Messages for Remittance Advices dated May 29, 2025 – June 5, 2025

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| TO: Area Health Education Center (AHEC) and Physician providers | RE: Place of Service Updates for Procedure Code 50435 | |
| The Arkansas Department of Human Services has updated coverage in the MEDSV and ASTSG contracts to allow procedure 50435 [EXCHANGE NEPHROSTOMY CATH] to be performed in an ASC Place of Service (24).  Claims analysis will be performed going back one year. | | |
| TO: Certified Nurse-Midwife providers | RE: Fetal Ultrasound Procedure Codes Covered for Certified Nurse Midwives | |
| Arkansas Department of Human Services has updated the system to include covering the below Fetal Ultrasound procedure codes when rendered by a Certified Nurse Midwife effective June 1, 2025.  76801 - OB US < 14 WKS SINGLE FETUS  76802 - OB US < 14 WKS ADDL FETUS  76805 - OB US >= 14 WKS SNGL FETUS  76810 - OB US >= 14 WKS ADDL FETUS  76811 - OB US DETAILED SNGL FETUS  76812 - OB US DETAILED ADDL FETUS  76813 - OB US NUCHAL MEAS 1 GEST  76814 - OB US NUCHAL MEAS ADD-ON  76815 - OB US LIMITED FETUS(S)  76817 - TRANSVAGINAL US OBSTETRIC | | |
| TO: Ambulatory Surgical Center (ASC), Area Health Education Center (AHEC), Arkansas Department of Health (ADH), Certified Nurse-Midwife (CNM), Hospital, Nurse Practitioner, Pharmacy, and Physician providers | RE: Age update for Procedure Code 90739 HEPB VACC 2/4 DOSE ADULT IM | |
| The Arkansas Department of Human Services has updated the age restriction for procedure code 90739 [HEPB VACC 2/4 DOSE ADULT IM] from 19-45 to 19-999. This update is retroactive to 10/1/2023.  Claims analysis will be performed to identify and reprocess any claims that may have denied before the age was updated. | | |
| TO: Rehabilitation Hospital Provider Type 26, Specialty R1 | RE: Acute Care Rehabilitation Hospital Prior Authorizations (PAs) | |
| Effective May 1, 2025, Arkansas Department of Human Services will make changes to allow Rehabilitation Hospital providers (PT26/R1) to submit initial PA requests through the Provider Portal for ten (10) days rather than seven (7) days.  PA Process 1. Providers may submit new Prior Authorization (PA) requests for the first ten (10) days of the Rehabilitation Hospital stay rather than seven (7).  2. The process to submit PA requests has not changed.  3. Providers will continue to submit PA request via the Provider Portal as they do today.  4. Include documentation supporting the PA request for the initial ten (10) days. The following documentation is needed:  --Admission History and Physical- This can be a summary of the H&P or the full document.  --Therapy evaluations with goals and any outcomes if available as of the date of submission.  --Daily clinical information to document the severity of illness and intensity of service for each day- This may include a summary of the daily clinical information, or a daily progress note for each date of service.  --Therapy notes showing time of session, participation, and progress.  --Discharge planning to document any issues that could affect discharge such as placement issues or equipment needs.  5. The submission of a PA request does not guarantee approval. Documentation submitted must support the medical necessity for the admission.  6. If additional/subsequent hospital days are needed, PA extensions can be requested through the normal process used today (PA Extensions may be requested through the Provider Portal).  7. Prior authorization of service does not guarantee eligibility for a member. Payment is still subject to verification that the member was eligible at the time services are provided.  8. All records are subject to retrospective review.  https://humanservices.arkansas.gov/wp-content/uploads/ON-013-25.docx | | |
| TO: nurse practitioner and physician Providers | RE: EPSDT Services - Extension of Benefit Requests | |
| Providers are to request the extension of benefits for procedure code 96110- Developmental Screening Services for Process Type 126 (Professional Services) through AFMC via the Provider Portal. https://portal.mmis.arkansas.gov  To submit the request for the extension of benefit, users will log onto the Provider Portal and submit a Prior Authorization request for the extension of benefit. Please include the Remittance Advice (RA) and clinical documentation to support the additional screening.  Please note:  • Requests for extensions must be submitted to DHS or its designated vendor.  • Requests for extension of benefits are considered only after a claim is filed and is denied because the patient’s benefit limits are exhausted.  • Benefit extension requests must be received within ninety (90) calendar days of the date of the benefit-exhausted denial.  • A copy of the Remittance Advice (RA) reflecting the claim’s denial for exhausted benefits must be submitted with the request.  • A copy of the claim is not required for the benefit extension request.  • An extension of benefit request must match the denied claim.  Contact information for AFMC is located at the below link. https://humanservices.arkansas.gov/wp-content/uploads/AFMC.doc  For additional information regarding how to submit the extension of benefit, please go to https://share.vidyard.com/watch/2N8NnemBmoBwrXtaRwvbJc | | |
| TO: All Providers | | RE: New Edit for NDC Units Billed |
| The Arkansas Department of Human Services has made updates to the MMIS core system to ensure claims are billed in accordance with the National Drug Code (NDC) billing instructions found in Section II of the appropriate Manuals noted in the Official Notice link below.  Effective May 1, 2025, a new edit will post and pay all claims which are not billed in accordance with Arkansas Policy related to the Drug Procedure (HCPCS/CPT) to NDC Relationship and Billing Principles.  - To ensure your claims are billed correctly and with appropriate units, providers should refer to examples found in Section II of the appropriate manuals noted in the Official Notice link below.  - There are NDC Units Calculator tools available through various vendors.  - Explanation of Benefit (EOB) 1257 – Submitted NDC Units are Greater than Covered HCPCS Units; will appear on your remittance advice for informational purposes. However, the detail will continue through processing without denial at this time.  After the 90-day grace period, edit 1014 will be changed to deny for the claim lines that are billed incorrectly. An additional official notice will be published indicating the grace period is ending.  https://humanservices.arkansas.gov/wp-content/uploads/ON-012-25.docx | | |

***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)***.***