cannot be billed to administer any medication given for family planning purposes. No other fee is billable when the provider decides not to supply family planning injectable medications.

**T1502** cannot be billed when the drug administered is not FDA approved.

See the table below when billing T1502:

| Procedure Code | Modifier | Eligibility Category |
|---|---|---|
| T1502 | EP | ARKids-A (Ages 0-20) |
| T1502 | SL | ARKids-B |
| T1502 | | Ages 19 and above |

| Procedure Code | Modifier | Age Restriction | Diagnosis | Diagnosis List | Review | PA |
|---|---|---|---|---|---|---|
| **90662** | **No** | **65y & up** | **No** | **No** | **No** | **No** |
| **90672** | **EP, TJ** | **2y – 18y** | **No** | **No** | **No** | **No** |
| NOTE: This procedure is billable for healthy individuals who are not pregnant. See Subsections A through E of this section for additional instructions. | | | | | | |
| **90672** | **SL** | **2y – 18y** | **No** | **No** | **No** | **No** |

# Provider Relations Outreach Specialist

| Procedure Code | Modifier | Age Restriction | Diagnosis | Diagnosis List | Review | PA |
|---|---|---|---|---|---|---|
| **90662** | **No** | **65y & up** | **No** | **No** | **No** | **No** |
| **90672** | **EP, TJ** | **2y – 18y** | **No** | **No** | **No** | **No** |
| NOTE: This procedure is billable for healthy individuals who are not pregnant. See Subsections A through E of this section for additional instructions. | | | | | | |
| **90672** | **No** | **19y – 49y** | **No** | **No** | **No** | **No** |
| NOTE: This procedure is billable for healthy individuals who are not pregnant. See Subsections A through E of this section for additional instructions. | | | | | | |
| **90685** | **EP, TJ** | **6m – 35m** | **No** | **No** | **No** | **No** |
| NOTE: See Subsections A through E of this section for additional instructions. | | | | | | |
| **90685** | **SL** | **6m – 35m** | **No** | **No** | **No** | **No** |
| NOTE: See Subsections A through E of this section for additional instructions. | | | | | | |
| **90686** | **EP, TJ** | **3y – 18y** | **No** | **No** | **No** | **No** |
| NOTE: This procedure is billable for healthy individuals who are not pregnant. See Subsections A through E of this section for additional instructions. | | | | | | |
| **90686** | **SL** | **3y – 18y** | **No** | **No** | **No** | **No** |
| NOTE: This procedure is billable for healthy individuals who are not pregnant. See Subsections A through E of this section for additional instructions. | | | | | | |
| **90686** | **No** | **19y – 99y** | **No** | **No** | **No** | **No** |
| NOTE: This procedure is billable for healthy individuals who are not pregnant. See Subsections A through E of this section for additional instructions. | | | | | | |
| **90688** | **EP, TJ** | **3y – 18y** | **No** | **No** | **No** | **No** |
| NOTE: This procedure is billable for healthy individuals who are not pregnant. See Subsections A through E of this section for additional instructions. | | | | | | |
| **90688** | **SL** | **3y – 18y** | **No** | **No** | **No** | **No** |
| NOTE: This procedure is billable for healthy individuals who are not pregnant. See Subsections A through E of this section for additional instructions. | | | | | | |
| **90688** | **No** | **19y & up** | **No** | **No** | **No** | **No** |
| NOTE: This procedure is billable for healthy individuals who are not pregnant. See Subsections A through E of this section for additional instructions. | | | | | | |

*Current Dental Terminology* (including procedure codes, nomenclature, descriptors and other data contained therein) is copyright © 2015 American Dental Association. All rights reserved. Applicable FARS/DFARS apply.

# Provider Relations Outreach Specialist

## Non-Emergent ED Visits – PCP Referrals

Non-emergent treatment occurs after an assessment has been performed and the beneficiary is deemed non-emergent, but elects to receive treatment in the Emergency Department (ED) rather than seeing their primary care provider (PCP) after being discharged from the ED. **A referral is required from the Medicaid beneficiary's PCP for non-emergent treatment. Without a referral, Arkansas Medicaid will not reimburse the ED/hospital.**

The PCP referral can be verbal or written *(see Section 171.410 of the Hospital Manual)*. Both verbal and written referrals should be entered and kept in the Medicaid beneficiary's medical record. If the referral is verbal, the date of service, time of referral, name of the referring provider and the PCP's employee who gave the referral, should be entered in the beneficiary's medical record, along with the referral instructions. **The non-emergent PCP referral rule applies to Medicaid beneficiaries of all ages.** It is at the discretion of the PCP whether to give a referral. Furthermore, a PCP is not required to make any referral simply because it is requested.

The only time Medicaid will reimburse for non-emergent treatment in the ED without a PCP referral is when non-emergent treatment is rendered on the same day the Medicaid beneficiary is assigned to a PCP by the ED. This will be done by using the Voice Response System *(see Section 213.400 of the Hospital Manual) on the same date of the service provided*. The PCP assignment charge must be billed on the same claim form as the non-emergent treatment. The hospital will receive a $5 fee for assigning the PCP selected by the Medicaid beneficiary. The outpatient hospital PCP enrollment fee is billed using revenue code 960.

***If a verbal or written referral is not received from the beneficiary's assigned PCP for a non-emergent visit, a hospital cannot list a referring provider on their billing claim form.***

**171.410 PCCM Referrals and Documentation** 7-1-05

1. Medicaid provides an optional referral form, form DMS-2610, to facilitate referrals. View or print form DMS-2610.

1. Additionally, PCP referrals may be oral, by note or by letter.
2. Referrals may be faxed.

2. Regardless of the means by which the PCP makes the referral, Medicaid requires documentation of the referral in the enrollee's medical record.
    1. Medicaid also requires documentation in the patient's chart by the provider to whom the referral is made.
    2. Providers of referred services must correspond with the PCP to the extent necessary to coordinate patient care and as requested by the PCP.

**213.400 PCP Enrollment in the Hospital Outpatient Department** 10-13-03

Medicaid covers emergency services only for beneficiaries with no PCP.

1. Staff at participating hospitals may facilitate beneficiaries' PCP selections.
    1. A Medicaid beneficiary must complete a form DMS-2609, *Primary Care Physician Selection and Change Form*, in order to enroll with a PCP. View or print form DMS-2609.
    2. Hospital personnel enter the PCP selection via the Voice Response System (VRS). View or print VRS contact information.
    3. The enrollment is effective immediately and its effective date is the date of entry.
    4. The hospital staff must forward a copy of the form DMS-2609 to the PCP entered on the VRS and give a copy to the enrollee.
2. Arkansas Medicaid reimburses hospitals (PCP Enrollment Fee—see Section 272.400 for special billing instructions) for the enrollment assistance.

If you have any questions, please contact your provider relations outreach specialist.

# Provider Relations Outreach Specialist

- **Beneficiary Open Enrollment dates - October 1-31**

## Open Enrollment: October 1-31, 2019

- If you want to stay with your PASSE, no action is needed.
- If you want to switch to a different PASSE, you can change one time during Open Enrollment.
- If you change your PASSE, the change will become effective on December 1, 2019.

* Call PASSE Beneficiary Support at **1-833-402-0672**

**Watch for your letter in the mail!**

For more information about the PASSE Program, visit our website:

www.passe.arkansas.gov

# Provider Relations Outreach Specialist

- **DMS-640 PCP Referral requirement for PASSE beneficiaries receiving school-based therapy services**

Dear Primary Care Physician,

School-based therapy services (physical, occupational and speech) for patients with an Individualized Educational Plan (IEP) and assigned to a PASSE will require a signed DMS 640 form from their primary care provider (PCP). This form is required as these services are billed to traditional Medicaid and not the assigned PASSE.

Providers will receive DMS 640 requests from schools that will include a cover letter explaining the child has an IEP and requires a DMS 640 form. The cover letter will say:

*"We are requesting that you review and approve the attached DMS 640 for school-based therapy. All occupational therapy, speech therapy and physical therapy provided in a school-based setting, in accordance with a child's IEP and billed by the school district, is billed directly to Medicaid and is* ***not*** *paid by the PASSE. This rule applies to all children."*

If you have any questions, please contact your AFMC Provider Relations specialist.

Sincerely,

**AFMC Provider Relations**

**For additional information regarding PASSE, contact:**

**DHS Provider Call Center**

- **Contact Information - 888.889.6451 or passe.provider.questions@dhs.arkansas.gov**

# Provider Relations Outreach Specialist

## Patient Centered Medical Home (PCMH) - 2020 PCMH Enrollment Dates

# Arkansas Medicaid PCMH Enrollment

## 2020 Performance Period
## Oct. 1 – Nov. 12

Enrollment eligibility: The practice must have at least 150 attributed beneficiaries at the time of enrollment.

New Performance Based Incentive Payment Attribution requirement: A Shared Performance Entity must have a minimum of 1,000 attributed beneficiaries after exclusions are applied.

### Enrollment Application

To enroll in the Arkansas Medicaid Patient-Centered Medical Homes (PCMH) Program, the Practice Participation Agreement form (DMS-844) can be accessed directly on the AHIN portal, or via the portal access link on paymentinitiative.org/enrollment.

### New Information Needed

Please provide the EMR your practice uses in the designated section of the enrollment application.

### Re-enrollment Application

If you are currently enrolled in the PCMH Program, you will receive an enrollment application for the 2020 performance program via email on October 1. The email will be distributed from the PCMH Enrollment Unit ARKPCMH@dxc.com and it will contain a list of participating providers that are currently enrolled with your PCMH. Providers who are currently enrolled with your PCMH are not required to be listed in Sections I and II of the enrollment application. Providers who are re-enrolling in the program are not required to provide a new signature. However, a signature is required for any provider(s) who will be included on the enrollment application for the first time.

# Provider Relations Outreach Specialist

If there are no changes to your PCMH's current enrollment, only the top of Section I and your Participating Providers List are required for re-enrollment in the PCMH Program for the 2020 performance period. If necessary, please use Sections I and II of the enrollment application to make any changes to your current enrollment and submit all pages, including your Participating Providers List, to ARKPCMH@dxc.com.

**Pooling Forms**

All signatures must be included on one enrollment application, and all PCMH leads must be copied on the submission email. Pooling forms **must not be altered from the original in any way.** If the pool has more members than can fit on one form, use multiple forms to complete the enrollment application. A cover letter with details for each member of the pool may be submitted with multiple pooling forms.

Please submit your complete and accurate enrollment application and pooling forms to the PCMH Enrollment Unit at ARKPCMH@dxc.com. **Faxed enrollment applications will not be accepted.**

If you have any questions, contact your AFMC Outreach specialist or the PCMH Enrollment Unit at ARKPCMH@dxc.com or 501-301-8311.

1020 W. 4TH ST., SUITE 300 | LITTLE ROCK, AR 72201 | 501-212-8600 | FAX: 501-375-0705

Provider Relations Outreach Specialist

## Patient Centered Medical Home (PCMH)

### - Quarterly Reports

- Addendum - https://www.paymentinitiative.org/pcmh-manual-and-additional-resources
- Manual - https://www.paymentinitiative.org/pcmh-manual-and-additional-resources

Provider Relations Outreach Specialist

## Patient Centered Medical Home (PCMH)

## - Activities due by 12/31/19

https://www.paymentinitiative.org/Websites/paymentinitiative/images/PCMH%20Documents/2019%20PCMH%20Program%20Policy%20Addendum_6.25.19.pdf

pages 6, 11-16

- **Care Plans for High Priority Patients**
- **Patient Literacy Assessment Tool**
- **Ability to receive patient feedback**
- **Care instructions for High Priority Patients**
- **10-day Follow up after an Acute Inpatient**
- **Developmental / Behavior Health Assessment for Children and Adolescents**

- Questions: pcmh@afmc.org

# PCP Caseloads

**ConnectCare Caseload Maximum and PCP Caseload Limits: All Medicaid Manuals, Section 171.210**

**171.210 ConnectCare Caseload Maximum and PCP Caseload Limits 10-8-10**

A. Each PCP may establish an upper limit to his or her Medicaid caseload, up to the default maximum of 2500.

1. The state may permit higher maximum caseloads in areas the federal government has designated as medically underserved.
2. The state may permit higher maximum caseloads for PCPs who state in writing that the default maximum will create a hardship for them, their patients and/or the community they serve.

B. The state will not require any PCP to accept a caseload greater than the PCP's requested caseload maximum.

C. At any time, a PCP may increase or decrease his or her maximum desired caseload by any amount, up to the default maximum by submitting a written request to the Provider Enrollment Unit, or on-line through the Medicaid website (https://medicaid.mmis.arkansas.gov/), Provider Enrollment Information, and Access to the Provider Information Portal.

D. To request an increase in a PCP caseload above the default maximum, the PCP must submit a written request to the Provider Enrollment Unit. View or print Provider Enrollment Unit contact information.

E. Prior to making the request for an increase of a caseload that is already at the default maximum, PCPs are encouraged to review their caseload for inactive patients to determine if those patients should be removed from their caseload. To do so, PCPs may use the Arkansas Medicaid Information Interchange (AMII) web portal. If it is determined that the inactive patients should be removed from his or her caseload, the PCP must:

1. Contact the patient in writing at least 30 days in advance of the effective date of the termination to give the patient the option of making a visit to the PCP to remain an active patient. If the patient does not choose to make a visit to the PCP, the termination can be effective at the end of 30 calendar days.
2. With approval from his or her Provider Relations Representative, the PCP may add and see new patients during the 30 calendar day notification process of inactive patients.
3. The notice must state that the enrollee has 30 calendar days in which to enroll with a different PCP.
4. The PCP must forward a copy of the notice to the enrollee and to the local DHS office in the enrollee's county of residence.

# PCP Patient Termination
# - PCP patient transfers by PCP request -
# All Medicaid Manuals, Section 173.620

### 173.620 PCP Transfers by PCP Request 9-15-09

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 current approved process for removing patients from a PCP caseload is listed below:

1. There must be an acceptable reason to remove the beneficiary from the PCP caseload (listed above in manual language).
2. PCP sends a letter to the beneficiary notifying them they have 30 days to find a new PCP.
3. At the end of the 30-day period, the PCP rechecks eligibility and for those beneficiaries still assigned to the PCP, the PCP sends a copy of the letter to the local DHS office and faxes a copy to ConnectCare at 501.375.0705 (Attention: Provider Relations).
4. ConnectCare will remove the beneficiary from the PCP caseload.

**Deceased Patient Removal Process**

Process for Deceased Beneficiaries – Removal from Caseload

1. PCP will write a letter on clinic letterhead including patient name, Medicaid number, DOB and the date of death.
2. PCP will send this information to their local DHS office and fax a copy to their AFMC Outreach Specialist at 501.375.0705 (Attention: Provider Relations).
3. The Outreach Specialist will give the information to ConnectCare for removal of the beneficiary from the PCP caseload. It has been confirmed with ConnectCare that a death certificate is not required but the information listed above is needed for the update.

Also, a 30-day notice to the beneficiary is not necessary in this situation.

1020 W. 4TH ST., SUITE 300 | LITTLE ROCK, AR 72201 | 501-212-8600 | FAX: 501-375-0705