SECTION II - ARKIDS FIRST - B

CONTENTS

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200.000 ARKIDS FIRST-B GENERAL INFORMATION

200.100 Introduction 2-1-10

Act 407 of 1997 established the ARKids First-B Program to extend health care coverage to Arkansas' uninsured children. The ARKids First-B Program integrates uninsured children into the health care system with benefits comparable to the state employees/teachers insurance program.

ConnectCare is the Primary Care Physician Managed Care Program utilized by the Arkansas Medicaid Program for the ARKids First-B Program. ARKids First-B providers must be enrolled in the Arkansas Medicaid Program and are bound by all policies and regulations in their respective Arkansas Medicaid provider manual, in addition to the policies and regulations of the ARKids First-B Program.

200.110 ARKids First-A and ARKids First-B 1-1-23

Medicaid-eligible children in the SOBRA eligibility category for pregnant women, infants, and children (category 61 PW) and newborn children born to Medicaid-eligible mothers (categories 52 and 63), are known as ARKids First-A clients. Uninsured, non-Medicaid-eligible children that meet additional established eligibility requirements will have health coverage under ARKids First-B, a CHIP separate child health program. All ARKids First clients will receive a program identification card without indication of level of coverage (either ARKids First-A or ARKids First-B).

A Medicaid eligibility verification transaction response either through the provider portal via the web or through the Voice Response System (VRS) will indicate that the individual is either an ARKids First-A client or an ARKids First-B client. The response will also indicate that cost sharing may be required for ARKids First-B clients. Refer to Section I of the Arkansas Medicaid provider manual for automated eligibility verification procedures.

When a child presents as an ARKids First-A eligible client, the provider must refer to the regular Medicaid provider policy manuals. When an ARKids First-B eligible client is identified, the

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provider must refer to the ARKids First-B Provider Manual for determination of levels of coverage, as well as the associated Medicaid provider policy manuals for the services provided.

200.200 Eligibility 7-1-20

Eligibility criteria for ARKids First-B are:

A. Family income must be above 142% and not exceed 211% plus five-percent (5%) disregard (216%) of the federal poverty level;

B. Applicants must be age eighteen (18) and under;

C. Applicants must have had no health insurance that covers comprehensive medical services, other than Medicaid, within the preceding ninety (90) days (unless insurance coverage was lost through no fault of the applicant);

D. Applicants whose health insurance is inaccessible are considered uninsured. An example of "inaccessible" is when an out of state, non-custodial parent, has HMO insurance for his or her children but the HMO network does not contain medical providers where the children reside; and

E. Children who do not have primary comprehensive health insurance or have non-group or non-employer-sponsored insurance, are considered to be uninsured. Primary comprehensive health insurance is defined as insurance that covers both physician and hospital charges.

An application must be completed by the applicant or family. Application forms are available at local Department of Human Services (DHS) county offices, Arkansas Department of Health local health units, churches, licensed day care centers, hospitals, selected physician offices and clinics, public schools, community and neighborhood centers, and pharmacies. Applicants may call the ARKids First-B toll free number or complete an online request by **visiting the Arkansas Medicaid website** to have an application mailed to them. **View or print the ARKids First-B telephone number.**

The State has assigned Aid Category 01 to ARKids First-B beneficiaries. The Aid Category Description for ARKids First-B beneficiaries is AK.

A Medicaid eligibility verification transaction response either through the provider portal via the web or through the Voice Response System (VRS) will indicate that the individual is an ARKids First-B beneficiary. The response will also indicate that cost sharing may be required. Refer to Section I of the Arkansas Medicaid provider manual for automated eligibility verification procedures.

200.300 ARKids First-B Identification Card 2-1-10

When eligibility is established, an ARKids First beneficiary receives an identification (ID) card for eligibility verification. New beneficiaries, in both the ARKids First-A and the ARKids First-B Programs, will be issued a generic ARKids First ID card. The card will not identify the beneficiary's program as an ARKids First-A, nor an ARKids First-B. The ID card beneficiary identification number will indicate the A or B status for an ARKids First beneficiary when the provider verifies eligibility at the time of each visit.

200.310 When a Beneficiary's ARKids First Eligibility Changes 2-1-10

The beneficiary's Medicaid ID number will not change when he or she moves from A to B or from B to A within the ARKids First umbrella program. The beneficiary will not be issued a new card when the change occurs. Existing ID cards will not be replaced, so it will not be possible for a provider to determine by viewing the ID card whether payment is eligible in the ARKids First-B program that requires additional cost-sharing or the ARKids First-A program.

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200.320 Provider Verification of Eligibility 7-1-20

The ARKids First identification card does not guarantee an individual's eligibility. Payment is subject to verification that the beneficiary is eligible at the time services are provided. It is crucial to the provider that eligibility is determined at each visit.

Eligibility verification transactions may be made through the provider portal via the web or through the Voice Response System (VRS). Refer to Section I of the Arkansas Medicaid provider manual for automated eligibility verification procedures.

200.330 ARKids First ID Card Example 7-1-04

View or print the ARKids First ID card example.

200.340 Non-Receipt or Loss of ID Card 2-1-10

When ARKids First-B beneficiaries report non-receipt or loss of an ID card, refer the beneficiary to the DHS County Office or the Division of County Operations, Customer Assistance. **View or print the Division of County Operations - Customer Assistance Section Contact Information.**

201.000 Electronic Signatures 10-8-10

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

210.000 PROGRAM POLICY

211.000 Provider Participation Requirements 11-1-06

ARKids First-B providers must meet the Provider Participation and enrollment requirements contained within Section 140.000 of this manual. Refer to Section II of the appropriate provider manual for additional provider participation requirements.

The ARKids First-B Provider Manual is supplied to indicate the services available to beneficiaries in the ARKids First-B Waiver Program, with some differences in requirements from the services available to the regular Medicaid population. If a service is not addressed in this manual, the information supplied in the appropriate provider manual applies.

220.000 COVERAGE

221.000 Scope 4-1-09

Covered services provided to ARKids First-B beneficiaries are within the same scope of services provided to Arkansas Medicaid ARKids First –A beneficiaries. However, some services are subject to different levels of benefits and cost sharing amounts are applied. Refer to the appropriate Arkansas Medicaid provider manual for the scope of each service covered under the ARKids First Program. See Section 221.100 of this manual for a listing of ARKids First-B Medical Care Benefits that indicate restrictions and required co-payment/co-insurance or cost-sharing amounts for covered services.

ARKids First-B beneficiaries receive preventive health care screens and treatment options within covered benefits. ARKids First-B beneficiaries are not entitled to the same benefits as children under the Arkansas Medicaid Child Health Services (EPSDT) Program and may not be billed as an EPSDT screen.

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221.100 ARKids First-B Medical Care Benefits 8-1-24

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

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

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

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

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

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

***ARKids First-B beneficiaries will pay a maximum of $5.00 per prescription. The beneficiary will pay the provider the amount of co-payment that the provider charges non-Medicaid purchasers up to $5.00 per prescription. For billing information to include Continuous Glucose Monitors (CGM), CGM supplies, patch or tubeless insulin pumps, blood glucose monitors (BGMs), and glucose testing supplies see the **DHS contracted Pharmacy Vendor's website**.

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

221.200 Exclusions 2-1-22

Services Not Covered for ARKids First-B Beneficiaries:

Adult Development Day Treatment (ADDT)

Audiological Services; EXCEPTION, Tympanometry, CPT procedure code*, when the diagnosis is within the ICD range. (**View ICD codes**.)

Child Health Services/Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)

Diapers, Underpads, and Incontinence Supplies

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Early Intervention Day Treatment (EIDT)

End Stage Renal Disease Services

Hearing Aids

Hospice

Hyperalimentation

Non-Emergency Transportation

Nursing Facilities

Orthotic Appliances and Prosthetic Devices

Personal Care

Private Duty Nursing Services

Rehabilitative Services for Children

Rehabilitative Services for Persons with Physical Disabilities (RSPD)

Targeted Case Management

Ventilator Services

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

222.000 Benefits - ARKids First-B Program

222.100 Medical Supplies Benefit 4-1-09

Only Prosthetics Program and Home Health Program providers may bill for items in the medical supplies category. Refer to Section 262.110 of this manual for a listing of medical supplies covered for ARKids First-B beneficiaries. Medical supplies benefits are $125.00 per month, per beneficiary. The $125.00 may be provided by the Home Health Program, the Prosthetics Program or a combination of the two. However, an ARKids First-B beneficiary may not receive more than a total of $125.00 of supplies per month unless extended benefits have been requested and granted. An extension of the $125.00 per month benefit may be considered when medically necessary. Refer to the respective Arkansas Medicaid Provider Manual for procedures regarding requests for extended benefits for medical supplies.

222.200 Durable Medical Equipment (DME) Benefit 7-1-11

Durable Medical Equipment (DME) benefit for ARKids First-B beneficiaries is $500.00 per state fiscal year (July 1 through June 30). There is a 10% co-insurance per item. DME may be billed by providers enrolled in the Prosthetics Program.

Refer to Section 262.120 of this manual for a listing of DME items covered by the ARKids First-B Program.

222.300 Dental Services Benefit 2-1-22

Dental services benefits for ARKids First-B beneficiaries are one periodic dental exam, bite-wing x-rays, and prophylaxis/fluoride treatments every six (6) months plus one (1) day. Scalings are covered once per State Fiscal Year (SFY). Orthodontia services are also covered for ARKids First-B beneficiaries.

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The **procedure codes listed in Section 262.150** may be billed for the periodic dental exams, interperiodic dental exams and prophylaxis/fluoride, and orthodontia services for ARKids First–B beneficiaries.

Refer to Section II of the Medicaid Dental Provider Manual for a complete listing of covered dental and orthodontia services. Procedures for dental treatment services that are not listed as a payable service in the Medicaid Dental Provider Manual may be requested on individual treatment plans for prior authorization review. These individually requested procedures and dental and orthodontia treatment services are subject to determination of medical necessity, review and approval by the Division of Medical Services dental consultants.

222.400 Vision Care Benefit Limit 4-1-09

One routine eye exam (refraction) every twelve months is covered for ARKids First-B beneficiaries.

Refer to Section II of the Visual Care Provider Manual for a complete listing of covered visual services.

222.500 Home Health Benefit 4-1-09

Home Health benefits for ARKids First-B beneficiaries are 10 visits per state fiscal year (July 1 through June 30). The 10 visits may be provided by a registered nurse or licensed practical nurse or a combination of the two. However, an ARKids First-B beneficiary will not have coverage for more than 10 visits per state fiscal year.

Refer to Section II of the Home Health Provider manual for further coverage details and billing procedures.

See Section 222.100 regarding benefits for medical supplies.

222.600 Occupational, Physical, and Speech-Language Therapy Benefits 1-1-21

Occupational, physical, and speech-language therapy services are available to beneficiaries in the ARKids First-B program and must be performed by a qualified, Medicaid participating Occupational, Physical, or Speech-Language Therapist. A referral for an occupational, physical, or speech-language therapy evaluation and prescribed treatment must be made by the beneficiary's PCP or attending physician if exempt from the PCP program. All therapy services for ARKids First–B beneficiaries require referrals and prescriptions be made utilizing the "Occupational, Physical and Speech Therapy for Medicaid Eligible Beneficiaries Under Age 21" form DMS-640. **View or print form DMS-640.**

Occupational, physical, and speech-language therapy referrals and covered services are further defined in the Physicians and in the Occupational, Physical, and Speech-Language Therapy Provider Manuals. Physicians and therapists must refer to those manuals for additional rules and regulations that apply to occupational, physical, or speech-language therapy services for ARKids First–B beneficiaries.

ARKids First-B has the same occupational, physical, and speech-language therapy services benefits as Arkansas Medicaid, which are found in the procedure codes for therapy services. **View or print the procedure codes for therapy services**.

All requests for extended therapy services must comply with the guidelines located within the Occupational, Physical, and Speech-Language Therapy Provider Manual.

222.700 Preventive Health Screens

222.710 Introduction 2-1-22

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

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

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

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

Newborn screens do not require PCP referral.

Certified nurse-midwives may provide newborn screens ONLY.

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

222.720 Hearing Screens 4-1-09

A hearing risk assessment is required for all children receiving a periodic complete medical preventive health screen. Medical screening providers must administer an age-appropriate hearing assessment. The age-specific procedures (Sections 222.810 – 222.850) may be helpful to determine the necessary procedures according to the child's age. Consult with audiologists or the Department of Education to obtain appropriate procedures to use for screening and methods of administering the risk assessment screens. This screening does not require machine audiology testing. Subjective testing may be provided as part of a hearing screening.

222.730 Vision Screens 4-1-09

A vision risk assessment is required for all children receiving a complete medical preventive health screen. The age-specific procedures (Sections 222.810 – 222.850) may be helpful to determine the necessary procedures according to the child's age. This screening does not require Titmus machine or other ophthalmological testing. Subjective testing may be provided as part of a vision screening. However, a vision risk assessment does not substitute for a full periodic preventive vision screen through a Medicaid participating vision provider.

A full annual vision screening by a Medicaid participating vision provider is exempt from the PCP referral requirement (see Section 222.400). When a full annual vision periodicity schedule screen coincides with the schedule for a periodic complete medical preventive health screen, the different screens may not be performed on the same day, or within seven (7) days of each other without claim denial citing duplication of services.

222.740 Preventive Dental Screens 4-1-09

An oral assessment is considered part of the complete medical preventive health screen; however, an oral assessment may not substitute for a full periodic preventive dental examination through a Medicaid dental provider. Assistance with establishing a dental home for the beneficiary is included as part of the medical screen. A PCP referral is not required for dental services provided by a Medicaid participating dentist; see Section 222.300 for further details on the dental services available to ARKids First – B beneficiaries. See Section 262.150 for

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procedure codes used by a Medicaid dental provider to bill for ARKids First-B preventive dental services.

222.750 Health Education 2-1-22

Health education is a required component of screening services and includes anticipatory guidance. The developmental assessment, comprehensive, physical examination, and the visual, hearing or dental screening provide the initial opportunity for providing health education. Health education and counseling to parents (or guardians) and children are required. Health education and counseling are designed to assist in understanding what to expect in terms of the child's development and to provide information about the benefits of healthy lifestyles and practices, as well as accident and disease prevention. **See Section 262.130** for procedure codes.

Health education can include but isn't limited to tobacco cessation counseling services to the parent/legal guardian of the child.

A. Counseling Visits (two (2) per SFY).

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

* Exempt from PCP referral requirements.

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

B. Referral of patient to an intensive tobacco cessation referral program.

C. These counseling sessions can be billed in addition to an office visit or EPSDT.

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

E. Tobacco cessation sessions do NOT require a PCP referral.

F. The provider must complete the counseling checklist and place in the patient records for audit. **View or Print the Arkansas Be Well Referral Form**.

Refer to Section 257.000 and Section 292.900 of the Primary Care Physician manual for more information.

222.800 Schedule for Preventive Health Screens 1-1-24

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. One visit per birth year for children ages 3 years through 18 years.

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Age			
3 years	7 years	11 years	15 years
4 years	8 years	12 years	16 years
5 years	9 years	13 years	17 years
6 years	10 years	14 years	18 years

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.

222.810 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 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) 1-1-24

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

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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 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. One (1) Developmental Screen to be performed before age 12 months using a validated tool recommended by the American Academy of Pediatrics in alignment with the Bright Futures Periodicity Schedule. **View the Bright/AAP Periodicity Schedule**. Children may not receive more than one screen without an extension of benefits.

222.830 Early Childhood (Ages 12 Months–4 Years) 4-1-24

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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 ages 30 months*, 3 and 4 years.

   *Note: For infants and children with specific risk conditions.
4. BMI (Body Mass Index) at ages 24 and 30 months, 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 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.

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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. Two (2) Developmental Screens to be performed between the ages of thirteen (13) months to forty-eight (48) months and a third (3rd) developmental screen to be performed between forty-eight (48) and sixty (60) months using validated tools recommended by the American Academy of Pediatrics in alignment with the Bright Futures Periodicity Schedule. **View the Bright/AAP Periodicity Schedule**. An extension of benefits is required to bill more than one (1) screening per twelve (12) month period and more than three (3) total screens between thirteen (13) and sixty (60) months of age.

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) 1-1-20

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.

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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.

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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.

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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.

222.900 Substance Abuse Treatment Services 8-1-18

Substance abuse treatment services have been integrated into the Outpatient Behavioral Health Services system. Refer to Section II of the Outpatient Behavioral Health Services manual for service definitions, information regarding reimbursement, PCP referral, extension of benefit requirements and other information.

223.000 Extended Benefits

223.100 Medical Supplies Extended Benefits 4-1-09

Beneficiaries in the ARKids First-B Program are allowed a monthly benefit of $125.00 for medically necessary medical supplies (see Section 222.100). Covered medical supplies are listed in Section 262.110 of this manual. In unusual circumstances, when a beneficiary's condition requires additional medical supplies that exceed the monthly benefit, the provider may request extended benefits. To apply for extended benefits for medically necessary medical supplies, Prosthetics and Home Health Providers must refer to and adhere to guidelines detailed in their respective provider manuals.

223.200 Occupational, Physical and Speech Therapy Extended Benefits 8-1-15

If the referring PCP or attending physician, in conjunction with the treating occupational, physical or speech therapy provider, determines the beneficiary requires additional daily speech therapy services other than those allowed through regular benefits indicated in Section 222.600, a request for extended therapy services may be made. The therapist must refer to the guidelines in the Occupational, Physical and Speech Therapy Provider Manual to properly apply for extended benefits.

224.000 Cost Sharing 2-1-22

Co-payment or coinsurance applies to all ARKids First-B services, with the exception of immunizations, preventive health screenings, family planning, prenatal care, eyeglasses, medical supplies and audiological services (only Tympanometry, CPT procedure code, when the diagnosis is within the ICD range (**View ICD codes**.)).

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

Co-payments or coinsurances range from up to $5.00 per prescription to 10% of the first day's hospital Medicaid per diem.

ARKids First-B families have an annual cumulative cost sharing maximum of 5% of their annual gross family income. The annual period is July 1 through June 30 SFY (state fiscal year). The ARKids First-B beneficiary's annual cumulative cost sharing maximum will be recalculated and the cumulative cost sharing counter reset to zero on July 1 each year.

The cost sharing provision will require providers to check and be alert to certain details about the ARKids First-B beneficiary's cost sharing obligation for this process to work smoothly. The following is a list of guidelines for providers:

1. On the day service is delivered to the ARKids First-B beneficiary, the provider must access the eligibility verification system to determine if the ARKids First-B beneficiary has current ARKids First-B coverage and whether or not the ARKids First-B beneficiary has met the family's cumulative cost sharing maximum.

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2. The provider must check the remittance advice received with the claim submitted on the ARKids First-B beneficiary, which will contain an explanation stating that the ARKids First-B beneficiary has met their cost sharing cap.
3. It is strongly urged that providers submit their claims as quickly as possible to the Arkansas Medicaid fiscal agent for payment so that the amount of the ARKids First-B beneficiary's co-payment can be posted to their cost share file and the amount added to the accrual.

224.100 Co-payment 6-1-10

Refer to Section 221.100 of this manual for services that require a co-payment. Co-payments for ARKids First-B beneficiaries are up to $5.00 per prescription and $10.00 per visit for outpatient services and $10.00 per trip for Emergency Ambulance Services.

224.200 Co-insurance 2-1-10

Refer to Section 221.100 of this manual for services that require co-insurance.

224.210 Durable Medical Equipment Co-insurance 7-1-11

Durable Medical Equipment (DME) will require a co-insurance amount equal to 10% of the Medicaid allowed amount per item.

224.220 Inpatient Hospital Co-Insurance 8-1-15

The co-insurance charge per inpatient hospital admission (including services in an inpatient psychiatric hospital and a psychiatric residential treatment facility) for ARKids First-B beneficiaries is10% of the hospital's Medicaid per diem, applied on the first covered day. For example:

An ARKids First-B beneficiary is an inpatient for four (4) days in a hospital with an Arkansas Medicaid per diem of $500.00. When the hospital files a claim for four (4) days, ARKids First-B will pay $1950.00; the beneficiary will pay $50.00.

Four (4 days) times $500.00 (the hospital per diem) = $2000.00 (hospital allowed amount).

Ten percent (10% ARKids First-B co-insurance rate) of $500.00 = $50.00 co-insurance.

Two thousand dollars ($2000.00 hospital allowed amount) minus $50.00 (co-insurance) = $1950.00 (ARKids First-B payment).

The ARKids First-B beneficiary is responsible for paying a co-insurance amount equal to 10% of the per diem for one (1) day, which is $50.00 in the above example.

240.000 PRIOR AUTHORIZATION

240.050 Prior Authorization (PA) Procedures 2-1-10

Procedures requiring prior authorization (PA) in the Arkansas Medicaid Program also require PA for ARKids First-B beneficiaries. Refer to the appropriate Arkansas Medicaid Provider Manual for details.

Prior authorization is also required for interperiodic preventive dental screens. Refer to Section 240.200 for details.

240.100 Inpatient Hospital Medicaid Utilization Management Program (MUMP) 10-13-03

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Pre-certification of inpatient hospital stays applies to ARKids First-B-covered admissions in exactly the same manner as it applies to Medicaid-covered admissions. Refer to the Physician/Independent Lab/CRNA/Radiation Therapy Center Provider Manual and the Hospital/Critical Access Hospital/End-Stage Renal Disease Provider Manual for the pre-certification procedures.

240.200 Prior Authorization (PA) Process for Interperiodic Preventive Dental Screens 2-1-22

Prior authorization for procedure code, Interperiodic Dental Screening Exam, must be requested on the ADA claim form or online with a brief narrative through the Prior Authorization Manipulation (PAM) software. **View or print the Department of Human Services Medicaid Dental Unit Address.** Refer to your Arkansas Medicaid Dental Services Provider Manual for detailed information on obtaining prior authorizations.

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

Refer to Section 222.300 of this manual for coverage and Section 262.150 billing information.

240.300 Prior Authorization (PA) for Outpatient and Inpatient Mental Health Services 10-14-16

Certain outpatient and inpatient mental health services require prior authorization. See the appropriate provider manual for a list of procedure codes that require PA. Requests for PA must be sent to the PA contractor. **View or print current contractor contact information.**

240.400 Prior Authorization for Other Services 7-1-04

Prior authorization may be required for services that are not specifically mentioned in this manual. Refer to the appropriate Medicaid Provider Policy Manual for information.

241.000 Administrative Reconsideration and Appeals 6-1-25

A. Medicaid allows only one (1) reconsideration of an adverse decision. Reconsideration requests must be submitted in accordance with Section 160.000 of Section I of this Manual.

B. When the state Medicaid agency or its designee denies a reconsideration request or issues any adverse decision, the beneficiary may appeal and request a fair hearing. A request for a fair hearing must be submitted in accordance with Sections 160.000, 190.000, and 191.000 of Section I of this Manual.

250.000 REIMBURSEMENT

250.010 Reimbursement Introduction 2-1-10

Reimbursement for services provided to ARKids First-B beneficiaries is based on the current Medicaid reimbursement methodology of the corresponding Medicaid program or service.

ARKids First-B family's annual cost-sharing has a 5% maximum.

When Providers Are Required To Refund a Co-pay or Co-insurance:

Providers will be required to refund to ARKids First-B families the amount that the provider collected from the family for cost-sharing if, at the time the claim is submitted and processed, the system determines that the family's cumulative cost-sharing maximum has been met. This may happen even though the family was required to provide cost-sharing on the date of service when the provider waits a period of time to submit the claim to Medicaid.

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Example: The family has not met its cost-sharing maximum on the date of service. Therefore, the provider collects the required cost-share amount. The provider submits the claim two months later. In the interim, the family's annual cumulative cost-sharing maximum has been met and the family will not be required to cost-share again until the next SFY. The system cannot track cost-sharing until the claim is processed. In this case, even though the family was required to cost-share on the date of service, that amount is not in the system until the claim is processed. On the date the claim adjudicated, the family had met its obligation for cost-sharing (i.e. other claims were adjudicated). Therefore, the provider must refund to the family the amount that the family paid. There will be a statement on the remittance advice that the cost-sharing maximum has been met and that Medicaid is paying the full Medicaid allowed rate for the service.

250.020 Fee Schedules 12-1-12

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

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

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

260.000 BILLING PROCEDURES

261.000 Introduction to Billing 2-1-10

Billing procedures for services provided to ARKids First-B beneficiaries are the same as those for Medicaid covered services. Refer to Section II of the appropriate Arkansas Medicaid Provider Manual for billing procedures.

261.100 Timely Filing 10-13-03

The timely filing requirements outlined in Section III of your Arkansas Medicaid Provider Manual apply to the ARKids First-B Program.

262.000 ARKids First-B Billing Procedures

262.100 CPT and/or HCPCS Procedure Codes 12-15-12

National codes must be used for both electronic and paper claims. Where only a local code is available, it can be used indefinitely, but it can be billed only on a paper claim.

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

262.110 Medical Supplies Procedure Codes 2-1-22

The following medical supplies procedure codes may be billed by Medicaid-enrolled Home Health and Prosthetics providers for ARKids First-B beneficiaries.

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

NOTE: * must be prior authorized. Form DMS-679 must be used for the request for prior authorization. **View or print form DMS-679 and instructions for completion.**

**The costs are not subject to the $125 medical supplies monthly benefit limit.

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

262.120 Durable Medical Equipment (DME) Procedure Codes 2-1-22

The following DME HCPCS procedure codes may be billed with appropriate modifiers by Medicaid-enrolled prosthetics providers for ARKids First-B beneficiaries.

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

NOTES: Codes denoted with an asterisk * must be prior authorized. Form DMS-679A must be used for the request for prior authorization. **View or print form DMS-679A and instructions for completion.**

** Code must be prior authorized through the Division of Medical Services, Utilization Review. Form DMS-679 must be used for the request for prior authorization. **View or print form DMS-679 and instructions for completion.**

Codes denoted with ^ symbol are approved for special circumstance “Initial” billing (See Section 242.111 of the Prosthetics Medicaid Provider Manual for details regarding “initial” billing). These codes must be billed WITHOUT A MODIFIER to indicate the “Initial” bill circumstance applies – EXCEPTION – if a modifier KH is specifically indicated, that modifier must be used.

262.130 Preventive Health Screening Procedure Codes 2-1-22

There are two (2) types of full medical preventive health screening procedure codes to be used when billing for this service for ARKids First-B beneficiaries; Newborn and Child Preventive Health Screening:

1. ARKids First-B Preventive Health Screening: Newborn

   The initial ARKids First-B preventive health screen for newborns is similar to Routine Newborn Care in the Arkansas Medicaid Physician and Child Health Services (EPSDT) Programs.

   For routine newborn care following a vaginal delivery or C-section, procedure code, with the required modifier UA and a primary detail diagnosis (**View ICD codes**.) must be used one time to cover all newborn care visits by the attending provider. Payment of these codes is considered a global rate and subsequent visits may not be billed in addition to code. These codes include the physical exam of the baby and the conference(s) with the newborn’s parent(s), and are considered to be the Initial Health Screening.

   For newborn illness care, e.g., neonatal jaundice, following a vaginal delivery or C-section, use procedure codes range. Do not bill codes (routine newborn care) in addition to the newborn illness care codes.

2. ARKids First-B Preventive Health Screening: Children

   Preventive health screenings in the ARKids First-B Program are similar to EPSDT screens in the Arkansas Medicaid Child Health Services (EPSDT) Program in content and application. Billing, however, differs from Child Health Services (EPSDT). All services, including the preventive health medical screenings, are billed in the CMS-1500 claim format for both electronic and paper claims.

   All preventive health screenings after the newborn screen are to be billed using the preventive health screening procedure codes.

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Providers may bill ARKids First-B for a sick child visit in addition to a preventive health screen procedure code for the same date of service if the screening schedule indicates a periodic screen is due to be performed.

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

[1] Exempt from PCP referral requirements
[2] Covered when specimen is referred to an independent lab
[3] Arkansas Medicaid description of the service

Immunizations and laboratory tests procedure codes are to be billed separately from comprehensive preventative health screens.

Billing for ARKids First-B services, including preventive health medical screenings and ARKids First-B SCHIP vaccine injection administration fees, are to be billed in the CMS-1500 claim format ONLY; for both electronic and paper claims.

262.140 Speech-Language Pathology, Occupational, and Physical Therapy Procedure Codes

262.141 Occupational, Physical, and Speech-Language Pathology Therapy Procedure Codes 1-1-21

Occupational, physical, and speech-language therapy procedure codes can be found in the following link: **View or print the procedure codes for therapy services.**

262.150 Billing Procedure Codes for Periodic Dental Screens and Services and Orthodontia Services 2-1-22

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

A. Initial/Periodic Preventive Dental Screens

Periodicity schedule once each six months plus one day – must be billed with procedure code.

B. Interperiodic Preventive Dental Screens

ARKids First-B beneficiaries may receive interperiodic preventive dental screening, if required by medical necessity. There are no limits on these services; however, prior authorization must be obtained in order to receive reimbursement. Refer to Section 240.200 of this manual for dental prior authorization information.

Procedure code must be billed for an interperiodic preventive dental screen. **This service requires prior authorization (see Section 240.200)**.

The procedure codes listed in the table below must be billed for prophylaxis/fluoride.

Refer to Section 222.300 for further details regarding dental services for ARKids First–B beneficiaries.

C. Orthodontia Services

Comprehensive Orthodontic Treatment – Permanent Dentition

Other Orthodontic Devices

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Refer to Section II of the Medicaid Dental Provider Manual for service definitions, information regarding reimbursement, prior authorization and other information pertaining to orthodontic treatment.

262.200 National Place of Service Codes 7-1-07

Refer to the appropriate Arkansas Medicaid Provider Manual for instructions.

262.300 Billing Instructions – Paper Claims Only 10-13-03

Refer to the appropriate Arkansas Medicaid Provider Manual for instructions.

262.400 Billing Procedures for Preventive Health Screens 2-1-22

ARKids First-B reimburses providers for preventive health screenings performed at the intervals recommended by the American Academy of Pediatrics.

References in this section indicate that ARKids First-B preventive health screenings are similar to Arkansas Medicaid Child Health Services (EPSDT) screens in content and application.

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

However, please note this important distinction:

Claims for ARKids First-B preventive health screenings electronically or by paper must be billed in the CMS-1500 claim format.

NOTE: Certified nurse-midwives are restricted to performing the preventive health screen, Newborn, only, and must bill either code, with the required UA modifier, for initial newborn screen or codes for newborn illness care.

A Certified nurse-midwife may NOT bill procedure codes for child preventive health screens.

262.410 Primary Care Physician Referral Requirements for Preventive Health Screens 2-1-22

All preventive health screens for ARKids First-B beneficiaries must be provided by the primary care physician (PCP) of the beneficiary or by PCP referral to a qualified practitioner.

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

Newborn preventive health screens are exempt from the PCP referral requirement.

Immunizations for childhood diseases are exempt from the PCP referral requirement.

262.420 Limitation on Laboratory Procedures Performed During a Preventive Health Screen 2-1-22

ARKids First-B preventive health screens will not include laboratory procedures unless the screen is performed by the beneficiary's PCP, is conducted pursuant to a referral from the PCP or is included in the exceptions listed below.

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

Exceptions

The following tests are exempt from the above limitations and may continue to be billed in conjunction with a preventive health screen performed in accordance with existing Medicaid policy only if they are performed within seven (7) calendar days following the screen:

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Claims for laboratory tests, other than those specified above, performed in conjunction with a preventive health screen will be denied unless the screen is performed by the PCP or pursuant to a referral from the PCP.

262.430 Vaccines for ARKids First-B Beneficiaries 2-1-22

ARKids First-B beneficiaries are not eligible for the Vaccines for Children (VFC) Program; however, vaccines can be obtained to administer to ARKids First-B beneficiaries who are under the age of 19 by contacting the Arkansas Department of Health and indicating the need to order ARKids-B SCHIP vaccines. **View or print the Department of Health contact information.**

Only a vaccine injection administration fee is reimbursed. When filing claims for administering vaccines for ARKids First-B beneficiaries, providers must use the CPT procedure code for the vaccine administered and the required modifier SL only for either electronic or paper claims. Providers must bill claims for ARKids First-B beneficiaries using the CMS-1500 claim format.

The following list contains the SCHIP vaccines available to ARKids-First-B beneficiaries through the Arkansas Department of Health.

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

262.431 Billing of Multi-Use and Single-Use Vials 1-1-23

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

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

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

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

   1. **Single-Use Vials:** If the provider must discard the remainder of a **single-use vial** or other package after administering the prescribed dosage of any given drug, Arkansas Medicaid will cover the amount of the drug discarded along with the amount administered. Discarded drugs shall be billed on a separate detail line with a JW (Drug wastage) modifier.
   2. **Multi-Use Vials:** Multi-use vials are not subject to payment for any discarded amounts of the drug. The units billed must correspond with the units administered to the beneficiary.
   3. **Documentation:** The provider must clearly document in the patient’s medical record the actual dose administered in addition to the exact amount wasted and the total amount the vial is labeled to contain.

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

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

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