SECTION II - CERTIFIED NURSE-MIDWIFE

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Certified Nurse Midwife Service providers must meet the Provider Participation and enrollment requirements contained within Section 140.000 of this manual as well as the following criteria to be eligible to participate in the Arkansas Medicaid Program:

A. A current copy of the certified nurse-midwife license from the Arkansas State Board of Nursing must accompany the provider application and Medicaid contract.

B. The certified nurse-midwife who provides intrapartum care must have a consulting agreement with a Medicaid-enrolled physician and must furnish the name of the consulting physician with the provider application and the Medicaid contract.

1. The consulting physician must be available within thirty (30) minutes of the hospital admitting the certified nurse-midwife's laboring patients or within thirty (30) minutes of the alternative birth site if the patient is not transported to the hospital.

2. A licensed certified nurse-midwife will not be deemed an agent or employee of the physician solely on the basis of a collaborative or consulting physician agreement and will be enrolled as an independent provider with the Arkansas Medicaid Program in the category of Certified Nurse-Midwife.

C. Subsequent changes in the name of the consulting physician must be immediately provided to Arkansas Medicaid.

D. The certified nurse-midwife who has prescriptive authority must furnish the Certificate of Prescriptive Authority Number issued by the Arkansas State Board of Nursing with the provider application and Medicaid contract. Any changes in prescriptive authority must be immediately reported to Arkansas Medicaid.

202.001 Electronic Signatures 10-8-10

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

202.100 Group Providers of Certified Nurse-Midwife Services 10-13-03

Group providers of certified nurse-midwife services must meet the following criteria in order to be eligible for participation in the Arkansas Medicaid Program.

If a certified nurse-midwife is a member of a group of certified nurse-midwives, each individual certified nurse-midwife and the group must both enroll according to the following criteria:

A. Each individual certified nurse-midwife within the group must enroll following the criteria established in Section 202.000.

B. All group providers are “pay to” providers only. The service must be performed and billed by a licensed and enrolled certified nurse-midwife within the group.

202.200 Providers in Arkansas and Bordering States 7-1-06

A. Providers in Arkansas and the six bordering states may be enrolled in the Medicaid Program as routine services providers if they meet all Arkansas Medicaid participation requirements outlined in Section 202.000.

B. Reimbursement may be available for all covered certified nurse-midwife services in the Arkansas Medicaid Program. Claims must be filed according to billing procedures provided in this manual.

202.210 Routine Services Provider 10-1-15

A. A routine services provider may be enrolled in the Medicaid Program as a provider of routine services.

B. Reimbursement may be available for all certified nurse-midwife services covered in the Arkansas Medicaid Program.

C. Claims must be filed according to Section 270.000 of this manual. This includes assignment of ICD and HCPCS codes for all services rendered

202.300 Certified Nurse-Midwives in States Not Bordering Arkansas 3-1-11

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

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

B. Limited services providers remain enrolled for one year.

1. If a limited services provider provides services to another Arkansas Medicaid beneficiary during the year of enrollment and bills Medicaid, the enrollment may continue for one year past the most recent claim’s last date of service, if the enrollment file is kept current.

2. During the enrollment period, the provider may file any subsequent claims directly to the Medicaid fiscal agent.

3. Limited services providers are strongly encouraged to file subsequent claims through the Arkansas Medicaid website because the front-end processing of web-based claims ensures prompt adjudication and facilitates reimbursement.

202.310 Limited Services Provider 3-1-11

Limited services providers may be enrolled in the Arkansas Medicaid Program to provide prior authorized or emergency services only.

A. "Prior authorized services" are those that are medically necessary and not available in Arkansas. Each request for these services must be made in writing, forwarded to the Utilization Review Section and approved before the service is provided. **View or print the Utilization Review Section contact information.**

B. "Emergency services" are defined as inpatient or outpatient hospital services that a prudent layperson with an average knowledge of health and medicine would reasonably believe are necessary to prevent death or serious impairment of health and which, because of the danger to life or health, require use of the most accessible hospital available and equipped to furnish those services.
Source: 42 U.S. Code of Federal Regulations §422.2 and §424.101.

To enroll, an Arkansas Medicaid application and contract must be downloaded from the Arkansas Medicaid website and submitted to Arkansas Medicaid Provider Enrollment. A provider number will be assigned upon approval of the provider application and Medicaid contract. **View or print the provider enrollment and contract package (Application Packet).** **View or print Medicaid Provider Enrollment Unit contact information.**

Limited services provider claims will be manually reviewed prior to processing to ensure that only emergency or prior authorized services are approved for payment.

203.000 Required Medical Records 11-1-09

In addition to the conditions related to record keeping in Section 142.300 certified nurse-midwives are required to keep the following patient records:

1. History and physical examinations.
2. Appropriate diagnosis or chief complaint, when applicable, on each visit.
3. Tests and results.
4. Diagnoses.
5. Treatment, including prescriptions.
6. Signature or initials of the certified nurse-midwife after each visit.
7. Copies of records pertinent to services delivered by the certified nurse-midwife and billed to Medicaid.
8. Records must contain service dates of any services billed to Medicaid, including service dates for all components of global services billed.
9. Record of physician referral or consultation, if applicable.

204.000 Ambulance Services 4-30-10

Ambulance service for Medicaid beneficiaries is covered by Medicaid when the ambulance transportation is medically necessary, as determined by the certified nurse-midwife.

It is the responsibility of the transportation provider to maintain documentation that will verify the medical necessity of transportation provided.

204.100 Certified Nurse Midwife's Role in Home Health Services 7-1-17

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

1. Medicare/Medicaid dual-eligibles.
2. Obstetrician/gynecologists for postpartum complications.
3. To revise a plan of care during a period covered by a current referral; however, the agency must forward copies of the signed and dated assessment and the revision to the PCP.

B. A PCP may refer a beneficiary to a specific Home Health agency only if he or she ensures the beneficiary's freedom of choice by naming at least one alternative agency.

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

204.101 Documentation of Services 7-1-17

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

A. Patient assessments.

B. Plans of care.

C. Physical therapy evaluations.

D. Treatment plans when applicable.

E. Case notes.

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

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

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

1. Regarding initiation of Home Health services, the face-to-face encounter must be related to the primary reason the beneficiary requires Home Health services and must occur within the ninety (90) days before or the thirty (30) days after the start of services.
2. Regarding initiation of medical equipment, the face-to face encounter must be related to the primary reason the beneficiary requires medical equipment and must occur no more than six (6) months prior to the start of services.
3. Conducted by one of the following practitioners:
   a. The primary care physician.
   b. A nurse practitioner working in collaboration with the primary care physician.
   c. A certified nurse midwife by the scope of practice.
   d. A physician assistant under the supervision of the primary care physician according to Arkansas Medicaid Physician Policy. Physician assistant services are services furnished according to A.C.A § 17-105-101 and rules and regulations issued by the Arkansas State Medical Board. Physician assistants

are dependent medical practitioners practicing under the supervision of the physician, for which the physician takes full responsibility. The service is not considered to be separate from the physician's service.

e. The attending acute or post-acute physician.

4. The non-physician must communicate the clinical findings of that face-to-face to the ordering physician. Those clinical findings must be incorporated into a document included in the beneficiary's medical record.

5. The physician ordering the services must assure clinical correlation between the face-to-face encounter and the associated Home Health document:

a. The primary reason the patient requires Home Health services.

b. The start of Home Health services.

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

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

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

204.102 Plan of Care Review 7-1-17

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

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

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

1. The physician establishes the start date of each new, renewed or revised plan of care.

a. A "renewed" plan of care has been reviewed in accordance with the 60-day requirement and has been authorized by the PCP or authorized attending physician to continue, either with or without revision.

b. A "revised" plan of care is developed in response to a change in the patient's condition that necessitates prompt review by the physician and reassessment by the case nurse.

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

204.103 Home Health Place of Service 7-1-17

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

Medicaid supplies, equipment and appliances suitable for use may be provided in any setting in which normal life activities take place.

204.200 Certified Nurse-Midwife's Role in the Prescription Drug Program 10-1-15

Medicaid covers prescription drugs in accordance with policies and regulations set forth in this section and pursuant to orders (prescriptions) from authorized prescribers. The Arkansas Medicaid Program complies with the Medicaid Prudent Pharmaceutical Purchasing Program (MPPPP) that was enacted as part of the Omnibus Budget Reconciliation Act (OBRA) of 1990. **This law requires Medicaid to limit coverage to drugs manufactured by pharmaceutical companies that have signed rebate agreements.** Except for drugs in the categories excluded from coverage, Arkansas Medicaid covers all drug products manufactured by companies with listed labeler codes.

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

Prescribers must refer to the Arkansas Medicaid Pharmacy website at **https://arkansas.magellanrx.com/provider/documents** to obtain the latest information regarding prescription drug coverage.

As additions or deletions by labelers are submitted to the state by the Centers for Medicare and Medicaid Services (CMS), the website is updated.

204.201 Tamper Resistant Prescription Applications 2-6-17

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

See the CMS website for technical information:

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

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

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

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

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

204.300 Certified Nurse-Midwife’s Role in the Child Health Services (EPSDT) Program and ARKids First-B Program 7-1-06

The Arkansas Medical Assistance Program includes a Child Health Services (EPSDT) Program for eligible individuals under age 21. The purpose of this program is to detect and treat health problems in their early stages and to provide well child health care such as immunizations.

Similar services are also covered through the ARKids First-B Program. This program covers children age 18 years and younger.

Certified nurse-midwives may provide routine newborn care that includes the physical examination of the baby and conference(s) with the newborn’s parents. These services are considered to be the initial Child Health Services (EPSDT) screen and may be covered as the initial preventive health screen for those eligible for the ARKids First-B Program.

Certified nurse-midwives interested in enrolling in the Child Health Services (EPSDT) Program or the ARKids First-B Program should contact the Central Child Health Services Office. **View or print the Central Child Health Services Office contact information.**

204.400 Certified Nurse-Midwife’s Role in Hospital Services 7-1-06

A. Medicaid covers medically necessary hospital services, within the constraints of the Medicaid Utilization Management Program (MUMP) and applicable benefit limitations. (Refer to Sections 213.200 through 213.220.)

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

C. Arkansas Foundation for Medical Care, Inc., (AFMC) is the Medicaid agency’s quality improvement organization (QIO).

1. AFMC reviews for the Medicaid Utilization Management Program (MUMP), all inpatient hospital transfers and all inpatient stays longer than four days.
2. The QIO also performs post-payment reviews of hospital claims for medical necessity determinations.

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

1. If Medicaid denies a hospital’s claim for lack of medical necessity, payments to certified nurse-midwives for evaluation and management services incidental to the hospitalization are subject to recoupment by the Medicaid agency.
2. Certified nurse-midwives and hospitals may not bill a Medicaid beneficiary for a service Medicaid has declared not medically necessary.
3. Certified nurse-midwives and hospitals may not bill as outpatient services any inpatient services previously denied for lack of medical necessity as inpatient services.

204.500 Certified Nurse-Midwife’s Role in Preventing Program Abuse 7-1-06

The Arkansas Medicaid Program has the responsibility for assuring quality medical care for its beneficiaries along with protecting the integrity of the funds supporting the program. The Division of Medical Services is committed to these goals, provides staff and resources to the

prevention, detection and correction of known abuse. These tasks can only be accomplished through the cooperation and support of the provider community.

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

Examples of the types of abuse you may detect include:

A. Beneficiary over-utilization of services

B. Beneficiary misuse or inappropriate utilization of services

C. Beneficiary misuse of I.D. card

D. Poor quality of service

E. Provider over-utilization or abuse

205.000 Role of Quality Improvement Organization 10-13-03

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

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

206.000 Certified Nurse-Midwife's "Direct Supervision" 10-13-03

The Arkansas Medicaid Program reimburses "direct supervision" to the extent such supervision is permitted by rules and regulations of the Arkansas State Board of Nursing. To determine whether the "direct supervision" is reimbursable, the Medicaid Program will apply the following criteria:

A. The person who is performing the service must be a paid employee of the certified nurse-midwife who is billing the Medicaid Program. A W-4 Form must be on file in the certified nurse-midwife's office. Supervised personnel may perform only duties that are within their scope of practice.

B. The certified nurse-midwife must monitor and be responsible for the quality of work performed by the employee under his or her "direct supervision." The certified nurse-midwife must be under the same roof and be immediately available to provide assistance and direction throughout the time the service is being performed.

210.000 PROGRAM COVERAGE

211.000 Introduction 7-1-06

The Medical Assistance Program is designed to assist Medicaid beneficiaries obtain medical care within the guidelines specified in Section I of this manual. Certified nurse-midwives who are licensed by the Arkansas State Board of Nursing and certified by the American College of Nurse-

Midwives (ACNM) and who are enrolled in the Arkansas Medicaid Program may be reimbursed for their services within the Arkansas Medicaid Program's limitations.

212.000 Scope 7-1-06

Licensed certified nurse-midwives may be reimbursed for their services to Medicaid beneficiaries. (See Section I of this manual for an explanation of the Medicaid ID card.) Services may be provided in a variety of settings, including an office, a birthing center or clinic, a beneficiary's home or a hospital.

Services performed by a certified nurse-midwife require a primary care physician (PCP) referral, except those services with family planning, obstetrical or gynecological diagnosis codes.

In accordance with Act 409 of 1995: "Nurse-Midwifery means the performance, for compensation, of nursing skills relevant to the management of women's health care, focusing on pregnancy, childbirth, the postpartum period, care of the newborn, family planning and gynecological needs of women, within a health care system that provides for consultation, collaborative management or referral as indicated by the health status of the client."

213.000 Benefit Limits 7-1-06

Medicaid beneficiaries are responsible for payment for services beyond the established benefit limits unless the Division of Medical Services (DMS) authorizes an extension of a particular benefit. If a beneficiary elects to receive a service for which DMS has denied a benefit extension, or for which DMS subsequently denies a benefit extension, the patient is responsible for payment.

NOTE: When serving ARKids First-B beneficiaries, Aid Category 01, use the ARKids First-B provider manual for benefit limits that are specific to that category.

213.100 Reserved 10-1-15

213.110 Reserved 10-1-15

213.200 Inpatient Hospital Services

213.210 Medicaid Utilization Management Program (MUMP) 4-1-07

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

Length-of-stay determinations are made by the Quality Improvement Organization (QIO), Arkansas Foundation for Medical Care, Inc. (AFMC), under contract to the Arkansas Medicaid Program.

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

The procedures for the MUMP are as follows:

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

B. If the attending certified nurse-midwife determines that the patient should not be discharged by the fifth day of hospitalization, a hospital medical staff member may contact AFMC and request an extension of inpatient days. The following information is required:

1. Patient name and address (including zip code)
2. Patient birth date
3. Patient Medicaid number
4. Admission date
5. Hospital name
6. Hospital provider identification number
7. Attending certified nurse-midwife provider identification number
8. Principal diagnosis and other diagnoses influencing this stay
9. Surgical procedures performed or planned
10. The number of days being requested for continued inpatient care
11. All available medical information justifying or supporting the necessity of continued stay in the hospital.

C. Contact AFMC for procedure precertification or length of stay review. **View or print AFMC contact information.** AFMC will base the number of days allowed for an extension on their medical judgment utilizing Medicaid guidelines.

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

E. Additional extensions may be requested as needed.

F. AFMC assigns an authorization number to an approved extension request and sends written notification to the hospital.

G. Reconsideration reviews of denied extensions may be requested by sending the medical record to AFMC through regular mail, or expedited by overnight express. The hospital will be notified by the next working day of the decision. **View or print AFMC contact information.**

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

I. If the fifth day of an admission falls on a Saturday, Sunday or holiday, it is recommended that the hospital provider call for an extension prior to the fifth day if the certified nurse-midwife has recommended a continued stay.

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

K. The retrospective or post payment random sample review will be continued for all admissions, including inpatient stays of four days or less, to ensure that medical necessity for the services is substantiated.

L. Admissions of retroactively eligible beneficiaries: If eligibility is identified while the patient is still an inpatient, the hospital may call for retrospective review of those days already used past the original four for a determination of post authorization and concurrent evaluation of future extended days.

If the retroactive eligibility is not identified until after discharge and the hospital bills and receives a denial for any days past the original four allowed, then the hospital may call for post-extension evaluation approval of the denied days, which, if granted, may be rebilled. If the length of stay is more than 30 days, the provider may submit the entire medical record to AFMC to review.

M. Out-of-state claims are subject to the determination of medical necessity for out-of-state treatment. In addition, the claim and records will be reviewed retrospectively for lengths of stay beyond the four days allowed. "Out-of-state" refers to states not bordering Arkansas.

N. Medicaid will automatically deny claims submitted for any days billed beyond the fourth day if the provider has not called for an extension request. There will be no exceptions granted except for claims reflecting third party liability.

O. If a patient is transferred from one facility to another, the receiving facility must contact AFMC within 24 hours of admitting the patient to qualify the inpatient stay. If an admission falls on a weekend or holiday, the provider must contact AFMC on the first working day following the admission.

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

Q. If a provider fails to contact AFMC for an extension of inpatient days due to the patient's having private insurance or Medicare Part A and later receives a denial due to non-covered service, lost eligibility, benefits exhausted, etc., post certification of days past the original four days may be obtained by the following procedures:

Send a copy of the denial notice received from the third party payer to AFMC. **View or print AFMC contact information.** Include a note requesting post certification and the full name of the requester and a phone number where the requester may be reached. Upon receipt of the denial copy and the provider request, an AFMC coordinator will call the provider and obtain certification information.

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

213.220 Benefit Limit – Inpatient Hospital Services 7-1-06

A. There is an annual benefit limit of 24 medically necessary days per state fiscal year (July 1 through June 30) for Medicaid beneficiaries ages 21 and older.

B. There is no inpatient hospital benefit limit for individuals under age 21 in the Child Health Services (EPSDT) Program.

C. Inpatient hospital services for ARKids First-B beneficiaries aged 1 year and older are limited to 4 days. Additional days of services must be prior authorized.

213.300 Inpatient Certified Nurse-Midwife Services

213.310 Inpatient Evaluation and Management Services 10-13-03

A. Medicaid covers certified nurse-midwife evaluation and management services for hospital inpatients on Medicaid-covered inpatient days only. The single exception to this policy is discharge day management. Medicaid does not remit the hospital's per diem for the day of discharge unless it is also the admission day. Medicaid reimburses certified nurse-midwives for medically necessary discharge day management unless the certified nurse-midwife evaluation and management services for that day are included in another service, such as surgery, delivery or routine newborn care; or unless the certified nurse-midwife does not customarily bill private-pay patients for discharge day management.

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

1. Exceeding benefit limits,
2. Failure to precertify inpatient days, when applicable or
3. Lack of medical necessity.

213.320 Professional Components of Diagnostic and Therapeutic Procedures 10-13-03

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

Reimbursement to certified nurse-midwives and independent laboratories for laboratory and radiology services for inpatients are solely for the professional component of machine tests, radiology and anatomical laboratory services.

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

213.400 Diagnostic Laboratory and Radiology/Other Services 7-1-22

The Medicaid Program's diagnostic laboratory and radiology/other services have benefit limits that apply to outpatient services.

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

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

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

View or print the essential health benefit procedure codes.

213.410 Diagnostic Laboratory and Radiology Other Services Benefit Limits 7-1-22

A. Medicaid established maximum amounts (benefit limits) for outpatient diagnostic laboratory and for outpatient radiology/other services for clients who are twenty-one (21) years of age or older.

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

View or print the essential health benefit procedure codes.

B. There are no diagnostic laboratory services benefit limits or radiology/other services benefit limits for clients under twenty-one (21) years of age, except for the limitations on fetal echography (ultrasound) and fetal non-stress tests.

C. There is no benefit limit on professional components of diagnostic laboratory or radiology/other services for hospital inpatient treatment.

D. There is no benefit limit on diagnostic laboratory services related to family planning. (See Section 272.431 for the family-planning-related clinical laboratory procedures.)

E. There is no benefit limit on diagnostic laboratory or radiology/other services performed in conjunction with emergency services in an emergency department of a hospital.

213.420 Diagnostic Laboratory and Radiology/Other Services Referral Requirements 7-1-22

A. A Certified Nurse-Midwife (CNM), referring a Medicaid client for diagnostic laboratory services or radiology/other services must specify a diagnosis code (ICD coding) for each test ordered and include pertinent supplemental diagnoses supporting the need for the test(s) in the order.

1. Reference diagnostic facilities, hospital labs, and outpatient departments performing reference diagnostics rely on the referring physicians and CNMs to establish medical necessity.
2. The diagnoses provide documentation of medical necessity to the reference diagnostic facilities that are performing the tests.
3. CNMs must follow Centers for Medicare and Medicaid Services (CMS) requirements for medical claim diagnosis coding when submitting diagnosis coding with their orders for diagnostic tests.
4. The Medicaid agency will enforce the CMS requirements for diagnosis coding, as those requirements are set forth in the ICD volume concurrent with the referral dates and the claim dates of service.
5. The following ICD diagnosis codes may not be used for billing. **(View ICD codes).**

B. The following benefit limits apply:

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

213.500 Outpatient Hospital Certified Nurse-Midwife Services 7-1-06

For the purpose of coverage and reimbursement determination, outpatient hospital certified nurse-midwife services are divided into the following two types of service:

A. Emergency Services

Special Coverage Requirements - Certified nurse-midwives may bill a hospital outpatient visit as an emergency when the patient's medical condition constitutes an emergency medical condition, in compliance with Section 1867 of the Social Security Act.

B. Non-Emergency Services

Special Coverage Requirements - Non-emergency certified nurse-midwife services in an outpatient hospital setting are covered as a visit and the professional component for machine tests, radiology and anatomical laboratory procedures.

213.510 Outpatient Hospital Benefit Limit 10-1-15

Beneficiaries aged 21 and older are limited to a total of 12 outpatient hospital visits a year. This benefit limit includes outpatient hospital services provided in an acute care/general hospital or a rehabilitative hospital. This yearly limit is based on the state fiscal year (July 1 through June 30). Outpatient hospital services include the following:

A. Non-emergency outpatient hospital and related certified nurse-midwife services.

B. Outpatient hospital therapy and treatment services related to certified nurse-midwife services.

Generally outpatient hospital services for beneficiaries under age 21 are not benefit limited.

The Arkansas Medicaid Program exempts the following ICD diagnoses from the extension of benefit requirements.

1. Malignant Neoplasm	**(View ICD codes.)**
2. HIV or AIDS	**(View ICD codes.)**
3. Renal failure	**(View ICD codes.)**
4. Pregnancy*	**(View ICD codes.)**

When a Medicaid beneficiary has exhausted the Medicaid established benefit limit for certified nurse-midwife outpatient hospital services, benefits are automatically extended for these diagnoses.

*OB ultrasounds and fetal non-stress tests are benefit limited. See Section 272.494 for coverage information.

213.600 Certified Nurse-Midwife Services Benefit Limit 3-15-10

Beneficiaries age 21 and older are limited to twelve (12) visits per state fiscal year (July 1 through June 30) for services provided by a certified nurse-midwife, physician's services, rural health clinic services, medical services furnished by a dentist, office medical services by an optometrist, services provided by an advanced nurse practitioner, or a combination of the six.

For example: A beneficiary who has had two office medical visits to the dentist, one office medical visit to an optometrist and two visits to a physician has used five of the limit of twelve visits per state fiscal year.

The following services are counted toward the 12 visits per state fiscal year limit established for the Certified Nurse-Midwife Program:

A. Certified nurse-midwife services

B. Physician services in the office, patient's home or nursing facility

C. Rural health clinic (RHC) core services

D. Medical services provided by a dentist

E. Medical services furnished by an optometrist

F. Advanced nurse practitioner services

Global obstetric fees are not counted against the 12-visit limit. Itemized obstetric office visits are counted in the limit.

Extensions of the benefit limit will be considered for services beyond the established benefit limit when documentation verifies medical necessity. Refer to Section 214.000 of this manual for procedures for obtaining extension of benefits.

Beneficiaries under age 21 in the Child Health Services (EPSDT) Program are not benefit limited.

213.700 Fetal Monitoring 10-1-15

Certified nurse-midwives may file claims for reimbursement from the Arkansas Medicaid Program for fetal monitoring tests based on policy described in Section 272.494 of this manual.

213.710 Fetal Non-Stress Test 2-1-22

The fetal non-stress test is limited to two (2) medically necessary fetal non-stress test procedures per pregnancy. Providers must follow the benefit extension procedures in Section 214.000 to request that Medicaid authorize payment of a third or subsequent claim after two (2) claims have been paid in a nine-month period. The procedure code for a fetal non-stress test is in the link below.

View or print the procedure codes for Certified Nurse Midwife (CNM) services.

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

213.720 External Fetal Monitor 10-13-03

The certified nurse-midwife may bill Medicaid for external fetal monitoring performed in the certified nurse-midwife's office.

External fetal monitoring may be billed in addition to the global obstetric fee. When itemizing obstetrical visits, certified nurse-midwives may bill for medically necessary external fetal monitoring in addition to their billing for the obstetrical office visit.

213.730 Fetal Echography (Ultrasound) 10-13-03

The Arkansas Medicaid Program has benefit limits regarding the Ultrasound when performed in conjunction with maternity care.

The Ultrasound is limited to two (2) per pregnancy. If it is necessary to exceed these limits, the certified nurse-midwife must submit Form DMS-699, Request for Extension of Benefits. Refer to Section 214.000 for information regarding the extension of benefits procedure.

214.000 Procedures for Obtaining Extension of Benefits for Certified Nurse-Midwife Services 2-1-05

Services with benefit limits may be considered for extension of benefits when benefits have been exhausted but additional services are medically necessary. Refer to the following sections for instructions when requesting extension of benefits.

214.100 Extension of Benefits for Clinical, Outpatient, Diagnostic Laboratory, and Radiology/Other Services 7-1-22

A. The Medicaid Program's diagnostic laboratory and radiology/other services have benefit limits that apply to outpatient services.

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

B. Certified Nurse Midwife (CNM) requests for extension of benefits for clinical, outpatient, diagnostic laboratory, and radiology/other services must be submitted to DHS or its designated vendor.

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

1. Requests for extension of benefits are considered only after a claim is filed and is denied due to the patient's benefit limits being exhausted.
2. Submit with the request a copy of the Medical Assistance Remittance and Status Report reflecting the claim's denial for exhausted benefits. Do not send a claim.

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

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

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

214.110 Completion of Form DMS-671, "Request For Extension of Benefits for Clinical, Outpatient, Diagnostic Laboratory, and Radiology/Other Services" 7-1-22

A. The Medicaid Program's diagnostic laboratory and radiology/other services have benefit limits that apply to outpatient services.

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

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

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

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

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

1. Consideration of requests for extension of benefits requires correct completion of all fields on the "Request for Extension of Benefits for Clinical, Outpatient, Diagnostic Laboratory and Radiology/Other Services" form (Form DMS-671). **View or print form DMS-671.**

2. Complete instructions for accurate completion of Form DMS-671 (including indication of required attachments) accompany the form. All forms are listed and accessible in **Section V** of each Provider Manual.

214.120 Documentation Requirements 7-1-22

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

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

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

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

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

C. Documentation requirements are as follows.

1. Clinical records *must*:

a. Be legible and include records supporting the specific request;

b. Be signed by the performing provider;

c. Include clinical, outpatient, or emergency room records for relevant dates of service in chronological order;

d. Include related diabetic and blood pressure flow sheets;

e. Include a current medication list for the date of service;

f. Include any obstetrical records related to a current pregnancy (when applicable); and

g. Include clinical indication for diagnostic laboratory and radiology/other services ordered with a copy of orders for diagnostic laboratory and radiology/other services signed by the physician.

2. Diagnostic laboratory and radiology/other reports *must* include:
   a. Clinical indication for diagnostic laboratory and radiology/other services ordered;
   b. Signed orders for diagnostic laboratory and radiology/other services;
   c. Results signed by the performing provider; and
   d. Current and all previous ultrasound reports, including biophysical profiles and fetal non-stress tests (when applicable).

214.130 Administrative Reconsideration of Extension of Benefits Denial 7-1-06

A request for administrative reconsideration of an extension of benefits denial must be in writing and sent to AFMC within 30 calendar days of the denial. The request must include a copy of the denial letter and additional supporting documentation as detailed in Section 214.120. The deadline request will be enforced as indicated in Sections 190.012 and 190.013 of this manual. A request received by AFMC within 35 calendar days of a denial will be deemed timely. A request received later than 35 calendar days gives rise to a rebuttable presumption that it is not timely.

214.140 Appealing an Adverse Action 7-1-06

Please see Section 190.000 for information regarding administrative appeals.

215.000 Coverage Limitations

215.100 New Patient Visit 7-1-06

One new patient visit is covered every three (3) years per beneficiary per attending provider.

215.200 Family Planning Coverage Information 1-1-24

A. Arkansas Medicaid encourages reproductive health and family planning by reimbursing physicians, nurse practitioners, certified nurse-midwives, clinics, and hospitals for a comprehensive range of family planning services.
   1. Family planning services do not require a PCP referral.
   2. Medicaid beneficiaries' family planning services benefits are in addition to their other medical benefits, when providers bill the services specifically as family planning services.
   3. Family Planning prescriptions are unlimited and do not count toward the benefit limit.
   4. Extension of benefits is not available for family planning services.
   5. Abortion is not a family planning service in the Arkansas Medicaid Program.

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

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

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

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

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

Billing guidelines:

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

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

215.210 Reserved 10-1-15

215.220 Family Planning Services for Women in Aid Category 61, PW-PL 1-1-23

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

215.230 Basic Family Planning Visit 7-1-06

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

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

B. Counseling and education regarding:

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

C. Prescription for any contraceptives selected by the beneficiary.

D. Laboratory services, including, as necessary:

1. Pregnancy test.
2. Hemoglobin and Hematocrit.
3. Sickle cell screening.
4. Urinalysis testing for albumin and glucose.
5. Papanicolaou smear for cervical cancer.
6. Testing for sexually transmitted diseases.

215.240 Periodic Family Planning Visit 7-1-06

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

215.250 Contraception 12-1-21

A. Prescription and Non-Prescription Contraceptives

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

B. Contraceptive Implant Systems

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

C. Intrauterine Devices (IUDs)

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

D. Medroxyprogesterone Acetate

1. Medicaid covers medroxyprogesterone acetate injections for birth control.

215.260 Expansion of Medicaid Eligibility for Pregnant Women 1-1-23

A. Arkansas Medicaid provides expanded coverage for pregnant women. Women in Aid Category 61 (PW) receive the full range of Medicaid benefits. Service settings may be both outpatient and inpatient, as appropriate.

Aid Category 61 also includes benefits to unborn children of alien pregnant women who meet the eligibility requirements. The benefits for this eligibility category are:

1. Prenatal services
2. Delivery
3. Postpartum services for 60 days (plus the days remaining in the month in which the 60-day period ends)

4. Services for conditions that may complicate the pregnancy

System eligibility verification will specify "PW unborn ch-no ster cov/FP."

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

B. When verifying a client's eligibility, please note the "AID CATEGORY CODE" and "AID CAT DESCRIPTION" fields. The "AID CATEGORY CODE" field contains the 2-digit numeric code identifying the client aid category. The "AID CAT DESCRIPTION" field contains an abbreviation of the aid category description, comprising 2 or more characters, usually letters, but sometimes numerals as well as letters.

1. Pregnant Women (PW) eligibility will occasionally overlap with eligibility in another category, such as Aid Category 20, TEA-GR. If a PW-eligible client is seeking services that are not for pregnancy or conditions that may complicate pregnancy and are not family planning services, other eligibility segments may be reviewed on the transaction response and other available electronic options. The woman may have benefits for the date of service in question under another aid category. If so, the service may be performed and the claim may be filed with Medicaid as usual.

2. Medicaid also provides coverage in Aid Category 61 (PW) to children who are eligible for all Medicaid benefits. The aid category code is the same as those of a pregnant woman.

   Aid Categories 62 (PW-PE), 65 (PW-NG), 66 (PW-EC) and 67 (PW-SD) only cover the pregnant woman. Aid Categories 65, 66 and 67 have lower income limits than those listed above for Aid Category 61. Only Aid Category 61 may include eligible pregnant women and/or children.

215.310 Medicare/Medicaid Coverage

Refer to Sections I and III of this manual for information regarding Medicaid payment of Medicare deductible and coinsurance information.

215.320 Observation Status 10-13-03

When billing for services to a patient in "observation status," certified nurse-midwives must adhere to Arkansas Medicaid definitions of inpatient and outpatient. Observation status is an outpatient designation. Certified nurse-midwives must also follow the guidelines and definitions in *Physician's Current Procedural Terminology* (CPT), under "Hospital Observation Services" and "Evaluation and Management Services Guidelines."

Arkansas Medicaid criteria determining inpatient and outpatient status:

A. If a patient is expected to remain in the hospital for less than 24 consecutive hours and this expectation is realized, the hospital and the certified nurse-midwife should consider the patient an outpatient; i.e., the patient is an outpatient unless the certified nurse-midwife has admitted her as an inpatient.

B. If the certified nurse-midwife or hospital expects the patient to remain in the hospital for 24 hours or more, Medicaid deems the patient admitted at the time the patient's medical record indicates the existence of such an expectation, even though the certified nurse-midwife has not yet formally admitted the patient.

C. Medicaid also deems a patient admitted to inpatient status at the time they have remained in the hospital for 24 consecutive hours, even if the certified nurse-midwife or hospital had no prior expectation of a stay of that or greater duration.

215.321 Medical Necessity Requirements 10-1-15

Certified nurse-midwife inpatient services must meet the Medicaid requirement of medical necessity. The Quality Improvement Organization (QIO) will deny payments for inpatient admissions and subsequent inpatient services when they determine that inpatient care was not necessary. Inpatient services are subject to QIO review for medical necessity whether the certified nurse-midwife admitted the patient or whether Medicaid deemed the patient admitted according to the criteria above.

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

215.322 Coverage Limitations 7-1-06

Outpatient surgical procedures are covered as all inclusive services only. One evaluation and management service, including certified nurse-midwife non-emergency outpatient visits, is covered per beneficiary per day.

215.323 Billing Examples 10-13-03

The following table gives examples of appropriate certified nurse-midwife billing for several common hospital scenarios. The billing instructions under the headings, "CERTIFIED NURSE-MIDWIFE MAY BILL...", do not necessarily include all services for which the certified nurse-midwife may bill. For instance, the instructions do not state that the provider may bill for interpretation of X-rays or diagnostic tests. The purpose of this table is to illustrate Arkansas Medicaid observation status policy and to give guidance for billing related evaluation and management services.

Arkansas Medicaid Observation Status Policy Illustration

PATIENT IS ADMITTED TO OBSERVATION	PATIENT IS	CERTIFIED NURSE-MIDWIFE MAY BILL FOR TUESDAY SERVICES:	CERTIFIED NURSE-MIDWIFE MAY BILL FOR WEDNESDAY SERVICES:
Tuesday, 3:00 PM	Still in Observation Wednesday, 3:00 PM	Appropriate level of Initial Observation Care	Appropriate level of Initial Hospital Care
Tuesday, 3:00 PM	Discharged Wednesday, 12:00 PM (noon)	Appropriate level of Initial Observation Care	Observation care discharge day management
Tuesday, 3:00 PM	Discharged Wednesday, 4:00 PM	Appropriate level of Initial Observation Care	Appropriate level of Initial Hospital Care
Tuesday, 3:00 PM, after outpatient surgery	Discharged Wednesday, 10:00 AM	Outpatient surgery	No evaluation and management services
Tuesday, 3:00 PM, after exam in Emergency Department – emergency or non-emergency	Discharged Tuesday, 7:00 PM	Appropriate level of Initial Observation Care	Not Applicable; patient was discharged Tuesday

240.000 PRIOR AUTHORIZATION

240.100 Procedure for Obtaining Prior Authorization 7-1-20

A. Certain medical and surgical procedures are covered only when prior authorized because of federal requirements or because of the elective nature of the surgery. DHS or its designated vendor issues prior authorizations for restricted medical and surgical procedures covered by the Arkansas Medicaid Program. **View or print contact information**.

B. Prior authorization determinations are in accordance with established medical and administrative criteria combined with the professional judgment of physician advisors.

C. Written documentation is not required for prior authorization. However, the patient's records must substantiate all information given. Any retrospective review of a case will rely on the written record.

D. It is the responsibility of the certified nurse-midwife who will perform the procedure to initiate the prior authorization request.

The following specific information must be furnished: (**If request is made by phone, all calls will be tape recorded.**)

1. Patient Name and Address;
2. Beneficiary Medicaid Identification Number;
3. Certified Nurse-Midwife Name and License Number;
4. Certified Nurse-Midwife Medicaid Provider Number;
5. Hospital Name; and
6. Date of Service for Requested Procedure.

The caller must provide **all** patient identification information and medical information related to the necessity of the procedure.

If surgery is involved, a copy of the authorization will be sent to the hospital where the service will be performed. If the hospital has not received a copy of the authorization before the time of admission, the hospital will contact the admitting certified nurse-midwife or DHS or its designated vendor to verify that prior authorization has been granted.

It is the responsibility of the primary surgeon to distribute a copy of the authorization to the assistant surgeon if the assistant has been requested and approved. The Medicaid Program will not pay for inpatient hospital services that require prior authorization if the prior authorization has not been requested and approved.

Consulting physicians are responsible for having their required or restricted procedures added to the PA file. A letter verifying the PA number will be sent to the consultant upon request.

Post-authorization will be granted only for emergency procedures or for services provided to a Medicaid beneficiary during a period of retroactive eligibility. Requests for emergency procedures must be made no later than the first working day after the procedure has been performed. In cases of retroactive eligibility, the provider must contact DHS or its designated vendor for post-authorization within sixty (60) days of the eligibility authorization date. **View or print contact information**.

240.110 Post-Procedural Authorization Process 7-1-06

Providers performing surgical procedures that require prior authorization are allowed 60 days from the date of service to obtain a prior authorization number. Providers must follow the post-procedural authorization process when obtaining an authorization number for the procedures listed in Section 213.500.

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

The beneficiary and provider identifying criteria and all of the medical data necessary to justify the procedures must be provided to AMFC.

As medical information will be exchanged for the previously performed procedures, these calls must be made by the certified nurse-midwife or a nursing member of his or her staff.

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

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

240.200 Prescription Drug Prior Authorization 10-13-03

Prescription drugs are available for reimbursement under the Arkansas Medicaid Program pursuant to an order from an authorized prescriber. A pharmacy must have prior authorization before dispensing certain drugs. It is the responsibility of the prescriber to request and obtain the prior authorization. Refer to the Arkansas Medicaid website at **https://medicaid.mmis.arkansas.gov/** for the following information:

A. Prescription drugs requiring prior authorization.

B. Criteria for drugs requiring prior authorization.

C. Forms to be competed for prior authorization.

D. Procedures required of the prescriber to request and obtain prior authorization.

250.000 REIMBURSEMENT

251.000 Method of Reimbursement 10-13-03

The methodology used by the Arkansas Medicaid Program to determine reimbursement rates for all certified nurse-midwives is a “fee schedule.” Under the fee schedule methodology, reimbursement is based on the lesser of the billed charge for each procedure or the maximum allowable for each procedure. The maximum allowable for a procedure is the same for all certified nurse-midwives.

251.010 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.

252.000 Rate Appeal Process 7-1-06

A provider may request reconsideration of a Medicaid Program decision by writing to the Assistant Director, Division of Medical Services. This request must be received within 20 calendar days following the application of policy and/or procedure or the notification of the provider of a procedure rate. Upon receipt of the request for review, the Assistant Director will determine the need for a Program/Provider conference and will contact the provider to arrange a conference if needed. Regardless of the Program decision, the provider will be afforded the opportunity for a conference, if he or she so wishes, for a full explanation of the factors involved and the Program decision. Following review of the matter, the Assistant Director will notify the provider of the action to be taken by the Division within 20 calendar days of receipt of the request for review or the date of the Program/Provider conference.

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

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

260.000 HOSPITAL/PHYSICIAN/CERTIFIED NURSE-MIDWIFE REFERRAL PROGRAM

260.100 Introduction 7-1-06

The intent of the Hospital/Physician/Certified Nurse-Midwife Referral Program is fourfold.

A. It provides the hospital, physician and certified nurse-midwife with a means to identify needy individuals to the Arkansas Department of Human Services (DHS) through written referral and assures follow-up contact with interested individuals by DHS.

B. It provides DHS with a means of reaching needy individuals who might not otherwise be aware of or apply for Medicaid benefits.

C. It informs needy individuals of possible Medicaid coverage that would help defray their medical expenses.

D. It enables the hospital, physician and certified nurse-midwife to know if an application is made and whether the patient is Medicaid eligible.

260.200 Hospital/Physician/Certified Nurse-Midwife Responsibility 7-1-06

The hospital, physician or certified nurse-midwife should inform needy individuals of possible medical assistance available under the Medicaid Program and refer all interested individuals to Arkansas Department of Human Services by means of form DMS-630, Referral for Medical Assistance. **View or print form DMS-630 and instructions for completion.**

The hospital, physician or certified nurse-midwife should be prepared to provide itemized statements on all individuals referred to the Arkansas Department of Human Services for potential use in the eligibility determination. The representative of the hospital, physician or certified nurse-midwife is responsible for the accurate completion of the Referral for Medical Assistance Form (DMS-630). After the required information has been entered on the form, the representative will read and explain the authorization section to the beneficiary before securing her signature. Once the signature is obtained, the representative will sign and date the form and forward it to the local county Human Services office in the client's county of residence.

The county Human Services Office addresses are available from the Arkansas Division of Medical Services.

260.300 County Human Services Office Responsibility 7-1-06

Upon receipt of the Referral for Medical Assistance form DMS-630, the local Department of Human Services county office will contact the beneficiary. Action must be completed within a specified period of time on all applications taken during follow-up. Once a determination has been made, the local County Human Services office will notify the hospital, physician or certified nurse-midwife by completing Section 2 of form DMS-630. The three (3) types of disposition are:

A. Did Not Respond or No Longer Interested - individual failed to respond to follow-up contact or stated he or she was no longer interested.

B. Denied - Application taken; individual was determined ineligible or eligibility could not be determined.

C. Approved - Application taken; applicant was determined eligible effective month/day/year.

The beneficiary is responsible for presenting his or her Medicaid identification card to the hospital, physician or certified nurse-midwife for billing purposes each time he or she receives a service.

260.400 Completion of Referral for Medical Assistance Form (DMS-630)

260.410 Purpose of Form 7-1-06

Section 1 of Form DMS-630 is used by hospitals/physicians/certified nurse-midwives to refer to the Arkansas Department of Human Services any needy individuals who might not otherwise be aware of or apply for Medical Assistance under the Medicaid Program. Section 2 of Form DMS-630 is used by the Arkansas Department of Human Services to notify the hospital/physician/certified nurse-midwife of the disposition of the referral on that patient.

260.420 Hospital/Physician/Certified Nurse-Midwife Completion - Section 1 7-1-06

Enter, in sequence, hospital/physician/certified nurse-midwife name and address; patient account number; local county Department of Human Services office name and address; client's first name, middle initial and last name; signature of hospital/physician/certified nurse-midwife representative; date signed; name of hospital/physician/certified nurse-midwife; signature of client, address and date signed.

260.430 County Department of Human Services Office Completion - Section 2 7-1-06

Leave blank; Section 2 will be completed by the local Department of Human Services county office.

260.440 Ordering DMS-630 Forms 10-1-15

When ordering Form DMS-630 please complete a Medicaid Form Request (Form HP-MFR-001) and mail it to the Provider Assistance Center. **View or print the Provider Assistance Center contact information.** Please give the provider's complete mailing address and the number of forms being requested. **View or print form DMS-630 and instructions for completion.**

260.500 Hospital/Physician/Certified Nurse-Midwife Referral for Newborns 7-1-06

Federal law mandates Medicaid coverage of infants born to Medicaid beneficiaries for a period of up to 12 months, as long as the mother remains Medicaid eligible (or would continue to be eligible if still pregnant) and as long as the infant resides with the mother.

A Hospital/Physician/Certified Nurse-Midwife Referral for Newborn Infant Medicaid Coverage Form (DCO-645) must be completed to report the birth of a Medicaid eligible infant. **View or print form DCO-645 and instructions for completion.** The referring provider must complete and mail the form to the DHS County Office of the mother's resident county within 5 days of the infant's birth, when possible. The form will serve the Division of County Operations as verification of the birth date of the infant as well as documentation of relationship.

If all vital information and signatures are on the form when received and it is verified that the mother was an Arkansas Medicaid beneficiary at the time of delivery and the DHS County Office has verified by collateral that the child lives with its mother, a newborn certification will be made within 20 working days from receipt of the completed Form DCO-645. The DHS County Office service representative must then complete Part III of the form and return it to the provider within the 20-day period. A Form DCO-700 will be mailed to the infant's mother to notify her of the application's approval or denial.

260.510 Ordering DCO-645 Forms 10-1-15

When ordering Form DCO-645, please complete a Medicaid Form Request (Form HP-MFR-001) and mail it to the Provider Assistance Center. **View or print the Provider Assistance Center contact information.** Please give the provider's complete mailing address and the number of forms being requested

270.000 BILLING PROCEDURES

271.000 Introduction to Billing 7-1-20

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

Procedure codes payable to certified nurse-midwives do not require modifiers unless specified in the policy.

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

272.000 CMS-1500 Billing Procedures

272.100 Reserved 10-1-15

272.110 Reserved 10-1-15

272.200 National Place of Service (POS) Codes 7-1-07

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

Place of Service	POS Codes
Inpatient Hospital	21
Outpatient Hospital	22
Doctor's Office	11
Patient's Home	12

Place of Service	POS Codes
Nursing Facility	32
Skilled Nursing Facility	31
Other Locations	99
Independent Laboratory	81
Ambulatory Surgical Center	24
Specialized Treatment Facility or Federally Qualified Health Center (FQHC)	56
Emergency Department for Emergency Services	23

272.300 Billing Instructions 11-1-17

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

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

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

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

272.310 Completion of CMS-1500 Claim Form 10-1-15

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

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

Field Name and Number		Instructions for Completion
11.	INSURED'S POLICY GROUP OR FECA NUMBER	Not required when Medicaid is the only payer.
a.	INSURED'S DATE OF BIRTH	Not required.
	SEX	Not required.
b.	OTHER CLAIM ID NUMBER	Not required.
c.	INSURANCE PLAN NAME OR PROGRAM NAME	Not required.
d.	IS THERE ANOTHER HEALTH BENEFIT PLAN?	When private or other insurance may or will cover any of the services, check YES and complete items 9, 9a and 9d. Only one box can be marked.
12.	PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE	Enter "Signature on File," "SOF" or legal signature.
13.	INSURED'S OR AUTHORIZED PERSON'S SIGNATURE	Enter "Signature on File," "SOF" or legal signature.
14.	DATE OF CURRENT: ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)	Required when services furnished are related to an accident, whether the accident is recent or in the past. Date of the accident. Enter the qualifier to the right of the vertical dotted line. Use Qualifier 431 Onset of Current Symptoms or Illness; 484 Last Menstrual Period.
15.	OTHER DATE	Enter another date related to the beneficiary's condition or treatment. Enter the qualifier between the left-hand set of vertical, dotted lines. The "Other Date" identifies additional date information about the beneficiary's condition or treatment. Use qualifiers: 454 Initial Treatment 304 Latest Visit or Consultation 453 Acute Manifestation of a Chronic Condition 439 Accident 455 Last X-Ray 471 Prescription 090 Report Start (Assumed Care Date) 091 Report End (Relinquished Care Date) 444 First Visit or Consultation
16.	DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION	Not required.

Field Name and Number		Instructions for Completion
17.	NAME OF REFERRING PROVIDER OR OTHER SOURCE	Primary Care Physician (PCP) referral is not required for certified nurse-midwife services except for EPSDT services other than newborn care. Enter the referral source, including name and title.
17a.	(blank)	Not required.
17b.	NPI	Enter NPI of the referring physician.
18.	HOSPITALIZATION DATES RELATED TO CURRENT SERVICES	When the serving/billing provider's services charged on this claim are related to a beneficiary's or participant's inpatient hospitalization, enter the individual's admission and discharge dates. Format: MM/DD/YY.
19.	ADDITIONAL CLAIM INFORMATION	Identifies additional information about the beneficiary's condition or the claim. Enter the appropriate qualifiers describing the identifier. See **www.nucc.org** for qualifiers.
20.	OUTSIDE LAB?	Not required.
	$ CHARGES	Not required.
21.	DIAGNOSIS OR NATURE OF ILLNESS OR INJURY	Enter the applicable ICD indicator to identify which version of ICD codes is being reported. Use "9" for ICD-9-CM. Use "0" for ICD-10-CM. Enter the indicator between the vertical, dotted lines in the upper right-hand portion of the field. Diagnosis code for the primary medical condition for which services are being billed. Use the appropriate version of the International Classification of Diseases. List no more than 12 ICD diagnosis codes. Relate lines A-L to the lines of service in 24E by the letter of the line. Use the highest level of specificity.
22.	RESUBMISSION CODE	Reserved for future use.
	ORIGINAL REF. NO.	Any data or other information listed in this field does not/will not adjust, void or otherwise modify any previous payment or denial of a claim. Claim payment adjustments, voids and refunds must follow previously established processes in policy.
23.	PRIOR AUTHORIZATION NUMBER	The prior authorization or benefit extension control number if applicable.
24A.	DATE(S) OF SERVICE	The "from" and "to" dates of service for each billed service. Format: MM/DD/YY. 1. On a single claim detail (one charge on one line), bill only for services provided within a single calendar month. 2. Some providers may bill on the same claim detail for two or more sequential dates of service within the same calendar month when the provider furnished equal amounts of the service on each day of the date sequence.

Field Name and Number		Instructions for Completion
B.	PLACE OF SERVICE	Two-digit national standard place of service code. See Section 272.200 for codes.
C.	EMG	Check “Yes” of leave blank if “No.” EMG identifies if the service was an emergency.
D.	PROCEDURES, SERVICES, OR SUPPLIES	
	CPT/HCPCS	One CPT or HCPCS procedure code for each detail. For unlisted procedure codes, enter the description of the service and attach a procedure report.
	MODIFIER	Modifier(s) if applicable.
E.	DIAGNOSIS POINTER	Enter the diagnosis code reference letter (pointer) as shown in Item Number 21 to relate to the date of service and the procedures performed to the primary diagnosis. When multiple services are performed, the primary reference letter for each service should be listed first; other applicable services should follow. The reference letter(s) should be A-L or multiple letters as applicable. The “Diagnosis Pointer” is the line letter from Item Number 21 that relates to the reason the service(s) was performed.
F.	$ CHARGES	The full charge for the service(s) totaled in the detail. This charge must be the usual charge to any client, patient, or other beneficiary of the provider’s services.
G.	DAYS OR UNITS	The units (in whole numbers) of service(s) provided during the period indicated in Field 24A of the detail.
H.	EPSDT/Family Plan	Enter E if the services resulted from a Child Health Services (EPSDT) screening/referral.
I.	ID QUAL	Not required.
J.	RENDERING PROVIDER ID #	Enter the 9-digit Arkansas Medicaid provider ID number of the individual who furnished the services billed for in the detail or
	NPI	Enter NPI of the individual who furnished the services billed for in the detail.
25.	FEDERAL TAX I.D. NUMBER	Not required. This information is carried in the provider’s Medicaid file. If it changes, please contact Provider Enrollment.
26.	PATIENT’S ACCOUNT N O.	Optional entry that may be used for accounting purposes; use up to 16 numeric or alphabetic characters. This number appears on the Remittance Advice as “MRN.”
27.	ACCEPT ASSIGNMENT?	Not required. Assignment is automatically accepted by the provider when billing Medicaid.
28.	TOTAL CHARGE	Total of Column 24F—the sum all charges on the claim.

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

272.400 Special Billing Procedures

272.410 Anesthesia Services 7-1-06

Services for anesthesia must be billed in the CMS-1500 claim format.

272.411 Reserved 10-1-15

272.412 Pudendal Nerve Block 2-1-22

CPT code may be billed when administering a pudendal nerve block.

View or print the procedure codes for Certified Nurse Midwife (CNM) services.

272.420 Clinic or Group Billing 10-13-03

Multiple providers who wish to have payment made to a group practice or clinic may bill Medicaid on the same claim. If applicable, enter the Arkansas Medicaid Clinic Number in Field 33 after "GRP#." Enter the attending provider number in Field 24K.

272.430 Family Planning Services for Beneficiaries 2-1-22

See Sections 215.200 through 215.260 for family planning coverage information.

Laboratory procedure codes covered for family planning are listed in **Section 272.431** of this manual.

For other billable family planning services, see Sections 272.440-272.533.

272.431 Family Planning Services Laboratory Procedure Codes 2-1-22

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

The following procedure code table explains family planning laboratory procedure codes.

View or print the procedure codes for Certified Nurse Midwife (CNM) services.

272.440 Billable Family Planning Services for Beneficiaries 2-1-22

A. Family planning services are covered for beneficiaries in full coverage aid categories and Aid Category 61 (PW-PL). For information regarding additional aid categories, see Section 124.000. **All procedure codes in these tables require a primary diagnosis code of family planning in each claim detail.** Laboratory procedure codes covered for family planning are listed in **Section 272.431**. Other billable family planning services are also listed in **Section 272.533**.

B. The following procedure code table explains the family planning visit services payable to certified nurse-midwives.

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

C. The following procedure table explains family planning codes payable to certified nurse-midwives.

View or print the procedure codes for Certified Nurse Midwife (CNM) services.

* For Family Planning modifiers, FP and SB are required.

** See Section 272.533 H for additional billing information.

272.441 Reserved 10-1-15

272.442 Reserved 10-1-15

272.443 Reserved 10-1-15

272.450 Laboratory Services Procedure Codes 10-13-03

Only laboratory services performed in the certified nurse-midwife's office or under his or her direct supervision may be billed to the Medicaid Program. Laboratory services ordered by the certified nurse-midwife but performed in an outside facility must be billed directly to Medicaid by the outside facility.

272.451 Specimen Collection 2-1-22

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

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

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

C. Specimen collection is not reimbursable when the provider collecting the specimen also performs laboratory tests on the specimen.

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

View or print the procedure codes for Certified Nurse Midwife (CNM) services.

272.452 Tobacco Cessation Counseling Services 2-1-22

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

⁂**(…)** 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.

View or print the procedure codes for Certified Nurse Midwife (CNM) services.

* Exempt from PCP referral requirements.

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

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

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

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

E. Sessions do not require a PCP referral.

F. If the beneficiary is under 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) counselling sessions limit described in section C above.

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

272.460 Medicare

272.461 Services Prior to Medicare Entitlement 7-1-07

Services that have been denied by Medicare with the explanation "Services Prior to Medicare Entitlement" may be filed with Medicaid. These services should be filed on the CMS-1500 claim form and forwarded to the Inquiry Unit. **View or print the Inquiry Unit contact information.** A copy of the Medicare denial should be attached to the claim. **View a CMS-1500 sample form.** A note of explanation should accompany these claims in order that they may receive special handling.

272.462 Services Not Medicare Approved 10-13-03

For patients with joint Medicare/Medicaid coverage, services that are denied by Medicare for lack of medical necessity are not payable by Medicaid.

272.470 Newborn Care 2-1-22

All newborn services must be billed under the newborn's own Medicaid identification number midwife can refer interested individuals to the Department of Human Services through the The parent(s) of the newborn will be responsible for applying for and meeting eligibility requirements for a newborn to be certified eligible. The hospital/physician/certified nurse-midwife can refer interested individuals to the Department of Human Services through the Hospital/Physician/Certified Nurse-Midwife Referral Program. If the newborn is not certified as Medicaid eligible, the parent(s) will be responsible for the charges incurred by the newborn.

View or print the procedure codes for Certified Nurse Midwife (CNM) services.

For routine newborn care following a vaginal delivery or C-section, procedure code should be used one time to cover all newborn care visits. Payment of these codes is considered a global rate and subsequent visits may not be billed in addition to. 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 Child Health Services (EPSDT) screen. Routine newborn care is exempt from the PCP requirement.

Note the descriptions, modifiers, and required diagnosis range. The newborn care procedure codes require a modifier and a primary detail diagnosis of V30.00-V37.21 for all providers. Refer to the appropriate manual(s) for additional information about newborn screenings.

For illness care (e.g., neonatal jaundice), use procedure codes. Do **not** bill in addition to these codes.

For newborn resuscitation, use procedure code.

May be billed on the CMS-1500 claim form or on the electronic claim transaction format. These codes may also be filed on the CMS-1500; paper or electronically for ARKids A beneficiaries. For ARKids B-beneficiaries, newborn screening codes must be billed electronically or on the paper CMS-1500 claim form. For information, call the Provider Assistance Center. **View or print the Provider Assistance Center contact information.**

For ARKids A (EPSDT) – Requires a CMS-1500 claim form; may be billed electronically or on paper.

For ARKids First B – Requires a CMS-1500 claim form; may be billed electronically or on paper.

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

272.471 Health Examinations for ARKids First-B Beneficiaries and Medicaid Beneficiaries Under Age 21 7-1-06

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

272.480 Nursing Home Visits 7-1-06

Providers should use the appropriate CPT procedure codes when billing for certified nurse-midwife visits in a nursing facility.

272.490 Obstetrical Care 10-13-03

There are two methods of billing for obstetrical care: (1) Global—All-Inclusive Rate (See Section 272.491) or (2) Itemized Billing (See Section 272.492).

272.491 Method 1 – "Global" or "All-Inclusive" Rate 2-1-22

A. One charge for total obstetrical care is billed. The single charge would include the following:

1. Antepartum care, which includes:
   a. initial and subsequent history
   b. physical examinations
   c. recording of weight
   d. blood pressure
   e. fetal heart tones
   f. routine chemical urinalyses
   g. maternity counseling
   h. office visit charge when diagnosis is pregnancy related
2. Admission to the hospital. All admissions and subsequent hospital visits for the treatment of false labor.
3. Delivery - vaginal delivery (with or without episiotomy, with or without forceps or breech delivery) and resuscitation of newborn infant when necessary.
4. Postpartum care, which includes hospital and office visits following vaginal delivery.

B. The global method must be used when the following conditions exist:

1. At least two months of antepartum care were provided culminating in delivery.
2. The patient was continuously Medicaid eligible for at least two months before delivery.

If either condition is not met, the claim will be denied. The denial will state either "monthly billing required" or "beneficiary ineligible for service dates."

C. When billing for global care, procedure code must be used.

View or print the procedure codes for Certified Nurse Midwife (CNM) services.

The provider should indicate in the date of service field of the claim form:

1. The first date of antepartum care after Medicaid eligibility has been established
2. The date of delivery
3. If these two dates are not entered and are not at least two months apart, payment will be denied. The filing deadline will be calculated based on the date of delivery.

D. No benefits are counted against the beneficiary's annual office visit benefit limit if the global method is used.

E. The global method of billing should be used when one or more certified nurse-midwives in a group sees the patient for one or more prenatal visits. The certified nurse-midwife who delivers the baby should be listed as the attending provider on the claim for global obstetric care.

272.492 Method 2 – "Itemized Billing" 2-1-22

Itemized billing must be used when the following conditions exist:

A. Less than two months of antepartum care was provided.

B. The patient was NOT Medicaid eligible for at least the last two months of the pregnancy.

C. If Method 2 is used to bill OB services, care should be taken to ensure that the services are billed within the 12-month filing deadline.

View or print the procedure codes for Certified Nurse Midwife (CNM) services.

D. If only the delivery is performed and neither antepartum nor postpartum services are rendered, procedure code should be billed for vaginal delivery. Procedure codes may not be billed in addition to procedure code. These procedures will be reviewed on a post-payment basis to ensure that they are not billed in addition to antepartum or postpartum care.

E. Providers may bill laboratory and X-ray services separately using the appropriate CPT procedure codes if this is the certified nurse-midwife's standard office practice.

1. When lab tests and/or x-rays are pregnancy related, the referring certified nurse-midwife must be sure to code appropriately when these services are sent to the lab or x-ray facility. The diagnostic facilities are completely dependent on the referring certified nurse-midwife for diagnosis information necessary for reimbursement.
2. The obstetrical laboratory profile procedure code consists of four components: complete blood count, VDRL, Rubella and blood typing with RH. If the ASO titer is performed, the test should be billed separately using the individual code.
3. As with any laboratory procedure, if the specimen is sent to an outside laboratory, only a collection fee may be billed. The laboratory may then bill Medicaid for the laboratory procedure. Refer to Section 272.450 of this manual.

NOTE: Payment will not be made for emergency room certified nurse-midwife charges for an OB patient admitted directly from the emergency room into the hospital for delivery.

272.493 Obstetrical Care Without Delivery 2-1-22

Certified nurse-midwives must use procedure code with modifier **UA** to bill for one to three visits for antepartum care without delivery.

Procedure code with no modifier must be used by providers to bill four to six visits for antepartum care without delivery. Procedure code with no modifier is to be used for 7 or more visits without delivery.

View or print the procedure codes for Certified Nurse Midwife (CNM) services.

This enables certified nurse-midwives rendering care to the patient during the pregnancy, but not delivering the baby, to receive reimbursement for their services provided. Coverage for this service will include routine sugar and protein analysis. One unit equals one visit. Units of service billed with this procedure code will not be counted against the patient's office visit benefit limit.

Providers must enter the "from" and "through" dates of service on the claim and the number of units being billed. One visit equals one unit of service. Providers must submit the claim within 12 months of the first date of service.

For example: An OB patient is seen by the certified nurse-midwife on 1-10-05, 2-10-05, 3-10-05, 4-10-05, 5-10-05 and 6-10-05. The patient then moves and begins seeing another provider prior to the delivery. The certified nurse-midwife may submit a claim with dates of service shown as 1-10-05 through 6-10-05 and 6 units of service entered in the appropriate field. This claim must be received by the Arkansas Medicaid fiscal agent prior to 12 months from 1-10-

05 to fall within the 12-month filing deadline. The certified nurse-midwife must have on file the patient's medical record that reflects each date of service being billed.

272.494 Fetal Non-Stress Test, Fetal Echography (Ultrasound) and External Fetal Monitoring 2-1-22

View or print the procedure codes for Certified Nurse Midwife (CNM) services.

A. The fetal non-stress test, procedure code, has a benefit limitation of two (2) per pregnancy. Prior authorization is not required.

B. CPT procedure code is applicable only to internal fetal monitoring during labor by a consultant. Procedure code with modifier **U1**, for external fetal monitoring, is payable to the certified nurse-midwife when performed in a certified nurse-midwife's office or clinic. Certified nurse-midwives may bill no more than one unit per day of external fetal monitoring, not to exceed two (2) per pregnancy.

C. Benefit limits apply to fetal echography (ultrasound), procedure codes.

D. Fetal echography is limited to two (2) per pregnancy. If it is necessary to exceed these limits, the certified nurse-midwife must request an extension of benefits. See Section 214.000 for benefit extension procedures.

272.495 Risk Management Services for Pregnancy 2-1-22

A certified nurse-midwife may provide the risk management services listed below if he or she employs the professional staff indicated in the service descriptions below. If a certified nurse-midwife does not choose to provide the risk management services but believes the patient would benefit from them, he or she may refer the patient to a clinic that offers risk management services for pregnancy. Each of the risk management services described in parts A through E has a limited number of units of service that may be furnished. Coverage of these risk management services is limited to a maximum of 32 cumulative units.

View or print the procedure codes for Certified Nurse Midwife (CNM) services.

A. Risk Assessment

A medical, nutritional and psychosocial assessment by the certified nurse-midwife or registered nurse to designate patients as high or low risk.

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

Maximum: 2 units per pregnancy

B. Case Management Services

Services by a certified nurse-midwife, licensed social worker or registered nurse that will assist pregnant women eligible under Medicaid in gaining access to needed medical, social, educational and other services. (Examples: locating a source of services, making an appointment for services, arranging transportation, arranging hospital admission, locating a physician to perform delivery following-up to verify that the patient kept appointment, rescheduling appointment).

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

C. Perinatal Education

Educational classes provided by a health professional (Certified Nurse-Midwife, Public Health Nurse, Nutritionist or Health Educator) to include:

1. Pregnancy
2. Labor and delivery
3. Reproductive health
4. Postpartum care
5. Nutrition in pregnancy

Maximum: 6 classes (units) per pregnancy

D. Nutrition Consultation – Individual

Services provided for high-risk pregnant women by a registered dietitian or a nutritionist eligible for registration by the Commission on Dietetic Registration to include at least one of the following:

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

Maximum: 9 units per pregnancy

E. Social Work Consultation

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

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

Maximum: 6 units per pregnancy

F. Early Discharge Home Visit

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

A certified nurse-midwife may order a home visit for the mother and/or infant discharged later than 24 hours if there is specific medical reason for home follow-up.

Procedure codes: CPT procedure codes as applicable.

272.500 Outpatient Hospital Services

272.501 Emergency Services 10-13-03

The appropriate CPT codes should be used when billing for certified nurse-midwife visits in an outpatient hospital setting for emergency services.

272.502 Non-Emergency Services 2-1-22

Procedure code (modifier **U3**) should be billed for a non-emergency certified nurse-midwife visit.

View or print the procedure codes for Certified Nurse Midwife (CNM) services.

272.503 Therapy and Treatment 10-13-03

The professional services related to all covered hospital therapy and treatment will be reimbursed according to Certified Nurse-Midwife Fee Schedule Rates for the appropriate CPT procedure code.

272.510 Pelvic Examinations, Removal of Sutures, Etc. 10-13-03

These services are not considered a separate service from an office visit. The charge for such services should be included in the office visit charge. Billing should be under the office visit procedure code that reflects the appropriate level of care.

272.520 Prior Authorization Control Number 10-13-03

When billing for procedures that have been prior authorized, enter the 10-digit prior authorization control number on the claim. See Sections 240.000 through 240.200 for additional information.

272.530 Substitute Certified Nurse-Midwife 10-1-15

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

A. Description of Service:

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

B. Substitute Certified Nurse-Midwife:

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

The following billing protocol must be utilized for substitute certified nurse-midwife circumstances:

1. The regular certified nurse-midwife submits the claim and receives payment using the regular Arkansas Medicaid provider number. The payment amount will be the lesser of the billed amount or the Arkansas Medicaid allowed amount for the service provided.
2. The modifier Q5 must be placed in form indicator 24D of the CMS-1500 claim form to indicate services were rendered by a substitute certified nurse-midwife.
3. The substitute certified nurse-midwife arrangement should not exceed 14 consecutive days. The substitute certified nurse-midwife arrangement does not apply to substitution for certified nurse-midwives in the same medical group with claims submitted in the name of the medical group. (For situations in which one group member substitutes for another, the substitution is noted by listing the substitute group member number as the rendering provider in field 24J on the CMS-1500 claim form, and the Q5 modifier is **not** used. The **group number** is listed as the billing provider.)

C. Locum Tenens Certified Nurse-Midwife:

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

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

The following billing protocol must be utilized for locum tenens certified nurse-midwife circumstances:

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

See the table below which compares the requirements for substitute and locum tenens certified nurse-midwives according to Arkansas Medicaid policy.

Requirement	Substitute Certified Nurse-Midwife	Locum Tenens Certified Nurse-Midwife
Must be enrolled as an Arkansas Medicaid provider	Yes	Yes
May be enrolled by the same group as the regular certified	No	No

nurse-midwife.		
Claims are submitted by the regular certified nurse-midwife's office and that office receives payment	Yes	Yes
Modifier required to identify arrangement	Yes, Q5	Yes, Q6
Maximum time frame allowed	14 days	60 days

272.531 National Drug Codes (NDCs) 1-1-23

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

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

A. Covered Labelers

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

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

Diagram 1

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

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

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

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

Diagram 2

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

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

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

Diagram 3

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

01111-456-71	01111**0**45671

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

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

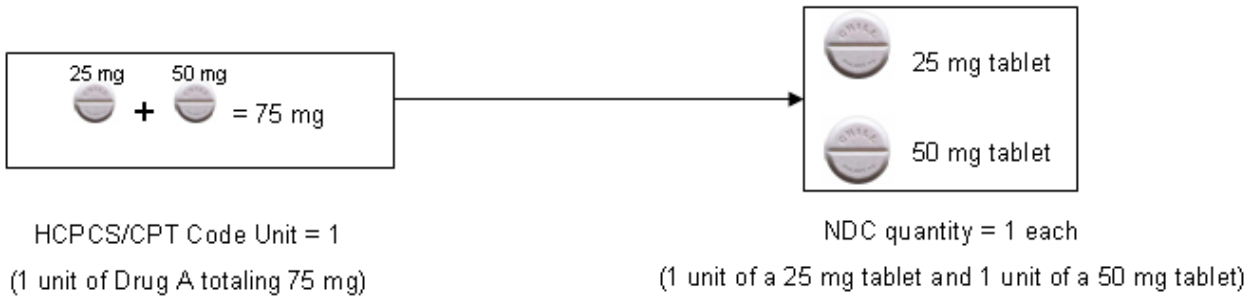
Exception: There is no requirement for an NDC when billing for vaccines, radiopharmaceuticals, and allergen immunotherapy.

I. Claims Filing

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

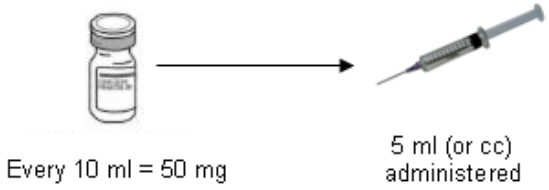
Example 1: The HCPCS/CPT code may specify up to 75 mg of the drug whereas the NDC quantity is typically billed in units, milliliters or grams. If the patient is provided 2 oral tablets, one at 25 mg and one at 50 mg, the HCPCS/CPT code unit would be 1 (1 total of 75 mg) in the example whereas the NDC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

Diagram 4



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

Diagram 5



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

NDC Quantity = 5 for the 5 ml administered

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

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

Providers are instructed to bill as follows:

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

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

NOTE: CMS definitions of modifiers:

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

B. Paper Claims Filing – CMS-1500

Providers are instructed to bill as follows:

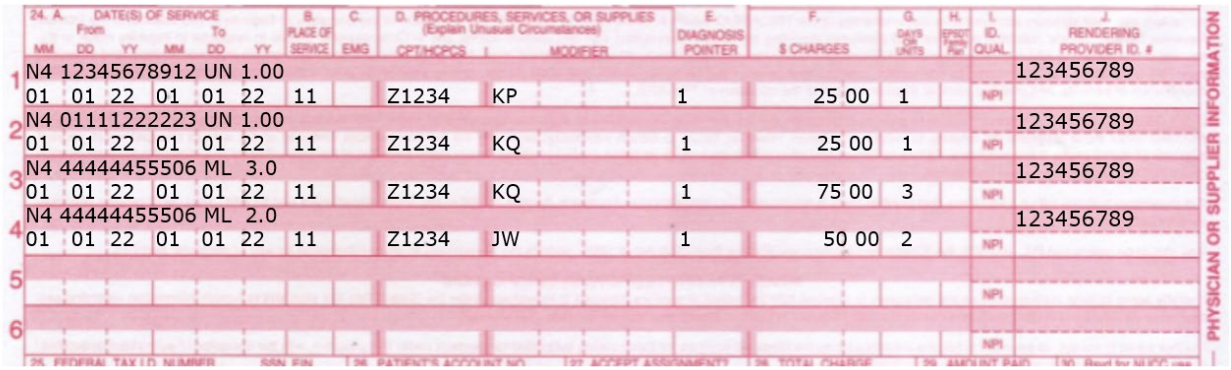
- 1 NDC for a procedure – 1st/only detail shall be billed with no modifier
- 2 NDCs for same procedure – 1st detail shall be billed with a KP and 2nd gets billed with a KQ modifier
- 3 NDCs for same procedure – 1st detail shall be billed with a KP and 2nd & 3rd detail get billed with a KQ modifier
-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

NOTE: CMS definitions of modifiers:

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

- JW = Drug wastage

Diagram 6



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

PHYSICIAN OR SUPPLIER INFORMATION

II. Adjustments

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

III. Record Retention

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

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

See Section 272.533 for additional information regarding drug code billing.

272.532 Obtaining a Prior Approval Letter 10-1-15

Providers must obtain prior approval, in accordance with the following procedures, for special pharmacy, therapeutic agents and treatments.

A. Before treatment begins, the Medical Director for Clinical Affairs for the Division of Medical Services (DMS) must approve any drug, therapeutic agent or treatment not listed as covered in this provider manual or in official DMS correspondence.

   This requirement also applies to any drug, therapeutic agent or treatment with special instructions regarding coverage in the provider manual or in official DMS correspondence.

B. The Medical Director for Clinical Affairs' prior approval is necessary to ensure approval for medical necessity. Additionally, all other requirements must be met for reimbursement.

   1. The provider must submit a history and physical examination with the treatment protocol before beginning the treatment.

   2. The provider will be notified by mail of the DMS Medical Director of Clinical Affairs' decision. No prior authorization number is assigned if the request is approved, but a prior approval letter is issued and must be attached to each claim. Any changes in treatment require resubmission and a new approval letter.

Send requests for a prior approval letter for pharmacy and therapeutic agents to the attention of the **Medical Director for Clinical Affairs for the Division of Medical Services**.

Refer to Section 272.533 for pharmacy and therapeutic agents for special billing procedures.

272.533 Injections, Therapeutic and/or Diagnostic Agents 1-1-23

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

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

Cannot be billed separately for Influenza Virus vaccines or Vaccines for Children (VFC) vaccines.

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

Cannot be billed when the drug administered is not FDA approved.

Covered drugs can be billed electronically or on paper. If requested, additional documentation may be required to justify medical necessity. Reimbursement for manually priced drugs is based on a percentage of the average wholesale price.

Arkansas Medicaid follows the billing protocol per the Federal Deficit Reduction Act of 2005 for drugs. See Section 272.531 for further information.

Administration of therapeutic agents is payable only if provided in a physician's office, place of service code "11." These procedures are not payable to the certified nurse-midwife if performed in any other setting. Therapeutic injections should only be provided by certified nurse-midwives experienced in the provision of these medications and who have the facilities to treat patients who may experience adverse reactions. The capability to treat infusion reactions with appropriate life support techniques should be immediately available. Only one administration fee is allowed per date of service unless "multiple sites" are indicated in the "Procedures, Services, or Supplies" field in the CMS-1500 claim form. Reimbursement for supplies is included in the administration fee. An administration fee is not allowed when drugs are given orally.

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 for therapeutic and chemotherapy administration procedure codes.

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

1. The provider must submit an electronic or paper claim that includes a description of the drug being represented by the unlisted procedure code on the claim form.
2. Documentation that further describes the drug provided must be attached and must include justification for medical necessity.
3. All other billing requirements must be met in order for payment to be approved.

C. **Immunizations**

Physicians may bill for immunization procedures on the CMS-1500 claim form. **View a CMS-1500 sample form.**

Coverage criteria for all immunizations and vaccines are listed in the **Procedure Code Tables – Arkansas Department of Human Services**.

Influenza virus vaccine through the Vaccines for Children (VFC) program is determined by the age of the beneficiary and which vaccine is used.

The administration fee for all vaccines is included in the reimbursement fee for the vaccine CPT procedure code.

D. **Vaccines for Children (VFC)**

The Vaccines for Children (VFC) Program was established to generate awareness and access for childhood immunizations. Arkansas Medicaid established new procedure codes for billing the administration of VFC immunizations for children under the age of 19 years of age. To enroll in the VFC Program, contact the Arkansas Department of Health. Providers may also obtain the vaccines to administer from the Arkansas Division of Health. **View or print Arkansas Department of Health contact information.**

Medicaid policy regarding immunizations for adults remains unchanged by the VFC Program.

Vaccines available through the VFC Program are covered for Medicaid-eligible children. Administration fee only is reimbursed. When filing claims for administering VFC vaccines, providers must use the CPT procedure code for the vaccine administered. Electronic and paper claims require modifiers **EP** and **TJ.** ARKids First-B beneficiaries are not eligible for the 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 First-B SCHIP vaccines. **View or print the Department of Health contact information.**

When vaccines are administered to beneficiaries of ARKids First-B services, only modifier **SL** must be used for billing. Any additional billing and coverage protocols are listed under the specific procedure code in the tables in this section of this manual. See Part F of this section.

E. **Billing of Multi-Use and Single-Use Vials**

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

1. 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.
2. 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.
    a. **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.
    b. **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.

c. **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.

See Section 272.531 for additional information regarding National Drug Code (NDC) billing.

F. **Process for Obtaining a Prior Authorization (PA) Number from the DHS contracted Prior Authorization vendor.**

Covered drugs may be billed electronically or on a paper claim. Additionally, these procedure codes requiring a PA will no longer require manual review during the processing of the claim.

A PA must be requested before treatment is initiated for any drug, therapeutic agent or treatment that indicates a PA is required in a provider manual or an official Division of Medical Services correspondence.

The PA requests should be completed using the approved contracted vendor PA request form **(View or print PA form.)**

A decision letter will be returned to the provider by fax or *e-mail* within five (5) business days.

If approved, the Prior Authorization number must be appended to all applicable claims, within the scope of the approval and may be billed electronically or on a paper claim with additional documentation when necessary.

Denials will be subject to reconsideration if received by the contracted vendor with additional documentation within fifteen (15) business days of date of denial letter.

A reconsideration decision will be returned within five (5) business days of receipt of the reconsideration request.

G. **Contact Information for Obtaining Prior Authorization**

View or print contact information to obtain the DHS or designated vendor step-by-step process for requesting prior authorization.

H. All family planning procedures require an FP modifier and a primary family planning diagnosis on the claim.

*Procedure code requires paper billing with applicable attachments and must follow NDC protocol. (See Section 272.531 for NDC protocol.)

See Section 240.000-240.200 for prior authorization procedures.

List 603 diagnosis codes include: (**View ICD Codes**.) Diagnosis List 603 restrictions apply to ages twenty-one (21) years and above unless otherwise indicated in the age restriction column.