Messages for Remittance Advices dated April 3, 2025 – April 10, 2025

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| TO: nurse practitioner, pharmacy, physician, and prosthetics providers | RE: Upcoming Changes for Preferred Blood Glucose Meters |
| Effective May 1, 2025, the following will be updated as a preferred option for Arkansas Medicaid.  - Freestyle Blood Glucose Meters and corresponding strips  The following Abbott blood glucose meters will be added as preferred products:  - FreeStyle Freedom Lite  - FreeStyle Lite  - FreeStyle Precision Neo  - Precision Xtra  The following Abbott blood glucose test strips will be added as preferred products:  - FreeStyle Insulinx  - FreeStyle Lite  - FreeStyle  - Precision Xtra  - FreeStyle Precision Neo  Effective May 1, 2025, the following will be updated as non-preferred options for Arkansas Medicaid.  - OneTouch Verio Reflect and corresponding test strips  - OneTouch Ultra2 and corresponding test strips  - OneTouch Verio Flex and corresponding test strips  True Metrix Meters and strips will remain as preferred diabetic supplies. Beneficiaries currently using a OneTouch product will need a new prescription for either a FreeStyle or True Metrix product beginning on May 1, 2025.  For any questions, contact the Prime Therapeutics Help Desk at 800-424-7895. | |
| TO: all providers | RE: Provider Input Requested Regarding Medicaid Vaccine Rates, Vaccine Administration Rates, and Billing |
| DHS recently emailed a survey link (https://forms.office.com/g/9975Uewd3c) to obtain provider input and information regarding Medicaid vaccine rates, vaccine administration rates, billing, payer mix, and cost. DHS seeks this information to determine the adequacy of rates for vaccines and their administration.  DHS chose to perform rate review for vaccines and their administration separately from other rates due to the seasonal nature of administration, the variety of providers who perform this service, and the varied settings where administration can be performed. As such, these rates do not neatly fit into any one provider group for analysis. DHS believes reviewing vaccines and their administration independently is the best way to get an accurate picture of how vaccines are being provided in Arkansas. Thank you in advance for taking a few minutes out of your very busy day to help gather this information, and as always, please reach out with any questions at ratereviews@dhs.arkansas.gov. | |

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| TO: All Providers | RE: Updates to NDC Modifier Processing |
| Modifier JG has been terminated by CMS effective 12/31/2024. The system has been updated to prevent the billing of HCPCS modifier JG for DOS on or after 1/1/2025.  As a reminder, effective January 1, 2023, Arkansas Department of Human Services enacted the following billing policy for NDCs. The system has also been updated to enforce this policy.  When submitting a claim with NDC(s) providers should bill as follows:  - When one (1) NDC is submitted on a claim for a procedure - the detail should be billed without modifier KP or KQ.  - When two (2) NDCs are submitted on a claim for the same procedure code, same date of service - a KP modifier is required on the first detail and a KQ modifier is required on the second detail.  - When three (3) NDCs are submitted on a claim for the same procedure code, same date of service - a KP modifier is required on the first detail and a KQ modifier is required on the second and third detail.  - When four (4) or more NDCs are reported, submit via CMS-1500 Claim Form.  - The first detail shall be billed with a KP modifier and second and subsequent details shall be billed with a KQ modifier.  - When reporting Wastage of each NDC, it should be billed on a separate line with a JW modifier and no KP or KQ modifier.  Note: 340B providers must also bill modifier TB (or JG for DOS through 12/31/2024).  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  Refer to the 'National Drug Codes (NDCs)' related section in your provider manual for more details.  Any claims processed inappropriately will be reprocessed. | |
| TO: HOSPITAL and PHYSICIAN providers | RE: Coverage for Procedure Code 58674 - LAPS ABLTJ UTERINE FIBROIDS |
| The Arkansas Department of Human Services has updated coverage for procedure code 58674, retroactive to 3/1/2024, under the contracts as noted below.  Provider ContractModifierPAMed RevGender  AMBSCSGYYF  ASTSG80, 81,82YYF  MEDSVYYF  OUTPAYYF  Claims analysis will be performed to identify and reprocess any claims that may have denied before the coverage was updated. | |

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| TO: All inpatient providers | RE: MUMP INPATIENT |
| Effective 3/25/2025: Inpatient providers can now submit claims spanning multiple Prior Authorization (PA) line segments with continuous authorized dates under the same prior PA, without cutting back or denying. Claims will continue to rely on the PA for processing and allocate the days to the corresponding PA line items under the same PA.  However, if authorized dates are not continuous, the claim will be reduced starting from the From Date of Service (FDOS) until continuity of authorized dates is reestablished.  Continuous dates are defined as follows: The end date of the current segment plus one day must match the effective date of the next segment. If the end date of the one PA line item is the same as the effective date of the next line item, this is considered overlapping, not continuous.  Prior Authorizations are no longer required for the first four days of an inpatient stay, even if the difference between the To Date of Service (TDOS) and admit date plus one exceeds four days.  A new Explanation of Benefits (EOB) will post to paid claims for any cutbacks due to PA units being exhausted for the Date of Service (DOS) billed. This EOB will instruct the provider to request a PA extension and rebill, rather than writing off the charges.  -- EOB 9012 – Cutbacks due to PA units exhausted. Request PA extension and rebill.  Additionally, CARC 151 and RARC N435 will be included on the EOB and the 835 file, indicating that a PA extension and rebill are required for the inpatient claim to adjudicate properly.  -- CARC 151: Payment Adjusted because the payer deems the information submitted does not support this many/frequency of services.  -- N435: Exceeds number/frequency approved/allowed with time period without support documentation. | |

***Thank you for your participation in the Arkansas Medicaid Program. If you have questions regarding these messages, please contact the Provider Assistance Center at (800) 457-4454 toll-free or locally at (501) 376-2211. Remittance Advices can be found using Search Payment History on the Arkansas Medicaid Provider Portal at*** [***https://portal.mmis.arkansas.gov/armedicaid/provider/Home/tabid/135/Default.aspx***](https://portal.mmis.arkansas.gov/armedicaid/provider/Home/tabid/135/Default.aspx)***.***