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

ARKids First-B

- Wellness screening periodicity schedule updates effective 1/1/2020
  ARKids First-B Manual Sections 222.800 - 222.850
- Official Notice

Beneficiary Education Sessions

- January – March
  https://afmc.org/individuals/arkansans-on-medicaid/beneficiary-education/beneficiary-education-training-sessions/

Episodes of Care

- Reports
  - January episode of care reports can be viewed on AHIN on or after Jan. 31, 2020

EPSDT

- EPSDT reason codes
- EPSDT screening periodicity schedule updates effective 1/1/2020
  EPSDT Manual Section 215.100 - 215.340
- Official Notice

PASSE

- PASSE Reimbursement for an EPSDT and sick visit performed on the same date of service

Patient-centered Medical Home (PCMH)

- 2019 - 2020 PCMH Manual Addendum
  https://www.paymentinitiative.org/pcmh-manual-and-additional-resources
- 2020 PCMH Program Policy Addendum
  https://www.paymentinitiative.org/pcmh-manual-and-additional-resources
- Metrics due by Feb. 28, 2020
- Activities due by March 31, 2020
- Questions: pcmh@afmc.org

PCP Caseloads

- ConnectCare online PCP assignment process
- 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
Opioid Addiction Treatment Resources

- Medication Assisted Treatment (MAT) Arkansas Medicaid is removing the PA requirements for specific drugs used to treat opioid use disorder
- Steps to obtain Your MAT waiver
  - Physician – https://pcssnow.org/medication-assisted-treatment/waiver-training-for-physicians/steps-to-obtain-your-mat-waiver-physicians/
  - APN – https://pcssnow.org/medication-assisted-treatment/waiver-training-for-nurses/
  - Physician Assistant – https://pcssnow.org/medication-assisted-treatment/waiver-training-for-pas/
- Mental health and addiction services in Arkansas
  - Narcansas - https://www.artakeback.org/narcansas/
  - State-Targeted Response grant funded treatment facilities in Arkansas https://www.artakeback.org/substance-abuse-treatment/
- AR-IMPACT (Improving Multi-disciplinary Pain Care and Treatment) is a free program designed to help health care providers better manage their chronic pain patients and those who need their opioid dosage reduced. https://arimpact.uams.edu/

- MATRIARC (Medication Assisted Treatment Recovery Initiative for Arkansas Rural Communities) is a partnership with the Psychiatric Research Institute and the Arkansas Department of Human Services designed to expand evidence-based treatment for opioid use disorders. https://psychiatry.uams.edu/clinical-care/cast-2/matriarc/
- Project ECHO is part of MATRIARC, weekly video conferences available to community health centers needing assistance in opioid addiction treatment. Video conferences are held each Friday from noon to 1 p.m., with experts in addiction, therapy and case management discussing a variety of subjects related to opioid abuse. https://psychiatry.uams.edu/clinical-care/cast-2/project-echo/

Questions:
Jennifer Shuler, MNSc, APRN, ACNP-BC, RN
Arkansas DHS Co-State Opioid Treatment Authority
501-396-6347
jennifer.shuler@dhs.arkansas.gov

What’s New

- What’s new for Arkansas Medicaid providers https://medicaid.mmis.arkansas.gov/Provider/Provider.aspx
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
Tonyia 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 Breedinglove ... 501-553-7642
kbreedinglove@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

8/5/19
The ARKids First – B periodic screening schedule follows the guidelines for the EPSDT screening schedule and is updated in accordance with the recommendations of the American Academy of Pediatrics.

From birth to 15 months of age, children may receive six (6) periodic screens in addition to the newborn screen performed in the hospital.

Children age 15 months to 24 months of age may receive two (2) periodic screens. Children age 24 months to 30 months may receive one (1) periodic screen, and children 30 months to 3 years old may receive one (1) periodic screen.

When a child has turned 3 years old, the following schedule will apply. There must be at least 365 days between each screen listed below for children age 3 years through 18 years.

<table>
<thead>
<tr>
<th>Age</th>
<th>3 years</th>
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Medical screens for children are required to be performed by the beneficiary’s PCP or receive a PCP referral to an authorized Medicaid screening provider. Routine newborn care, vision screens, dental screens and immunizations for childhood diseases do not require PCP referral. See Section 262.130 for procedure codes.

Newborn Screen (Ages 3 to 5 Days)

A. History (initial/interval) to be performed.

B. Measurements to be performed:
   1. Height and Weight
   2. Head Circumference

C. Physical Examination to be performed at 3 to 5 days of age. At each visit a completed physical examination is essential with the infant totally unclothed.

D. Developmental/Surveillance and Psychosocial/Behavioral Assessment, to be performed by history and appropriate physical examination and, if suspicious, by specific objective developmental testing. Parenting skills should be fostered at every visit

E. Procedures—General

These may be modified depending upon the entry point into the schedule and the individual need.
1. Hereditary/Metabolic Screening to be performed at age 1 month, if not performed either during the newborn evaluations or at the preferred one of 3-5 days. Metabolic screening (e.g., thyroid, hemoglobinopathies, PKU, galactosemia) should be done according to state law.

2. Immunization(s) to be performed as appropriate. Every visit should be an opportunity to update and complete a child’s immunizations.

222.820 Infancy (Ages 1–9 Months)

A. History (Initial/Interval) to be performed at ages 1, 2, 4, 6, and 9 months.

B. Measurements to be performed
   1. Height and Weight at ages 1, 2, 4, 6, and 9 months.
   2. Head Circumference at ages 1, 2, 4, 6, and 9 months.

C. Sensory Screening, subjective, by history
   1. Vision at ages 1, 2, 4, 6, and 9 months.
   2. Hearing at ages 1, 2, 4, 6, and 9 months.

D. Developmental/Surveillance and Psychosocial/Behavioral Assessment to be performed at ages 1, 2, 4, 6, and 9 months; to be performed by history and appropriate physical examination and, if suspicious, by specific objective developmental testing. Parenting skills should be fostered at every visit.

E. Physical Examination to be performed at ages 1, 2, 4, 6, and 9 months. At each visit, a complete physical examination is essential with the infant totally unclothed.

F. Procedures - General

   These may be modified depending upon the entry point into the schedule and the individual need.

   1. Hereditary/Metabolic Screening to be performed at age 1 month, if not performed either during the newborn evaluation or at the preferred age of 3-5 days. Metabolic screening (e.g., thyroid, hemoglobinopathies, PKU, galactosemia) should be done according to state law.

   2. Immunization(s) to be performed at ages 1, 2, 4, 6, and 9 months. Every visit should be an opportunity to update and complete a child’s immunizations.

   3. Hematocrit or Hemoglobin risk assessment at 4 months with appropriate testing of high risk factors.

G. Other Procedures

   1. Lead screening risk assessment to be performed at ages 6 and 9 months. Additionally, screening should be done in accordance with state law where applicable.

   2. Tuberculin surveillance to be performed at ages 1 and 6 months per recommendations of the American Academy of Pediatrics (AAP) Committee on
H. Anticipatory Guidance to be performed at ages 1, 2, 4, 6, and 9 months. Age-appropriate discussion and counseling should be an integral part of each visit for care.

1. Injury prevention at ages 1, 2, 4, 6, and 9 months.
2. Violence prevention at ages 1, 2, 4, 6, and 9 months.
3. Sleep positioning counseling at ages 1, 2, 4, and 6 months. Parents and caregivers should be advised to place healthy infants on their backs when putting them to sleep. Side positioning is a reasonable alternative but carries a slightly higher risk of SIDS.
4. Nutrition counseling at ages 1, 2, 4, 6, and 9 months. Age-appropriate nutrition counseling should be an integral part of each visit.

I. Oral Health risk assessment: The Bright Futures/AAP “Recommendation for Preventative Pediatric Health Care,” (i.e. Periodicity Schedule) recommends all children receive a risk assessment at the 6- and 9-month visits. For the 12-, 18-, 24-, 30-month, and the 3- and 6-year visits, risk assessment should continue if a dental home has not been established. View the Bright/AAP Periodicity Schedule

Subsequent examinations should be completed as prescribed by the child’s dentist and recommended by the Child Health Services (EPSDT) dental schedule.

J. Developmental Screen to be performed at age 9 months using a standardized tool such as the Ages and Stages Questionnaire (ASQ) or Brigance Screens II. Any additional test must be approved by the Division of Medical Services (DMS) prior to use.
1. Vision at ages 3 and 4 years. Note: If the 3-year-old patient is uncooperative, re-screen within 6 months.

2. Hearing at age 4 years.

E. Developmental/Surveillance and Psychosocial/Behavioral Assessment to be performed at ages 12, 15, 18, 24, and 30 months and ages 3 and 4 years. To be performed by history and appropriate physical examination and, if suspicious, by specific objective developmental testing. Parenting skills should be fostered at every visit.

F. Physical Examination to be performed at ages 12, 15, 18, 24, and 30 months and ages 3 and 4 years. At each visit, a complete physical examination is essential, with the infant totally unclothed or with the older child undressed and suitably draped.

G. Procedures – General

These may be modified depending upon the entry point into the schedule and the individual need.

1. Immunization(s) to be performed at ages 12, 15, 18, 24, and 30 months and ages 3 and 4 years. Every visit should be an opportunity to update and complete a child’s immunizations.

2. Hematocrit or Hemoglobin risk assessment at 4 months with appropriate testing and follow up action if high risk to be performed at ages 12, 15, 18, 24, and 30 months and ages 3 and 4 years.

H. Other Procedures

Testing should be done upon recognition of high risk factors.

1. Lead screening risk assessment to be performed at ages 12 and 24 months. Additionally, screening should be done in accordance with state law where applicable, with appropriate action to follow if high risk positive.

2. Tuberculin test to be performed at ages 12 and 24 months and ages 3 and 4 years. Testing should be done upon recognition of high-risk factors per recommendations of the Committee on Infectious Diseases, published in the current edition of AAP Red Book: Report of the Committee on Infectious Diseases. Testing should be performed on recognition of high risk factors.

3. Risk Assessment for Hyperlipidemia to be performed at ages 24 months and 4 years with fasting screen, if family history cannot be ascertained, and other risk factors are present, screening should be at the discretion of the physician.

I. Anticipatory Guidance to be performed at ages 12, 15, 18, 24, and 30 months and at ages 3 and 4 years. Age-appropriate discussion and counseling should be an integral part of each visit for care.

1. Injury prevention to be performed at ages 12, 15, 18, 24, and 30 months and at ages 3 and 4 years.

2. Violence prevention to be performed at ages 12, 15, 18, 24, and 30 months and at ages 3 and 4 years.
3. Nutrition counseling to be performed at ages 12, 15, 18, 24, and 30 months and ages 3 and 4 years. Age-appropriate nutrition counseling should be an integral part of each visit.

J. Oral Health Risk assessment: The Bright Futures/AAP “Recommendation for Preventative Pediatric Health Care,” (i.e., Periodicity Schedule) recommends all children receive a risk assessment at the 6- and 9-month visits. For the 12-, 18-, 24-, 30-month, and the 3- and 6-year visits, risk assessment should continue if a dental home has not been established. View the Bright/AAP Periodicity Schedule.

Subsequent examinations should be as prescribed by the dentist and recommended by the Child Health Services (EPSDT) dental schedule.

K. Developmental Screen to be performed at age 18 and 30 months using standardized tools such as the Ages and Stages Questionnaire (ASQ) or Brigance Screens-II. Any additional tests must be approved by DMS prior to use.

L. Autism Screen to be performed at age 18 and 24 months (or 30 months if screen was not completed at 24 months) using a standardized tool such as the Modified Checklist for Autism in Toddlers (M-CHAT) or the Pervasive Developmental Disorders Screening Tests-II (PDDSDT-II) Stage1. Any additional test must be approved by DMS prior to use.

222.840 Middle Childhood (Ages 5 - 10 Years)

A. History (Initial/Interval) to be performed at ages 5, 6, 7, 8, 9, and 10 years.

B. Measurements to be performed
   1. Height and Weight at ages 5, 6, 7, 8, 9, and 10 years.
   2. Blood Pressure at ages 5, 6, 7, 8, 9, and 10 years.
   3. Body Mass Index at ages 5, 6, 7, 8, 9, and 10 years.

C. Sensory Screening, objective, by a standard testing method
   1. Vision at ages 5, 6, 8, and 10 years.
   2. Hearing at ages 5, 6, 8, and 10 years.

D. Sensory Screening, subjective, by history
   1. Vision at ages 7 and 9.
   2. Hearing at ages 7 and 9.

E. Developmental/Surveillance and Psychosocial/Behavioral Assessment to be performed at ages 5, 6, 7, 8, 9, and 10 years. To be performed by history and appropriate physical examinations and, if suspicious, by specific objective developmental testing. Parenting skills should be fostered at every visit.

F. Physical Examination to be performed at ages 5, 6, 7, 8, 9, and 10 years. At each visit, a complete physical examination is essential with the child undressed and suitably draped.

G. Procedures - General
These may be modified depending upon entry point into schedule and individual need.

1. Immunization(s) to be performed at ages 5, 6, 7, 8, 9, and 10 years. Every visit should be an opportunity to update and complete a child’s immunizations.

2. Hematocrit or Hemoglobin to be performed for patients at high risk at ages 5, 6, 7, 8, 9, and 10 years.

3. High Cholesterol to be performed at least once between the ages of 9 and 11, using a non-HDL cholesterol test that does not require fasting. Abnormal results should be followed up with a fasting lipid profile.

H. Other Procedures

Testing should be done upon recognition of high-risk

1. Tuberculin test to be performed at ages 5, 6, 7, 8, 9, and 10 years. Testing should be done upon recognition of high-risk factors.

2. Risk Assessment for Hyperlipidemia to be performed at ages 6, 7, 8, 9, and 10 years with fasting if family history cannot be ascertained, and other risk factors are present, screening should be at the discretion of the physician.

3. Oral Health Risk Assessment: The Bright Futures/AAP “Recommendation for Preventative Pediatric Health Care,” (i.e., Periodicity Schedule) recommends all children receive a risk assessment at the 6- and 9-month visits. For the 12-, 18-, 24-, 30-month, and the 3- and 6-year visits, risk assessment should continue if a dental home has not been established. View the Bright/AAP Periodicity Schedule.

Subsequent examination should be as prescribed by the dentist and recommended by the Child Health Services (EPSDT) dental schedule.

I. Anticipatory Guidance to be performed at ages 5, 6, 7, 8, 9, and 10 years. Age-appropriate discussion and counseling should be an integral part of each visit for care.

1. Injury prevention to be performed at ages 5, 6, 7, 8, 9, and 10 years.

2. Violence prevention to be performed at ages 5, 6, 7, 8, 9, and 10 years.

3. Nutrition counseling to be performed at ages 5, 6, 7, 8, 9, and 10 years. Age-appropriate counseling should be an integral part of each visit.

222.850 Adolescence (Ages 11 - 18 Years) 1-1-20

Developmental, psychosocial and chronic disease issues for children and adolescents may require frequent counseling and treatment visits separate from preventive care visits.

A. History (Initial/Interval) to be performed at ages 11, 12, 13, 14, 15, 16, 17, and 18 years.

B. Measurements to be performed

1. Height and Weight at ages 11, 12, 13, 14, 15, 16, 17, and 18 years.

2. Blood Pressure at ages 11, 12, 13, 14, 15, 16, 17, and 18 years.

3. Body Mass Index at ages: 11, 12, 13, 14, 15, 16, 17, and 18 years.

C. Sensory Screening, subjective, by history
1. Vision at ages 11, 13, 14, 16, and 17 years.
2. Hearing at ages 11, 12, 13, 14, 16, 17, and 18 years.

D. Sensory Screening, objective, by a standard testing method
1. Vision at ages 12, 15, and 18 years.
2. Hearing at ages 12, 15, and 18 years.

E. Developmental/Surveillance and Psychosocial/Behavioral Assessment to be performed at ages 11, 12, 13, 14, 15, 16, 17, and 18 years. To be performed by history and appropriate physical examination, if suspicious, by specific objective developmental testing. Parenting skills should be fostered at every visit.

F. Physical Examination to be performed at ages 11, 12, 13, 14, 15, 16, 17, and 18 years. At each visit, a complete physical examination is essential, with the child undressed and suitably draped.

G. Procedures – General
These may be modified, depending upon entry point into schedule and individual need.
1. Immunization(s) to be performed at ages 11, 12, 13, 14, 15, 16, 17, and 18 years. Every visit should be an opportunity to update and complete a child’s immunizations.
2. High Cholesterol screening to be performed at least once between the ages of 17 and 18, using a non-HDL cholesterol test that does not require fasting. Abnormal results should be followed up with a fasting lipid profile.

H. Other Procedures
Testing should be done upon recognition of high risk factors.
1. Tuberculin test to be performed at ages 11, 12, 13, 14, 15, 16, 17, and 18 years.
2. Risk assessment for Hyperlipidemia to be performed annually with fasting screen if family history cannot be ascertained and other risk factors are present. Screening should be at the discretion of the physician.
3. Hematocrit or Hemoglobin to be performed for those patients at high risk at ages 11-18.
4. STI/HIV screening to be performed at ages 11, 12, 13, 14, 15, 16, 17, and 18 years. All sexually active patients should be screened for sexually transmitted diseases (STDs). Adolescents should be screened for sexually transmitted infections (STIs) per recommendations in the current addition of the AAP Red Book: Report of the Committee on Infectious Diseases, Additionally, all adolescents should be screened for HIV according to the AAP statement once between the ages of 16 and 18, making every effort to preserve confidentiality of the adolescent. Those at increased risk of HIV infection, including those who are sexually active, participate in injection drug use, or are being tested for other STIs, should be tested for HIV and reassessed annually.
5. Depression screening ages 12 through 18 using screening tools such as Patient Health Questionnaire (PHQ)-2 or other tools available in the GLAD-PC toolkit.
I. Anticipatory Guidance to be performed at ages 11, 12, 13, 14, 15, 16, 17, and 18 years. Age-appropriate discussion and counseling should be an integral part of each visit for care.

1. Injury prevention to be performed at ages 11, 12, 13, 14, 15, 16, 17, and 18 years.
2. Violence prevention to be performed at ages 11, 12, 13, 14, 15, 16, 17, and 18 years.
3. Nutrition counseling to be performed at ages 11, 12, 13, 14, 15, 16, 17, and 18 years. Age-appropriate nutrition counseling should be an integral part of each visit.
TO: Arkansas Medicaid Health Care Providers – ARKids First-B

EFFECTIVE DATE: January 1, 2020

SUBJECT: Provider Manual Update Transmittal ARKIDS-3-18

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Explanation of Updates

Sections 222.800, 222.810, 222.820, 222.830, 222.840, and 222.850 have been updated to include the new screening schedule.

This update transmittal memorandum indicates which sections of your provider manual have been revised. Electronic versions of provider manuals available from the Arkansas Medicaid website have changes incorporated. See Section I for instructions on updating a paper copy of the manual.

If you have questions regarding this transmittal, 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.

If you need this material in an alternative format, such as large print, please contact the Office of Rules Promulgation at (501) 320-6266.

Arkansas Medicaid provider manuals (including update transmittals), official notices, notices of rule making, and remittance advice (RA) messages are available for downloading from the Arkansas Medicaid website: https://medicaid.mmis.arkansas.gov/Provider/Docs/Docs.aspx.

Thank you for your participation in the Arkansas Medicaid Program.

/s/ Janet Mann
Janet Mann
Director
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.
## SECTION II - CHILD HEALTH SERVICES (EPSDT)

### CONTENTS

#### 200.000 CHILD HEALTH SERVICES (EPSDT) GENERAL INFORMATION
- 201.000 Arkansas Medicaid Participation Requirements for Child Health Services (EPSDT) Providers Except School-Based Child Health Services Providers
- 202.000 Arkansas Medicaid Participation Requirements for School-Based Child Health Services Providers

#### 210.000 PROGRAM COVERAGE
- 211.000 Introduction
- 212.000 Scope
- 212.100 Reserved
- 212.200 EPSDT Minimum Documentation Requirements
- 212.300 Electronic Signatures
- 213.000 Provider’s Role in the Child Health Services (EPSDT) Program
- 214.000 PCP Referral Requirements
- 214.100 Freedom of Choice
- 214.200 Prescription of Treatment for Child Health Services (EPSDT) Services Not Specifically in the Medicaid State Plan
- 214.300 Foster Care Intake Physical Examination in the EPSDT Program
- 215.000 Child Health Services (EPSDT) Screen Information
- 215.100 Immunization Record
- 215.200 Child Health Services (EPSDT) Medical Screening Components
- 215.210 Health and Developmental History
- 215.220 Unclothed Physical Examination
- 215.230 Developmental Assessment
- 215.240 Visual Evaluation
- 215.250 Hearing Evaluation
- 215.260 Oral Assessment
- 215.270 Laboratory Procedures (CPT Codes)
- 215.280 Nutritional Assessment
- 215.290 Health Education
- 215.300 Exemplary Age-specific Child Health Services (EPSDT) Medical Screening Procedures
  - 215.301 Newborn Screen (Ages 3 to 5 Days)
  - 215.310 Infancy (Ages 1–9 months)
  - 215.320 Early Childhood (Ages 12 months–4 years)
  - 215.330 Middle Childhood (Ages 5–10 years)
  - 215.340 Adolescence (Ages 11-20 years)
- 216.000 Vision Screen
- 217.000 Hearing Screen
- 218.000 Dental Screening Services
- 219.000 Lead Toxicity Screening

#### 220.000 PRIOR AUTHORIZATION

#### 230.000 REIMBURSEMENT
215.100 Schedule for Child Health Services (EPSDT) Medical/Periodicity Screening

The periodic EPSDT screening schedule has been changed in accordance with the most recent recommendations of the American Academy of Pediatrics.

From birth to 15 months of age, children may receive six (6) periodic screens in addition to the newborn screen performed in the hospital.

Children age 15 months to 24 months of age may receive two (2) periodic screens. Children age 24 months to 30 months may receive one (1) periodic screen, and children 30 months to 3 years old may receive one (1) periodic screen.

When a child has turned 3 years old, the following schedule will apply. There must be at least 365 days between each screen listed below for children age 3 years through 20 years.

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</tbody>
</table>

Most medical and hearing screens for children require a PCP referral before the screens may occur. Routine newborn care, vision screens, dental screens and immunizations for childhood diseases do not require PCP referral. See Section 242.100 for procedure codes.
215.301 Newborn Screen (Ages 3 to 5 Days) 1-1-20

A. History (initial/interval) to be performed.

B. Measurements to be performed
   1. Height and Weight
   2. Head Circumference

C. Physical Examination to be performed at 3 to 5 days of age. At each visit a completed physical examination is essential with the infant totally unclothed.

D. Developmental/Surveillance and Psychosocial/Behavioral Assessment, to be performed by history and appropriate physical examination and, if suspicious, by specific objective developmental testing. Parenting skills should be fostered at every visit.

E. Procedures-General
   These may be modified depending upon the entry point into the schedule and the individual need.
   1. Hereditary/Metabolic Screening to be performed at age 1 month, if not performed either during the newborn evaluations or at the preferred age of 3-5 days. Metabolic screening (e.g. thyroid, hemoglobinopathies, PKU, galactosemia) should be done according to state law.
   2. Immunization(s) to be performed as appropriate. Every visit should be an opportunity to update and complete a child’s immunizations.

215.310 Infancy (Ages 1–9 months) 1-1-20

A. History (Initial/Interval) to be performed at ages 1, 2, 4, 6, and 9 months.

B. Measurements to be performed
   1. Height and Weight at ages 1, 2, 4, 6, and 9 months.
   2. Head Circumference at ages 1, 2, 4, 6, and 9 months.

C. Sensory Screening, subjective, by history
   1. Vision at ages 1, 2, 4, 6, and 9 months.
   2. Hearing at ages 1, 2, 4, 6, and 9 months.

D. Developmental/Surveillance and Psychosocial/Behavioral Assessment to be performed at ages 1, 2, 4, 6, and 9 months. To be performed by history and appropriate physical examination and, if suspicious, by specific objective developmental testing. Parenting skills should be fostered at every visit.

E. Physical Examination to be performed at ages 1, 2, 4, 6, and 9 months. At each visit, a complete physical examination is essential with the infant totally unclothed.

F. Procedures - General
These may be modified depending upon the entry point into the schedule and the individual need.

1. Hereditary/Metabolic Screening to be performed at age 1 month, if not performed either during the newborn evaluation or at the preferred age of 3-5 days. Metabolic screening (e.g., thyroid, hemoglobinopathies, PKU, galactosemia) should be done according to state law.

2. Immunization(s) to be performed at ages 1, 2, 4, 6, and 9 months. Every visit should be an opportunity to update and complete a child’s immunizations.

3. Hematocrit or Hemoglobin risk assessment at age 4 months with appropriate testing of high risk factors.

G. Other Procedures

1. Lead screening risk assessment to be performed at ages 6 and 9 months. Additionally, screening should be done in accordance with state law where applicable.

2. Tuberculin surveillance to be performed at ages 1 and 6 months per recommendations of the American Academy of Pediatrics (AAP) Committee on Infectious Diseases, published in the current edition of AAP Red Book: Report of the Committee on Infectious Diseases. Testing should be performed on recognition of high risk factors.

H. Anticipatory Guidance to be performed at ages 1, 2, 4, 6, and 9 months. Age-appropriate discussion and counseling should be an integral part of each visit for care.

1. Injury prevention at ages 1, 2, 4, 6, and 9 months.

2. Violence prevention at ages 1, 2, 4, 6, and 9 months.

3. Sleep positioning counseling at ages 1, 2, 4, and 6 months. Parents and caregivers should be advised to place healthy infants on their backs when putting them to sleep. Side positioning is a reasonable alternative but carries a slightly higher risk of SIDS.

4. Nutrition counseling at ages 1, 2, 4, 6, and 9 months. Age-appropriate nutrition counseling should be an integral part of each visit.

I. Oral Health Risk Assessment:

The Bright Futures/AAP “Recommendation for Preventative Pediatric Health Care,” (i.e., Periodicity Schedule) recommends all children receive a risk assessment at the 6- and 9-month visits. For the 12-, 18-, 24-, 30-month, and the 3- and 6-year visits, risk assessment should continue if a dental home has not been established. View the Bright/AAP Periodicity Schedule

Subsequent examinations should be completed as prescribed by the child’s dentist and recommended by the Child Health Services (EPSDT) dental schedule.

J. Developmental Screen to be performed at age 9 months using a standardized tool such as the Ages and Stages Questionnaire (ASQ) or Brigance Screens-II. Any additional test must be approved by DMS prior to use.
A. History (Initial/Interval) to be performed at ages 12, 15, 18, 24, and 30 months and ages 3 and 4 years.

B. Measurements to be performed
   1. Height and Weight at ages 12, 15, 18, 24, and 30 months and ages 3 and 4 years.
   2. Head Circumference at ages 12, 15, 18, and 24 months.
   3. Blood Pressure at 30 months* and ages 3 and 4 years.
      * Note for infants and children with specific risk conditions.
   4. BMI (Body Mass Index) at ages 24 and 30 months, and ages 3 and 4 years.

C. Sensory Screening, subjective, by history
   1. Vision at ages 12, 15, 18, 24, and 30 months
   2. Hearing at ages 12, 15, 18, 24, and 30 months and age 3 years.

D. Sensory Screening, objective, by a standard testing method
   1. Vision at ages 3 and 4 years. Note: If the 3-year-old patient is uncooperative, re-screen within 6 months.
   2. Hearing at age 4 years.

E. Developmental/Surveillance and Psychosocial Behavioral Assessment to be performed at ages 12, 15, 18, 24, and 30 months and ages 3 and 4 years. To be performed by history and appropriate physical examination and, if suspicious, by specific objective developmental testing. Parenting skills should be fostered at every visit.

F. Physical Examination to be performed at ages 12, 15, 18, 24, and 30 months and 3 and 4 years. At each visit, a complete physical examination is essential, with the infant totally unclothed or with the older child undressed and suitably draped.

G. Procedures – General
   These may be modified depending upon the entry point into the schedule and the individual need.
   1. Immunization(s) to be performed at ages 12, 15, 18, 24, and 30 months and ages 3 and 4 years. Every visit should be an opportunity to update and complete a child’s immunizations.
   2. Hematocrit or Hemoglobin risk assessment at 4 months with appropriate testing and follow up action if high risk to be performed at ages 12, 15, 18, 24, and 30 months and ages 3 and 4 years.

H. Other Procedures
   Testing should be done upon recognition of high risk factors.
   1. Lead screening risk assessment to be performed at ages 12 and 24 months. Additionally, screening should be done in accordance with state law where applicable, with appropriate action to follow if high risk positive.
2. Tuberculin test to be performed at ages 12 and 24 months and ages 3 and 4 years. Testing should be done upon recognition of high-risk factors per recommendations of the Committee on Infectious Diseases, published in the current edition of AAP Red Book: Report of the Committee on Infectious Diseases. Testing should be performed on recognition of high risk factors.

3. Risk Assessment for Hyperlipidemia to be performed at ages 24 months and 4 years with fasting screen. If family history cannot be ascertained and other risk factors are present, screening should be at the discretion of the physician.

I. Anticipatory Guidance to be performed at ages 12, 15, 18, 24, and 30 months and at ages 3 and 4 years. Age-appropriate discussion and counseling should be an integral part of each visit for care.

1. Injury prevention to be performed at ages 12, 15, 18, 24, and 30 months and at 3 and 4 years.

2. Violence prevention to be performed at ages 12, 15, 18, 24, and 30 months and at 3 and 4 years.

3. Nutrition counseling to be performed at ages 12, 15, 18, 24, and 30 months and 3 and 4 years. Age-appropriate nutrition counseling should be an integral part of each visit.

J. Oral Health Risk Assessment:

The Bright Futures/AAP “Recommendation for Preventative Pediatric Health Care,” (i.e., Periodicity Schedule) recommends all children receive a risk assessment at the 6- and 9-month visits. For the 12-, 18-, 24-, 30-month, and the 3- and 6-year visits, risk assessment should continue if a dental home has not been established. View the Bright/AAP Periodicity Schedule

Subsequent examinations should be as prescribed by the dentist and recommended by the Child Health Services (EPSDT) dental schedule.

K. Developmental Screen to be performed at ages 18 months and 30 months using standardized tools such as the Ages and Stages Questionnaire (ASQ) or Brigance Screens-II. Any additional tests must be approved by DMS prior to use.

L. Autism Screen to be performed at ages 18 and 24 months (or 30 months if screen was not completed at 24 months) using a standardized tool such as the Modified Checklist for Autism in Toddlers (M-CHAT) or the Pervasive Developmental Disorders Screening Tests-II (PDDSDT-II) Stage1. Any additional test must be approved by DMS prior to use.

215.330 Middle Childhood (Ages 5-10 years)

A. History (Initial/Interval) to be performed at ages 5, 6, 7, 8, 9, and 10 years.

B. Measurements to be performed

1. Height and Weight at ages 5, 6, 7, 8, 9, and 10 years.

2. BMI (Body Mass Index) at all ages.

3. Blood Pressure at ages 5, 6, 7, 8, 9, and 10 years.

C. Sensory Screening, objective, by a standard testing method.
1. Vision at ages 5, 6, 8, and 10 years.
2. Hearing at ages 5, 6, 8, and 10 years.

D. Sensory Screening, subjective, by history.
   1. Vision at ages 7 and 9.
   2. Hearing at ages 7 and 9.

E. Developmental/Surveillance and Psychosocial Behavioral Assessment to be performed at ages 5, 6, 7, 8, 9, and 10 years. To be performed by history and appropriate physical examinations and, if suspicious, by specific objective developmental testing. Parenting skills should be fostered at every visit.

F. Physical Examination to be performed at ages 5, 6, 7, 8, 9, and 10 years. At each visit, a complete physical examination is essential with the child undressed and suitably draped.

G. Procedures - General
These may be modified depending upon entry point into schedule and individual need.
   1. Immunization(s) to be performed at ages 5, 6, 7, 8, 9, and 10 years. Every visit should be an opportunity to update and complete a child’s immunizations.
   2. Hematocrit or Hemoglobin to be performed for patients at high risk at age 5, 6, 7, 8, 9, and 10 years.
   3. High Cholesterol screening to be performed at least once between the ages of 9 and 11, using a non-HDL cholesterol test that does not require fasting. Abnormal results should be followed up with a fasting lipid profile.

H. Other Procedures
Testing should be done upon recognition of high-risk factors.
   1. Tuberculin test to be performed at ages 5, 6, 7, 8, 9, and 10 years. Testing should be done upon recognition of high-risk factors.
   2. Risk Assessment for Hyperlipidemia to be performed at ages 6, 7, 8, 9, and 10 years with fasting. If family history cannot be ascertained and other risk factors are present, screening should be at the discretion of the physician.
   3. Oral Health Risk Assessment:
      The Bright Futures/AAP “Recommendation for Preventative Pediatric Health Care,” (i.e., Periodicity Schedule) recommends all children receive a risk assessment at the 6- and 9-month visits. For the 12-, 18-, 24-, 30-month, and the 3- and 6-year visits, risk assessment should continue if a dental home has not been established. View the Bright/AAP Periodicity Schedule
      Subsequent examination should be as prescribed by the dentist and recommended by the Child Health Services (EPSDT) dental schedule.

I. Anticipatory Guidance to be performed at ages 5, 6, 7, 8, 9, and 10 years. Age-appropriate discussion and counseling should be an integral part of each visit for care.
1. Injury prevention to be performed at ages 5, 6, 7, 8, 9, and 10 years.
2. Violence prevention to be performed at ages 5, 6, 7, 8, 9, and 10 years.
3. Nutrition counseling to be performed at ages 5, 6, 7, 8, 9, and 10 years. Age-appropriate counseling should be an integral part of each visit.

215.340 Adolescence (Ages 11-20 years)

Developmental, psychosocial and chronic disease issues for children and adolescents may require frequent counseling and treatment visits separate from preventive care visits.

A. History (Initial/Interval) to be performed at ages 11, 12, 13, 14, 15, 16, 17, 18, 19, and 20 years.

B. Measurements to be performed
   1. Height and Weight at ages 11, 12, 13, 14, 15, 16, 17, 18, 19, and 20 years.
   2. Blood Pressure at ages 11, 12, 13, 14, 15, 16, 17, 18, 19, and 20 years.
   3. BMI (Body Mass Index) at all ages.

C. Sensory Screening, subjective, by history
   1. Vision at ages 11, 13, 14, 16, 17, 19, and 20 years.
   2. Hearing at ages 11, 13, 14, 16, 17, 18, 19, and 20 years.

D. Sensory Screening, objective, by a standard testing method
   1. Vision at ages 12, 15, and 18 years.
   2. Hearing at ages 12, 15, and 18 years.

E. Developmental/Surveillance and Psychosocial/Behavioral Assessment to be performed at ages 11, 12, 13, 14, 15, 16, 17, 18, 19, and 20 years. To be performed by history and appropriate physical examination, if suspicious, by specific objective developmental testing. Parenting skills should be fostered at every visit.

F. Physical Examination to be performed at ages 11, 12, 13, 14, 15, 16, 17, 18, 19, and 20 years. At each visit, a complete physical examination is essential, with the child undressed and suitably draped.

G. Procedures – General
   These may be modified, depending upon entry point into schedule and individual need.
   1. Immunization(s) to be performed at ages 11, 12, 13, 14, 15, 16, 17, 18, 19, and 20 years. Every visit should be an opportunity to update and complete a child’s immunizations.
   2. High Cholesterol screening to be performed at least once between the ages of 17 and 21, using a non-HDL cholesterol test that does not require fasting. Abnormal results should be followed up with a fasting lipid profile.

H. Other Procedures
Testing should be done upon recognition of high risk factors.

1. Tuberculin test to be performed at ages 11, 12, 13, 14, 15, 16, 17, 18, 19, and 20 years.

2. Risk assessment for Hyperlipidemia to be performed annually with fasting screen if family history cannot be ascertained and other risk factors are present. Screening should be at the discretion of the physician.

3. Sexually Transmitted Infection (STI) screening to be performed at ages 11, 12, 13, 14, 15, 16, 17, 18, 19, and 20 years. All sexually active patients should be screened. Hematocrit or Hemoglobin to be performed for those patients at high risk at ages 11-20 years.

4. HIV screening to be performed one time between ages 15 and 18 years. Additionally, all adolescents should be screened for HIV, making every effort to preserve confidentiality of the adolescent, according to the AAP statement. View the AAP screening statement. Those at increased risk of HIV infection, including those who are sexually active, participate in injection drug use, or are being tested for other STIs, should be tested for HIV and reassessed annually.

5. Depression screening to be performed each year between ages 12 through 20 using screening tools such as the Patient Health Questionnaire (PHQ)-2 or other tools available in the Guidelines for Adolescent Depression in Primary Care (GLAD-PC) toolkit.

I. Anticipatory Guidance to be performed at ages 11, 12, 13, 14, 15, 16, 17, 18, 19, and 20 years. Age-appropriate discussion and counseling should be an integral part of each visit for care.

1. Injury prevention to be performed at ages 11, 12, 13, 14, 15, 16, 17, 18, 19, and 20 years.

2. Violence prevention to be performed at ages 11, 12, 13, 14, 15, 16, 17, 18, 19, and 20 years.

3. Nutrition counseling to be performed at ages 11, 12, 13, 14, 15, 16, 17, 18, 19, and 20 years. Age-appropriate nutrition counseling should be an integral part of each visit.
TO: Arkansas Medicaid Health Care Providers – Child Health Services/Early and Periodic Screening, Diagnosis, and Treatment

EFFECTIVE DATE: January 1, 2020

SUBJECT: Provider Manual Update Transmittal EPSDT-1-18

<table>
<thead>
<tr>
<th>REMOVE</th>
<th>INSERT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Section</td>
<td>Effective Date</td>
</tr>
<tr>
<td>215.100</td>
<td>7-1-05</td>
</tr>
<tr>
<td>—</td>
<td>—</td>
</tr>
<tr>
<td>215.310</td>
<td>10-13-03</td>
</tr>
<tr>
<td>215.320</td>
<td>10-13-03</td>
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<td>215.330</td>
<td>10-13-03</td>
</tr>
<tr>
<td>215.340</td>
<td>7-1-05</td>
</tr>
</tbody>
</table>

Explanation of Updates
Section 215.100 and 215.310 have been updated to include age range, screening, and assessment information.
Section 215.301 is a new section containing newborn screening information.
Section 215.320, 215.330, and 215.340 have been updated to include BMI, age range, and screening information.

This update transmittal memorandum indicates which sections of your provider manual have been revised. Electronic versions of provider manuals available from the Arkansas Medicaid website have changes incorporated. See Section I for instructions on updating a paper copy of the manual.

If you have questions regarding this transmittal, 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.
If you need this material in an alternative format, such as large print, please contact the Office of Rules Promulgation at (501) 320-6266.

Arkansas Medicaid provider manuals (including update transmittals), official notices, notices of rule making, and remittance advice (RA) messages are available for downloading from the Arkansas Medicaid website: https://medicaid.mmis.arkansas.gov/Provider/Docs/Docs.aspx.

Thank you for your participation in the Arkansas Medicaid Program.

/s/ Janet Mann
Janet Mann
Director
PASSE Reimbursement for an EPSDT and sick visit performed on the same date of service

Thank you for attending the annual Medicaid Educational conference December 17. We would like to inform you of the following PASSE Update:

Medicaid’s Office of Chief Council has reviewed the Consent Decree, the EPSDT Manual, and PASSE Contracts and has advised that the Consent Decree applies to an EPSDT visit occurring on the same day as a sick-child visit. The EPSDT Manual Section II 242.100 (note A), states that Modifier 25 must be indicated in the first position of the second billed service to surpass the Medicaid policy to not bill modifiers on a sick visit when performed on the same date of service as an EPSDT screening. Additionally, because the Consent Decree applies, the full rate should be paid for each visit.

If claims were paid incorrectly, please reach out to the appropriate PASSE for reprocessing.

Summit
(844) 462-0022

Arkansas Total Care
(866) 282-6280

Empower
(855) 429-1028

As always, we want to be your best resource and assist you with all of your Medicaid needs. Please contact your AFMC provider relations outreach specialist if you have any questions.

Sincerely,
AFMC Provider Relations
243.000 Quality Metrics Tracked for Performance Based Incentive Payments

DMS assesses the following Quality Metrics tracked for Performance-Based Incentive Payments (PBIP) according to the targets below. The quality metrics are assessed only if the Shared Performance Entity has at least the minimum number of attributed beneficiaries in the category described for the majority of the performance period. To receive a PBIP, the Shared Performance Entity must meet at least two-thirds of the Quality Metrics on which the entity is assessed.

The Quality Metrics are assessed at the level of the shared performance entity for Voluntary pools and the Petite Pool. Quality Metrics for the default pool are assessed on an individual PCMH-level.

Achievement of targets for Quality Metrics 9, 10, and 11 can be calculated only if the required metric data is submitted through the AHIN Provider Portal. Failure to provide the required data by January 31, 2020 will cause failure to meet targets for Quality Metrics 9, 10, and 11.

<table>
<thead>
<tr>
<th>Metric #</th>
<th>Metric Name</th>
<th>Description</th>
<th>Minimum Attributed Beneficiaries</th>
<th>2019 Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>PCP visits</td>
<td>Percentage of a practice’s high priority beneficiaries who have been seen by any PCP within their PCMH at least twice in the past 12 months</td>
<td>25</td>
<td>84%</td>
</tr>
<tr>
<td>2</td>
<td>Infant wellness</td>
<td>Percentage of beneficiaries who turned 15 months old during the performance period who receive at least five wellness visits in their first 15 months (0 – 15 months)</td>
<td>25</td>
<td>62%</td>
</tr>
<tr>
<td>3</td>
<td>Child wellness</td>
<td>Percentage of beneficiaries 3-6 years of age who had one or more well-child visits during the measurement year</td>
<td>25</td>
<td>71%</td>
</tr>
<tr>
<td>4</td>
<td>Adolescent wellness</td>
<td>Percentage of beneficiaries 12-20 years of age who had one or more well-care visits during the measurement year</td>
<td>25</td>
<td>50%</td>
</tr>
<tr>
<td>5</td>
<td>URI</td>
<td>Percentage of beneficiary, age 1 year and older, events with a diagnosis of non-specified URI that had antibiotic treatment during the measurement period</td>
<td>25</td>
<td>&lt;=47%</td>
</tr>
<tr>
<td>Metric #</td>
<td>Metric Name</td>
<td>Description</td>
<td>Minimum Attributed Beneficiaries</td>
<td>2019 Target</td>
</tr>
<tr>
<td>---------</td>
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</tr>
<tr>
<td></td>
<td></td>
<td><strong>Quality Metrics: Incentive Payment (Claims-Based)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>HbA1c</td>
<td>Percentage of diabetes beneficiaries who complete annual HbA1C, between 18-75 years of age</td>
<td>25</td>
<td>75%</td>
</tr>
<tr>
<td>7</td>
<td>COB</td>
<td>Percentage of beneficiaries age 18 and older with concurrent use of prescription opioids and benzodiazepines</td>
<td>25</td>
<td>&lt;=35%</td>
</tr>
<tr>
<td>8</td>
<td>Tamiflu</td>
<td>Percentage of beneficiaries 1-18 years of age who received Tamiflu and respiratory antibiotics on the same day</td>
<td>25</td>
<td>&lt;=20%</td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>eCQMs Quality Metrics: w/Target</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9</td>
<td>Controlling BP</td>
<td>Percentage of patients 18-85 years of age who had a diagnosis of hypertension and whose blood pressure was adequately controlled (&lt;140/90mmHg) during the measurement period (All payer source)</td>
<td>25</td>
<td>58%</td>
</tr>
<tr>
<td>10</td>
<td>HbA1c Poor control</td>
<td>Percentage of patients 18-75 years of age with diabetes who had hemoglobin A1c &gt; 9.0% during the measurement period (All payer source)</td>
<td>25</td>
<td>&lt;= 33%</td>
</tr>
<tr>
<td>11</td>
<td>Tobacco Use</td>
<td>Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months AND who received cessation counseling intervention if identified as a tobacco user during the measurement period (All payer source)</td>
<td>25</td>
<td>75%</td>
</tr>
</tbody>
</table>
Technical Specifications for Quality Metrics Tracked for PBIP

**Metric 1: PCP Visits**

<table>
<thead>
<tr>
<th>Numerator</th>
<th>Denominator</th>
<th>Category</th>
<th>Measure Steward</th>
<th>Population Base</th>
</tr>
</thead>
<tbody>
<tr>
<td>Numerator includes the number of those high priority beneficiaries with 2 of the selected visit types and criteria with their attributed PCMH</td>
<td>Denominator includes beneficiaries designated high priority by practices according to Section 241.000 and attributed to the PCMH for at least 6 months</td>
<td>Quality Metric: w/Target</td>
<td>Homegrown</td>
<td>Child/Adult</td>
</tr>
</tbody>
</table>

**Metric 2: Infant Wellness**

<table>
<thead>
<tr>
<th>Numerator</th>
<th>Denominator</th>
<th>Category</th>
<th>Measure Steward</th>
<th>Population Base</th>
</tr>
</thead>
<tbody>
<tr>
<td>Numerator includes number of beneficiaries who had 5 or more wellness visits during first 15 months of life (0-15 months)</td>
<td>Denominator includes number of beneficiaries who turned 15 months old during the measurement year</td>
<td>Quality Metric: w/Target</td>
<td>NCQA</td>
<td>Child</td>
</tr>
</tbody>
</table>

**Metric 3: Child Wellness**

<table>
<thead>
<tr>
<th>Numerator</th>
<th>Denominator</th>
<th>Category</th>
<th>Measure Steward</th>
<th>Population Base</th>
</tr>
</thead>
<tbody>
<tr>
<td>Numerator includes number of beneficiaries who had one or more wellness visits during the measurement year</td>
<td>Denominator includes number of beneficiaries 3 to 6 years old on the anchor (last) date of the measurement year</td>
<td>Quality Metric: w/Target</td>
<td>NCQA</td>
<td>Child</td>
</tr>
</tbody>
</table>
**Metric 4: Adolescent Wellness**

<table>
<thead>
<tr>
<th>Numerator</th>
<th>Denominator</th>
<th>Category</th>
<th>Measure Steward</th>
<th>Population Base</th>
</tr>
</thead>
<tbody>
<tr>
<td>Numerator includes number of beneficiaries who had one or more wellness visits during the measurement year</td>
<td>Denominator includes number of beneficiaries 12 to 20 years old on the anchor (last) date of the measurement year</td>
<td>Quality Metric: w/Target; Incentive Focus</td>
<td>NCQA</td>
<td>Child</td>
</tr>
</tbody>
</table>

*Focus Metric for the 2019 Performance Period*

**Metric 5: URI**

<table>
<thead>
<tr>
<th>Numerator</th>
<th>Denominator</th>
<th>Category</th>
<th>Measure Steward</th>
<th>Population Base</th>
</tr>
</thead>
<tbody>
<tr>
<td>Numerator includes those beneficiary events that were dispensed a prescription for an antibiotic, at least one AHFS code, within twenty days from the initial event’s start date</td>
<td>Denominator includes all events for attributed beneficiaries, who are 1 year of age and older, on the detail &quot;from&quot; date of service with a primary or secondary diagnosis of non-specified URI in combination with a CPT or HCPCS code</td>
<td>Quality Metric: w/Target</td>
<td>DMS (Homegrown) EOC (URI Non-Specified)</td>
<td>Child/Adult</td>
</tr>
</tbody>
</table>

**Metric 6: HbA1c**

<table>
<thead>
<tr>
<th>Numerator</th>
<th>Denominator</th>
<th>Category</th>
<th>Measure Steward</th>
<th>Population Base</th>
</tr>
</thead>
<tbody>
<tr>
<td>Numerator includes number of beneficiaries 18 to 75 years old with a diagnosis of diabetes who completed a HbA1c test during the measurement period</td>
<td>Denominator includes number of beneficiaries 18 to 75 years who have a diagnosis of diabetes</td>
<td>Quality Metric: w/Target</td>
<td>NCQA</td>
<td>Adult</td>
</tr>
</tbody>
</table>
## Metric 7: Concurrent Opioids and Benzodiazepines Use

<table>
<thead>
<tr>
<th>Numerator</th>
<th>Denominator</th>
<th>Category</th>
<th>Measure Steward</th>
<th>Population Base</th>
</tr>
</thead>
<tbody>
<tr>
<td>Numerator includes number of beneficiaries with two or more prescription claims for any benzodiazepine with unique dates of service and concurrent use of opioids and benzodiazepines for 30 or more cumulative days</td>
<td>Denominator includes number of beneficiaries age 18 and older on the anchor (first) date of the measurement year with an IPSD and with 2 or more prescriptions for opioids with unique dates of service, for which the sum of the days' supply is 15 or more</td>
<td>Quality Metric: w/Target</td>
<td>Pharmacy Quality Alliance</td>
<td>Adult</td>
</tr>
</tbody>
</table>

## Metric 8: Tamiflu

<table>
<thead>
<tr>
<th>Numerator</th>
<th>Denominator</th>
<th>Category</th>
<th>Measure Steward</th>
<th>Population Base</th>
</tr>
</thead>
<tbody>
<tr>
<td>Numerator includes number of beneficiaries who received Tamiflu and respiratory antibiotics on the same day</td>
<td>Denominator includes number of beneficiaries 1-18 years old on the first date of the measurement period and received a Tamiflu prescription</td>
<td>Quality Metric: w/Target</td>
<td>DMS (Homegrown)</td>
<td>Child</td>
</tr>
</tbody>
</table>

## Metric 9: Controlling Blood Pressure

<table>
<thead>
<tr>
<th>Numerator</th>
<th>Denominator</th>
<th>Category</th>
<th>Measure Steward</th>
<th>Population Base</th>
</tr>
</thead>
<tbody>
<tr>
<td>Numerator includes number of patients whose blood pressure at the most recent visit is adequately controlled (systolic blood pressure &lt; 140 mmHg and diastolic blood pressure &lt; 90 mmHg) during the measurement (All payer source)</td>
<td>Denominator includes number of patients 18 to 85 years of age who had a diagnosis of essential hypertension within the first six months of the measurement period or any time prior to the measurement period (All payer source)</td>
<td>Quality Metric: w/Target</td>
<td>eCQM (Effective Clinical Care)</td>
<td>Adult</td>
</tr>
</tbody>
</table>
**Metric 10: HbA1c Poor Control**

<table>
<thead>
<tr>
<th>Numerator</th>
<th>Denominator</th>
<th>Category</th>
<th>Measure Steward</th>
<th>Population Base</th>
</tr>
</thead>
<tbody>
<tr>
<td>Numerator includes number of patients whose most recent HbA1c level (performed during the measurement period) is &gt;9.0% (All payer source)</td>
<td>Denominator includes number of patients 18-75 years of age with diabetes with a visit during the measurement period (All payer source)</td>
<td>Quality Metric: w/Target</td>
<td>eCQM (Effective Clinical Care)</td>
<td>Adult</td>
</tr>
</tbody>
</table>

**Metric 11: Tobacco Use**

<table>
<thead>
<tr>
<th>Numerator</th>
<th>Denominator</th>
<th>Category</th>
<th>Measure Steward</th>
<th>Population Base</th>
</tr>
</thead>
<tbody>
<tr>
<td>Numerator includes number of patients who were screened for tobacco use at least once within 24 months AND who received tobacco cessation intervention if identified as a tobacco user (All payer source)</td>
<td>Denominator includes number of patients aged 18 years and older seen for at least two visits or at least one preventive visit during the measurement period (All payer source)</td>
<td>Quality Metric: w/Target</td>
<td>eCQM (Community, Population and Public Health)</td>
<td>Adult</td>
</tr>
</tbody>
</table>
Informational Metrics

DMS assesses the following informational metrics tracked for the PCMH program. The Informational Metrics are reported as “claims-based metrics” with at least the one minimum number of attributed beneficiaries in the category described for the majority of the performance period on the PCMH provider report. Breast Cancer Screening, Cervical Cancer Screening, and Colorectal Cancer Screening are collected as “Effective Clinical Care” metrics, while Low Back Pain is collected as an “Efficiency and Cost Reduction Use of Healthcare Resources” metric. All eCQM Informational Metrics are due through the AHIN Provider Portal by January 31, 2020.

<table>
<thead>
<tr>
<th>Metric</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>30-day readmissions</td>
<td>Thirty-day readmissions rate</td>
</tr>
<tr>
<td>Asthma Medication Ratio (Child)</td>
<td>Percentage of beneficiaries 5–18 years of age who were identified as having persistent asthma and had a ratio of controller medications to total asthma medications of 0.50 or greater during the measurement year</td>
</tr>
<tr>
<td>Asthma Medication Ratio (Adult)</td>
<td>Percentage of beneficiaries 19–64 years of age who were identified as having persistent asthma and had a ratio of controller medications to total asthma medications of 0.50 or greater during the measurement year</td>
</tr>
<tr>
<td>ADHD</td>
<td>Percentage of beneficiaries 6-12 years of age with an ambulatory prescription dispensed for ADHD medication that was prescribed by their PCMH, who had a follow-up visit within 30 days by any practitioner with prescribing authority</td>
</tr>
<tr>
<td>Warfarin</td>
<td>Percentage of beneficiaries age 18 years and older who are on chronic Warfarin (Coumadin) therapy and who receive an INR test during each 12 week interval with Warfarin during the measurement period</td>
</tr>
<tr>
<td>Chlamydia Screening (Child)</td>
<td>The percentage of women 16-20 years of age who were identified as sexually active and who had at least one test for chlamydia during the measurement period</td>
</tr>
<tr>
<td>Chlamydia Screening (Adult)</td>
<td>The percentage of women 21-24 years of age who were identified as sexually active and who had at least one test for chlamydia during the measurement period</td>
</tr>
<tr>
<td>Eye exam</td>
<td>Percentage of diabetic beneficiaries 18-75 years of age who had an eye exam (retinal) performed</td>
</tr>
<tr>
<td>Diabetes Short-Term Complications</td>
<td>Number of inpatient hospital admissions for diabetes short-term complications (ketoacidosis, hyperosmolarity, or coma) per 100,000 enrollee months for Medicaid beneficiaries age 18 and older</td>
</tr>
<tr>
<td>COPD or Asthma Admissions</td>
<td>Number of inpatient hospital admissions for chronic obstructive pulmonary disease (COPD) or asthma per 100,000 enrollee months for beneficiaries age 40 and older</td>
</tr>
<tr>
<td>Metric</td>
<td>Description</td>
</tr>
<tr>
<td>------------------------</td>
<td>------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Medication therapy</td>
<td>Percentage of beneficiaries 18 years of age and older who received at least 180 treatment days of ambulatory medication therapy for a select therapeutic agent (angiotensin converting enzyme (ACE) inhibitors or angiotensin receptor blockers (ARB) or diuretics) during the measurement year and at least one therapeutic monitoring event for the therapeutic agent in the measurement year.</td>
</tr>
<tr>
<td>HIV Viral Load</td>
<td>Percentage of beneficiaries with a diagnosis of HIV with at least one HIV viral load test during the measurement year</td>
</tr>
<tr>
<td>Childhood Immunization</td>
<td>Percentage of children age 2 who had four diphtheria, tetanus and acellular pertussis (DTaP); three polio (IPV); one measles, mumps and rubella (MMR); three haemophilus influenza type B (HiB); three hepatitis B (Hep B), one chicken pox (VZV); four pneumococcal conjugate (PCV); one hepatitis A (HepA); two or three rotavirus (RV); and two influenza (flu) vaccines by their second birthday.</td>
</tr>
<tr>
<td>Breast Cancer Screening</td>
<td>Percentage of women 50–74 years of age who had a mammogram to screen for breast cancer</td>
</tr>
</tbody>
</table>
| Cervical Cancer Screening | *Percentage of women 21-64 years of age who were screened for cervical cancer using either of the following criteria:  
Women age 21-64 who had cervical cytology performed every 3 years  
Women age 30-64 who had cervical cytology/human papillomavirus (HPV) co-testing performed every 5 years                                                                 |
| Colorectal Cancer Screening | Percentage of beneficiaries 50-75 years of age who had appropriate screening for colorectal cancer                                                                                                   |
| Low Back Pain          | Percentage of beneficiaries 18-50 years of age with a principal diagnosis of low back pain who did have an imaging study (plain X-ray, MRI, CT scan) within 28 days of the diagnosis |

*Informational Metrics: w/PCMH State Averages (Claims-Based)*
## 241.000 Activities Tracked for Practice Support

### Activities for the 2020 Performance Period

- All PCMHs must meet all activities by the following deadlines in order to be eligible for practice support:
  - 3-month activities by 3/31/2020
  - 6-month activities by 6/30/2020
  - 12-month activities by 12/31/2020
- For information on remediation, please refer to the [2019-2020 PCMH Provider Manual](#).

<table>
<thead>
<tr>
<th>Activity</th>
<th>3-Month</th>
<th>6-Month</th>
<th>12-Month</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Identify top 10% of high-priority patients</td>
<td>✓</td>
<td></td>
<td></td>
</tr>
<tr>
<td>B. Make available 24/7 access to care.</td>
<td></td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>C. Track same-day appointment requests.</td>
<td></td>
<td></td>
<td>✓</td>
</tr>
<tr>
<td>D. Capacity to receive direct e-messaging from patients.</td>
<td></td>
<td></td>
<td>✓</td>
</tr>
<tr>
<td>E. Childhood / Adult Vaccination Practice Strategy.</td>
<td></td>
<td></td>
<td>✓</td>
</tr>
<tr>
<td>F. Join SHARE or participate in a network that delivers hospital discharge information to practice within 48 hours.</td>
<td></td>
<td></td>
<td>✓</td>
</tr>
<tr>
<td>G. Medication Management</td>
<td></td>
<td></td>
<td>✓</td>
</tr>
</tbody>
</table>
H. Care Plans for High Priority Patients

I. Patient Literacy Assessment Tool

J. Ability to receive patient feedback

K. Care instructions for High Priority Patients

L. 10-day Follow up after an Acute Inpatient Stay

M. Developmental / Behavior Health Assessment for Children and Adolescents

<table>
<thead>
<tr>
<th>Details on Activities Tracked for Practice Support</th>
</tr>
</thead>
</table>

**Activity A: Identify top 10% of high-priority patients**

<table>
<thead>
<tr>
<th>Activity A Deadline: 3/31/2020</th>
</tr>
</thead>
</table>

1. Perform this by using:
   
   a. DMS patient panel data that ranks patients by risk at beginning of performance period; and/or,

   b. The practice’s patient-centered assessment to determine which patients are high-priority.

2. Submit this list to DMS via the provider portal.
ConnectCare online PCP assignment process

Primary care providers (PCPs) can now submit DMS-2609 PCP assignment/change requests to ConnectCare via an online web page.

Types of PCP change forms that should be sent to ConnectCare using the web page are assignment/change requests for beneficiaries who need to be assigned to your PCP within the last 90 days and the PCP has a full caseload or age range which you need overridden and the beneficiary assigned to the PCP.

In order to set up your clinic to use the online process, please contact your AFMC provider relations outreach specialist who will assist you in setting up your clinic’s online account.

Helpful hints for use with the online DMS-2609 PCP assignment/change request process:

- **Make sure the DMS-2609 form is filled out completely** (if no beneficiary email is available, this spot will need to be left blank).
- The request for assignment must be submitted in the online system within 30 days of the date the patient/legal guardian signed the DMS-2609.
- The date of assignment requested should be within 90 days of the date the DMS-2609 was signed by patient/legal guardian.
- You must use the clinic email address you gave your AFMC provider relations outreach specialist when you set up your online account to submit PCP change requests through the website. Otherwise the request will not be received by ConnectCare.
- The reply from ConnectCare should have a confirmation number related to the entry that was made, as ConnectCare can’t send patient name/PHI information back to you. This is the only way to confirm or track the information entered.
- If you don’t receive a reply to your submitted request as being received by ConnectCare, please contact your AFMC provider relations outreach specialist.
- Please don’t share your clinic’s PCP change form web link with other provider groups. This is specific to your clinic PCPs.
- If the date of assignment needed is farther back than 90 days, you will need to note on the PCP change form the reason for needing the assignment backdated farther than 90 days and contact your AFMC provider relations outreach specialist for direction. Do not submit the PCP change form to ConnectCare.
ConnectCare Caseload Maximum and PCP Caseload Limits: All Medicaid Manuals, Section 171.210

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.
To: All XDEA Waivered Prescribers  
From: Division of Medical Services

Effective Jan. 1, 2020, Arkansas Medicaid is putting measures in place to comply with Act 964 of 2019 regarding Medication Assisted Treatment (MAT). Pursuant to this act, Medicaid will remove the prior authorization requirement on the following drugs used to treat opioid use disorder:

- Suboxone film (buprenorphine/naloxone sublingual film)
- Buprenorphine sublingual tablets

In order to receive MAT, a client must have a valid prescription, and the treatment must follow the guidelines issued by the Substance Abuse and Mental Health Services Administration (SAMHSA) that are current as of the date of treatment. Medical necessity reviews will be conducted in accordance with SAMSHA guidelines. For more information on these guidelines, please visit SAMSHA’s website.

Medicaid will conduct webinars and work with third-party oversight agencies to increase compliance and educate providers on how to access MAT and comply with SAMSHA guidelines.

If you have additional questions or need assistance, please contact your AFMC Provider Relations outreach specialist.

Sincerely,
AFMC Provider Relations
Steps to Obtain Your MAT Waiver

1. **Check Your Eligibility**
   To apply for a waiver you must have a valid medical license and an active DEA number. Apply for a DEA number with Drug Enforcement Agency’s Diversion Control Division (Registration Support) [here].

2. **Take 8-hour MAT waiver training**
   PCSS offers for FREE the required 8-hour medication assisted treatment (MAT) training on [PCSS].

3. **Complete your Notification of Intent (NOI) Form**
   Once you have finished the 8-hour MAT waiver training, complete the NOI form [online] and submit it to the Substance Abuse and Mental Health Services Administration (SAMHSA) for review.

4. **Forward your Certificate of Completion to SAMHSA**
   When you complete the 8-hour waiver training, PCSS will send you via email your Certificate of Completion. Email the certificate to SAMHSA.

Once SAMHSA has obtained all documentation, the process may require up to 45 days.
Steps to Obtain Your MAT Waiver

1. Check Your Eligibility
   To apply for a waiver you must have a valid medical license and an active DEA number. Apply for a DEA number with Drug Enforcement Agency’s Diversion Control Division (Registration Support) here.

2. Take 24 hours of required MAT waiver training
   PCSS offers for FREE the required 24 hours of medication assisted treatment (MAT) waiver training with continuing education (8- and 16-hour MAT waiver trainings).

3. Complete your Notification of Intent (NOI) Form
   Once you have finished the 24 hours of MAT waiver training, complete the NOI form online and submit it to the Substance Abuse and Mental Health Services Administration (SAMHSA) for review.

4. Forward your Certificates of Completion to SAMHSA
   When you complete the 8- and 16-hour MAT waiver trainings, PCSS will send you via email your Certificates of Completion for each. Email the certificates to SAMHSA.

Once SAMHSA has obtained all documentation, the process may require up to 45 days.
Steps to Obtain Your MAT Waiver

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Funding for this initiative was made possible (in part) by grant no. 5U79TI26554 from SAMHSA. The views expressed in written conference materials or publications and by speakers and moderators do not necessarily reflect the official policies of the Department of Health and Human Services; nor do they represent endorsement by the U.S. Government.
All Arkansans have access to mental health & addiction services.

- Individual & Group Counseling
- Family Counseling
- Substance Abuse & Addiction Counseling & Treatment
- Parent & Child Counseling for Children Under 4
- Medication Management
- Help During a Mental Health Crisis

If you have Medicaid, or are without insurance coverage and can’t pay for treatment on your own, you can get counseling and treatment services paid for by the state.

Visit humanservices.arkansas.gov/about-dhs/daabhs/mentalhealth for more information.

**Steps to Access Care**

1. **Call the DHS Mental Health & Addiction Services Support Line**
   - Available: Monday - Friday 8 a.m. - 4:30 p.m.
   - 1-844-763-0198

2. Let person answering phone know if you have insurance. It’s okay if you don’t.

3. Choose a provider to call for an appointment.
   - **TIP:** You might want to call all of the choices to get the soonest available appointment. For counseling services, providers are expected to see you within 10 days.

4. At your first appointment, you will meet your provider who will talk with you and decide what services you may need.
   - **TIP:** Bring a list of your doctors and the medications you are taking.

5. Some providers may require proof of income and a small payment at the time of services. Ask if your provider has a sliding fee scale based on income.
# Arkansas Community Mental Health Center Directory

<table>
<thead>
<tr>
<th>Area</th>
<th>Provider</th>
<th>Telephone</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Ouachita Behavioral Health and Wellness</td>
<td>501-624-7111</td>
</tr>
<tr>
<td>2</td>
<td>Counseling Associates, Inc.</td>
<td>501-336-8300</td>
</tr>
<tr>
<td>3</td>
<td>Counseling Clinic, Inc.</td>
<td>501-315-4224</td>
</tr>
<tr>
<td>4</td>
<td>Delta Counseling Associates</td>
<td>870-367-2461</td>
</tr>
<tr>
<td>5</td>
<td>Western Arkansas Counseling &amp; Guidance Center</td>
<td>479-452-6650</td>
</tr>
<tr>
<td>6</td>
<td>Centers for Youth and Families</td>
<td>501-666-8686</td>
</tr>
<tr>
<td>7</td>
<td>Mid-South Health Systems, Inc.</td>
<td>870-972-4000</td>
</tr>
<tr>
<td>8</td>
<td>Ozark Guidance Center, Inc.</td>
<td>479-750-2020</td>
</tr>
<tr>
<td>9</td>
<td>Professional Counseling Associates</td>
<td>501-221-1843</td>
</tr>
<tr>
<td>10</td>
<td>South Arkansas Regional Health Center</td>
<td>870-862-7921</td>
</tr>
<tr>
<td>11</td>
<td>Southeast Arkansas Behavioral Healthcare System, Inc.</td>
<td>870-534-1834</td>
</tr>
<tr>
<td>12</td>
<td>Southwest Arkansas Counseling &amp; Mental Health Center, Inc.</td>
<td>870-773-4655</td>
</tr>
</tbody>
</table>
How Does Naloxone Reverse An Overdose?

Naloxone, an opioid antagonist, is a medication used to reverse the effects of an opioid-induced overdose. Though it should be used in an emergency situation (a suspected opioid overdose), Naloxone has no effect on non-opioid overdoses. Naloxone is available for purchase at some pharmacies throughout Arkansas.

To reduce the morbidity and mortality of opioid overdoses in Arkansas, Arkansas Governor Asa Hutchinson has a standing order allowing Arkansas-licensed pharmacists to initiate naloxone therapy including ordering, dispensing and/or administering naloxone, along with any necessary supplies for administration, to eligible persons who are at risk of experiencing an opioid-related overdose, or who are family members, friends, or others who are in a position to assist a person at risk of experiencing an opioid-related overdose.

[This standing order was issued pursuant to Act 284 of 2017 (SB 142) [Arkansas Code § 17–92–101(16)] to authorize licensed pharmacists in Arkansas to order, dispense and/or administer naloxone according to the provisions of Arkansas Code § 17–92–101(16) and the requirements of this standing order.]

The Arkansas State Board of Pharmacy has compiled a variety of resources to assist in this initiative, including a copy of the protocol that pharmacists should use in naloxone distribution. The complete list of resources can be found here: http://www.pharmacyboard.arkansas.gov/naloxone. The U.S. Attorney General also has a public health advisory to urge more Americans to carry Naloxone.
State-Targeted Response grant funded treatment facilities in Arkansas

The facilities are funded for observational detox programs. In addition, Quapaw House has a medical detox program. The STG-grant funded facilities are providing (1) Substance Abuse assistant treatment & (2) Medicated assistance treatment.

*Seeking treatment? Substance abuse treatment may be provided in a person's catchment area (with financial criteria requirements).

---

1. Ozark Guidance Counseling
   - Contact Information: 2400 S. 48th Streeet
     Springdale, AR 72762
     479-756-2020
     www.ozarkguidance.org
   - Counties: Baxter, Benton, Boone, Carroll, Madison, Marion, Newton, Washington

2. Counseling Associates
   - Contact Information: 150 Salem Road, Suite 1
     Conway, AR 72034
     501-324-4300
     www.counselingassociates.org
   - Counties: Cleburne, Searcy, Stone, Van Buren

3. Northeast Arkansas Community Center d/b/a Mid-South Health Systems
   - Contact Information: 2707 Brownsville Road
     Jonesboro, AR 72401
     870-972-4000
     www.mhsri.org
   - Counties: Craighead, Clay, Cross, Crittenden, Fulton, Greene, Independence, Jackson, Lawrence, Lee, Mississippi, Monroe, St. Claire, St. Genevieve, Scott, St. Louis, Union

4. 10th District Substance Abuse Program d/b/a New Beginnings C.A.S.A.
   - Contact Information: 402 York Street
     Warren, AR 72681
     870-722-7979
     www.nobase.org
   - Counties: Arkansas, Ashley, Bradley, Chicot, Cleveland, Desha, Drew, Grant, Jefferson, Lincoln

5. Quapaw House
   - Contact Information: 812 Mountain Pine Road
     Hot Springs, AR 71901
     501-977-4856
     www.quapawhouseinc.org
   - Counties: Conway, Clark, Faulkner, Garland, Hot Springs, Johnson, Montgomery, Pope, Perry, Pike, Yell

6. Southwest Arkansas Counseling and Mental Health Center (SWACHC)
   - Contact Information: 2904 Arkansas Blvd
     Texarkana, AR 71854
     870-733-4655
     www.swachc.com
   - Counties: Caddo, Chad, Dallas, Howard, Hempstead, Little River, Lafayette, Miller, Nevada, Ouachita, Saline, Union
AR-IMPACT (Improving Multi-disciplinary Pain Care and Treatment) is a free program designed to help health care providers better manage their chronic pain patients and those who need their opioid dosage reduced.

AR-IMPACT was launched through a partnership between UAMS, the Arkansas Medical Society, the Arkansas Academy of Family Medicine, the Arkansas Department of Health, and the Arkansas State Medical Board. It is also possible through the generosity of Arkansas Blue Cross and Blue Shield and the Office of the State Drug Director.

**CONTACT US**

To contact the AR-IMPACT team, get on their distribution list or to request a video conference on a certain topic, e-mail us at [AR-IMPACT@uams.edu](mailto:AR-IMPACT@uams.edu) or follow us on Twitter: [@ArkansasImpact](https://twitter.com/ArkansasImpact)

Follow us on Facebook at [www.facebook.com/ArkansasImpact/](https://www.facebook.com/ArkansasImpact/)
MATRIARC (Medication Assisted Treatment Recovery Initiative for Arkansas Rural Communities) is a partnership with the Psychiatric Research Institute and the Arkansas Department of Human Services designed to expand evidence-based treatment for opioid use disorders.

An addiction psychiatrist is available free of charge via telephone to offer consultations to primary care physicians, general psychiatrists, advanced practice nurses, physician assistants and mental health professionals providing medication-assisted treatment to patients dealing with opioid use disorder.

The service is available Monday through Friday, from 8:30 a.m. to 4:30 p.m., excluding state holidays. Call (501) 526-8459 or (833) 872-7404 to speak to a trained addiction specialist.
Project ECHO

Project ECHO is part of MATRIARC, weekly video conferences available to community health centers needing assistance in opioid addiction treatment. Video conferences are held each Friday from noon to 1 p.m., with experts in addiction, therapy and case management discussing a variety of subjects related to opioid abuse.

Participants also have the opportunity for in-person telemedicine consultations with an addiction psychiatrist from PRI’s Center for Addiction Services Treatment program. To connect to the video conference, e-mail video@uams.edu or call (501) 686-8666.

For more information, contact Anner Douglas at ADouglas2@uams.edu or (501) 526-8459, (833) 872-7404.
What’s New for Arkansas Medicaid Providers

- [https://medicaid.mmis.arkansas.gov/Provider/Provider.aspx](https://medicaid.mmis.arkansas.gov/Provider/Provider.aspx)

**MUMP Prior Authorization Extensions**

Added 12/26/19

Beginning 01/29/2020 the process that providers currently use to request additional days on an existing Inpatient Stay Prior Authorization will change. After 01/28/2020 providers will no longer use the PA process Type “Inpatient Extensions” when needing to request additional days be added to an existing PA. The provider will now go to the current approved Inpatient Stay PA and request additional days by adding a line item for the additional days being requested.

**Provider Electronic Solutions (PES) Transition**

Updated 12/19/19

DXC Technology’s Medicaid software, Provider Electronic Solutions (PES), enables health care providers to verify beneficiary eligibility, request prior authorizations, and submit claims electronically. However, because PES software will be decommissioned, providers who use PES are strongly encouraged to transition to the Arkansas Medicaid HealthCare Provider Portal before their software becomes obsolete.

**Global OB Billing**

Updated 12/4/19

All Arkansas OB/Gyn Medicaid Providers:

Below are changes to Global OB Billing for claims. This change becomes effective with claims billed on or after January 1, 2020.

- The fee schedules and reimbursement rules will remain the same for all Global OB services.
- A new selection will be added in the drop-down box for “Date Type” called “Initial Treatment Date” in the Claim Information panel of a professional claim in the provider portal.
- For electronic claims, the first date of care will be billed in the Initial Treatment Date field of the professional claim form.
- For CMS 1500 paper claim forms, field 15 will be utilized for required qualifier of “454” and the “Initial Treatment Date”.
- If no Initial Treatment Date or an Invalid date is entered on either paper or electronic claim forms, an edit will set and deny the detail with the global procedure code on the claim.
- The provider will no longer span dates of service on the claim line for the entire Global OB period of care.
- Providers will bill the date of delivery on the claim line (as “from” and “to” Dates of Service)
The system will use the date of delivery and the first date of care to calculate and ensure that at least two months of care were given, thereby allowing payment for the Global OB service that was billed. If two months of care were not provided, the Global OB service will be denied; claims that fall into this category today are denied if two months of care were not provided.

If a Date of Service is a “spanned date” for a Global OB procedure billed, the detail will deny.

Added 12/5/19
Assessment Dates Available on Portal Eligibility Check

Effective 12/5/19 Behavioral Health Independent Assessment effective dates (both from and to) for PASSE members will be available on the Provider Portal Eligibility check.