TOC not required

292.551 Family Planning Services For Beneficiaries

~~2-1-22~~1-1-24

Family planning services are covered for beneficiaries in full coverage 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**. **Please note: See the tables below within this section to determine restrictions applicable to some procedures**. Laboratory procedure codes covered for family planning are listed in Section 292.552.

A. Sterilization

A copy of the properly completed Sterilization Consent Form (DMS-615), with all items legible, must be attached to each sterilization claim submitted from each provider before payment may be approved. Providers include hospitals, physicians, anesthesiologists, and assistant surgeons. It is the responsibility of the physician performing the sterilization procedure to distribute correct legible copies of the signed consent form (DMS-615) to the hospital, anesthesiologist, and assistant surgeon.

Though prior authorization is not required, an improperly completed Sterilization Consent Form (DMS-615) results in the delay or denial of payment for the sterilization procedures. The checklist lists the items on the consent form that are reviewed before payment is made for any sterilization procedure. Use this checklist before submitting any consent form and claim for payment to be sure that all criteria have been met. View or print form DMS-615 (English) and the checklist. View or print form DMS-615 (Spanish) and the checklist.

B. The following procedure table explains family planning procedure codes payable to physicians. These codes require modifier FP except for hospital-based physicians. (See Sections D, E and F below for codes payable to hospital-based physicians.)

View or print the procedure codes for Physician/Independent Lab/CRNA/Radiation Therapy Center services.

*CPT codes represent procedures to treat medical conditions as well as for elective sterilizations.

**This procedure requires special billing instructions. Refer to Section 292.553.

***Reimbursement for laboratory procedures requiring a venous blood specimen includes the collection fee when performed by the same provider.

¤This procedure code is not to be billed with an FP modifier but should follow the anesthesia billing protocol as seen in Sections 272.100, 292.440 through 292.442 and 292.444 through 292.447.

C. The following procedure code table explains the family planning visit services payable to physicians.

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

D. The following procedure code table explains the codes that are payable to hospital-based physicians.

*CPT codes represent procedures to treat medical conditions as well as for elective sterilizations; however, these procedure codes are not allowable for Aid Category 69.

**This procedure requires special billing instructions. Refer to Section 292.553.

E. The following procedure code table explains the family planning visit services payable to the hospital-based physicians.

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

F. Effective 1/1/2024,~~-~~ 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 i~~I~~npatient 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**~~**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 ~~**see**~~ **LARC billing combinations for billing codes**.
4. The 340-B rules and modifiers to the LARC code combinations apply, when applicable.

G. The following procedure code table explains the pathology procedure code payable to hospital-based physicians.

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

Family planning laboratory codes are found in **Section 292.552**.

TOC not required

214.330 Family Planning Coverage Information

~~1-15-16~~1-1-24

A. Arkansas Medicaid encourages reproductive health and family planning by reimbursing nurse practitioners 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 214.321 through 214.333 of this manual for service description and coverage information.

C. Nurse practitioners desiring to participate in the Medicaid Family Planning Services Program may do so by providing the services listed in Sections 214.321 through 241.333 to Medicaid beneficiaries of childbearing age.

D. Nurse practitioners 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. Physicians
4. Rural Health Clinics
5. Federally Qualified Health Centers
6. Family planning clinics
7. Physicians
8. Certified Nurse-Midwives

E. Effective 1/1/2024, 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 ~~i~~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 **sSee 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 252.430 through 252.431 of this manual.

TOC not required

215.200 Family Planning Coverage Information

~~10-1-15~~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 i~~I~~npatient 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 s~~**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.

TOC not required

216.000 Family Planning

~~10-1-15~~1-1-24

States participating in the Medicaid Program are required to cover family planning services. Arkansas Medicaid covers family planning services in a variety of settings, including hospitals. See Sections 216.100-216.110, 216.130-216.132, 216.515 and 216.540-216.550 for Family Planning Information.

Effective 1/1/2024~~,~~ 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:

A. The Hospital should continue to bill the inpatient stay on an i~~I~~npatient claim (CMS-1450, formerly UB-04).

B. 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.

C. 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 **see LARC billing combinations for billing codes**.

D. The 340-B rules and modifiers to the LARC code combinations apply, when applicable.

1. Inpatient Hospital Services (continued)

Long-Acting Reversible Contraceptives (LARC)

Effective for claims with dates of service on or after January 1, 2024, all acute care hospitals will be reimbursed in addition to the per diem rates for Food and Drug Administration approved Long-Acting Reversible Contraceptives (LARCs) to include the IUD and contraceptive implants, and insertion and removal. LARC reimbursement will be the same as found in Attachment 4.19-B page 1v.

State of Arkansas
94th General Assembly
Regular Session, 2023

A Bill

HOUSE BILL 1385

By: Representatives Vaught, Scott
By: Senators B. Davis, C. Tucker

For An Act To Be Entitled

AN ACT TO ENSURE THAT HEALTHCARE PROVIDERS ARE PROPERLY REIMBURSED BY THE ARKANSAS MEDICAID PROGRAM FOR PROVIDING LONG-ACTING REVERSIBLE CONTRACEPTION IMMEDIATELY AND DURING POSTPARTUM; AND FOR OTHER PURPOSES.

Subtitle

TO ENSURE THAT HEALTHCARE PROVIDERS ARE PROPERLY REIMBURSED BY THE ARKANSAS MEDICAID PROGRAM FOR PROVIDING LONG-ACTING REVERSIBLE CONTRACEPTION IMMEDIATELY AND DURING POSTPARTUM.

BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF ARKANSAS:

SECTION 1. Arkansas Code Title 20, Chapter 77, Subchapter 1, is amended to add an additional section to read as follows:

20-77-148. Long-acting reversible contraception coverage — Legislative findings.

(a) The General Assembly finds that:

(1) The Arkansas Medicaid Program currently covers long-acting reversible contraception;

(2) Due to the payment model used by the program for coverage of pregnant women, healthcare providers have found that providing long-acting reversible contraception during postpartum is cost prohibitive; and

(3) Action should be taken to ensure that healthcare providers

can provide long-acting reversible contraception during postpartum.

(b)(1) The Arkansas Medicaid Program shall reimburse a healthcare provider for providing long-acting reversible contraception immediately and during postpartum.

(2) Reimbursement under subdivision (b)(1) of this section shall be in addition to the regular payments for services to pregnant women provided by a healthcare provider.

(c) The Department of Human Services shall apply for any federal waiver, Medicaid state plan amendment, or other authorization necessary to implement this section.

APPROVED: 4/11/23

RECEIVED
SEP 21 2023
BUREAU OF
LEGISLATIVE RESEARCH

RULES SUBMITTED FOR REPEAL

Rule #1: DDS Policy 1088 – Burial Insurance

Rule #2: DDS Policy 2001 – Building and Contents Insurance Claims

ARKANSAS DEPARTMENT OF HUMAN SERVICES
DIVISION OF DEVELOPMENTAL DISABILITIES SERVICES
DDS DIRECTOR'S OFFICE POLICY MANUAL

Policy Type	Subject of Policy	Policy No.
Administrative	Burial Insurance	1088

1. **Purpose**: The purpose of this policy is to ensure that burial insurance is offered to any person residing in a Human Development Center (HDC) and to ensure that affected DDS community providers are informed about the existence of burial insurance when an individual moves from an HDC to the community.

2. **Scope**: This policy applies to all employees of DDS.

3. **Definitions**:

A. Burial Insurance – An insurance policy purchased by or for an individual specifically for the purpose of providing funds for burial expenses.

B. Consent – Written permission from the decision-maker approving the purchase of a specific benefit amount of burial insurance.

C. Designated staff member – The employee of an HDC who has been specified by the HDC administrator to perform tasks related to burial insurance.

D. Decision maker – The individual with the legal authority to consent to or refuse the expenditure of funds. This may be an adult individual receiving services, the parent(s) of a minor child receiving services, or an adult individual's legal guardian.

4. **Procedures**:

A. Prior to or upon admission, the designated staff member will request from the individual, the parent(s), a responsible party, or the legal guardian copies of any burial and/or life insurance policies that are in effect for the individual being admitted.

B. Prior to or upon admission, a designated staff member will discuss with the decision maker burial insurance options that are available.

C. If the decision maker decides to purchase burial insurance, the designated staff member will obtain written consent to purchase burial insurance for the individual and will notify the funeral home chosen by the decision maker. Refusal of burial insurance by the decision maker will also be documented.

D. The cost of the burial insurance will be the responsibility of the decision-maker.

Policy Type	Subject of Policy	Policy No.
Administrative	Burial Insurance	1088

E. Information about burial insurance will be presented to the decision maker at least annually, if burial insurance appears to be warranted and the purchase of burial insurance has previously been refused.

F. The funeral home that sells the burial insurance will normally be named as the beneficiary. If the funeral home that sold the policy will not be the funeral home to conduct the burial, and a transfer of benefits from the former funeral home to the latter is not an option, the designated staff member will ask the decision maker to name another beneficiary.

G. Upon the discharge of an individual from an HDC, the designated staff member will provide information for the continuation of burial insurance to the decision maker, the individual's DDS Service Specialist, and to the DDS community provider who will be providing the individual's services.

5. **Record Keeping**:

Written consent forms for the purchase of burial insurance will be completed and placed in the individual's Master File within 15 days of admission or at the time of signing if the burial insurance is purchased at a later date. Copies of all policies will be maintained in the Master File.

Reviewed: Arkansas Legislative Council Administrative (Rules and Regulations) Subcommittee _____ 2003

ARKANSAS DEPARTMENT OF HUMAN SERVICES
DIVISION OF DEVELOPMENTAL DISABILITIES SERVICES
DDS DIRECTOR'S OFFICE POLICY MANUAL

Policy Type	Subject of Policy	Policy No.
Fiscal	Building and Contents Insurance Claims	2001

1. Purpose. This policy has been prepared to explain the real property insurance claim responsibility of the Department of Human Services Division of Developmental Disabilities Services.

2. Scope. This policy concerns all business managers of Developmental Disabilities Services and other interested parties. The DDS Director/designee(s) has responsibility for ensuring compliance.

3. Agency Responsibility. DDS will carry real property insurance on State buildings and certain of their contents held in trust by the DDS Board.

4. Procedural Additions. Procedures for making insurance claims against real property damage are kept in and disseminated by Department of Human Services – Division of Management Services.

REPEAL-EO 23-02

Replacement Notation: This Policy replaces DDS Deputy Director's Office Policy Number 1001 effective October 17, 1979.

Effective Date: March 15, 1993 Sheet 1 of 1

References: Board Action December 15, 1979