Statement of Necessity and Rule Summary
Maternal Health Providers

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Statement of Necessity

The Division of Medical Services (DMS) implements Acts 124, 140, 627, and 965 of 2025. These Acts mandate the Arkansas Medicaid Program to provide coverage and reimbursement for purchase of self-measurement blood pressure monitoring services for pregnant women and postpartum women, and establish coverage for two new provider types, doulas and lactation consultants. Acts 124 and 140 also require Medicaid coverage of continuous glucose monitoring (CGM), This requirement does not require a change to the Medicaid provider manuals or a State Plan Amendment, as CGMs are already covered by Medicaid.

Summary

To comply with the Acts, DMS creates a new Nonclinical Maternal Care Medicaid Provider manual providing rules for doulas and lactation consultants and updates the Prosthetics Provider Manual to cover the purchase of blood pressure monitors. DMS will submit to the Centers for Medicare & Medicaid an amendment to the Arkansas Medicaid State Plan for the new provider types.

Changes made after Public Comments and based on CMS Requests

1. In response to comments, the title of the new manual changed to Supportive Maternal Care (SMC) Provider Manual.
2. Updated SMC throughout to address the concern that lactation counselors should not be required to perform clinical services; changed language around the documentation of treatment plans to clarify that these are service delivery plans and are non-clinical in nature.
3. Updated manuals to increase the length of time for which beneficiaries may receive lactation services to twelve (12) months postpartum.
4. Revised doula services to allow the PASSEs the option of covering doula services for their members.
5. Based on feedback, revised provisions to allow doulas who are also lactation consultants or counselors to bill for both service types; but providers may not double bill (or bill for providing both services at the same time) and records must reflect the times that each service was provided.
6. Removed referral provision for doula services and instead will issue a standing recommendation from our medical director to allow all pregnant women to access doula services.
7. Updated doula to a total of six visits without additional restrictions on when the visits can be used, plus attendance at delivery, but note that beneficiaries who need additional services may request an extension of benefits.

8. Clarified that remote monitoring applies to all pregnant women (updated billing for providers in the Certified Nurse Midwife, Nurse Practitioner, and Physician manuals).
9. Eliminated limits on ultrasounds and fetal non-stress tests to expand access to fetal monitoring, particularly for women in rural areas. This required adding the following manual revisions to the rule to implement and allow the testing – Ambulatory Surgical Center, Chiropractic, Certified Nurse Midwife, Hospital, Nurse Practitioner, Physician and Podiatrist.
10. Added coverage of replacement cuffs with A4663 as a covered code with a reimbursement rate of $25.93.
11. Prosthetics Manual section 212.204 updated to include replacement cuffs.
12. Added clarifying language to State Plan Amendment to address and conform to all of the above and based upon CMS guidance.

TOC required

215.110 Benefit Limits for Diagnostic Laboratory and Radiology/Other Services

97-1-226

A. Both diagnostic laboratory and radiology/other services in all settings, including ASCs, are subject to a benefit limit.

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. Magnetic resonance imaging (MRI) services are exempt from the radiology/other services benefit limit per SFY.

C. Individuals under twenty-one (21) years of age are not subject to the diagnostic laboratory services benefit limit or to the radiology/other services benefit limit~~, except for the limitations on fetal echography (ultrasound) and fetal non-stress tests~~.

215.111 ~~Benefit Limits for Fetal Ultrasound and Fetal Non-Stress Tests~~ Reserved

~~2-1-05~~9-1-26

~~A. Fetal echography (ultrasound) and fetal non-stress tests are limited to 2 each per pregnancy for all ages.~~

~~B. Medicaid will consider extending these benefits if the procedures are medically necessary.~~

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TOC not required

212.000 Coverage of Chiropractic Services 97-1-262

A. Chiropractic services must be administered by a licensed chiropractor, meeting minimum standards promulgated by the Secretary of Health and Human Services under Title XVIII of the Social Security Act. Manipulation of the spine for the treatment of subluxation is the **only** chiropractic service covered by Medicaid.

B. Benefits.

1. Benefits are not limited for beneficiaries under twenty-one (21) years of age (in the Child Health Services/Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Program)~~, except for the limitations on fetal echography (ultrasound) and fetal non-stress tests~~.
2. Medicaid covers chiropractic services for beneficiaries twenty-one (21) years of age and older, with a benefit limit of twelve (12) visits per State Fiscal Year (SFY: July 1 through June 30).
3. Two (2) chiropractic X-rays per SFY are covered by Medicaid. However, an X-ray is not required for treatment.
4. Chiropractic X-rays count against the five-hundred-dollar per SFY radiology/other services benefit limit.

   Radiology/other services include without limitation diagnostic X-rays, ultrasounds, and electronic monitoring/machine tests, such as electrocardiograms (ECG or EKG).
5. The radiology/other services benefit may be extended when medically necessary (see Section 214.000). All X-rays and documentation must be kept in the beneficiary's medical record for a period of five (5) years for audit purposes. Chiropractic services may be provided in the provider's office, the patient's home, a nursing home, or another appropriate place.

C. For beneficiaries who are eligible for Medicare and Medicaid, see Section I of this manual for additional coinsurance and deductible information. See **Section III** for instructions on filing joint Medicare/Medicaid claims.

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TOC not required

213.410 Diagnostic Laboratory and Radiology Other Services Benefit Limits 97-1-262

A. Medicaid established maximum amounts (benefit limits) for outpatient diagnostic laboratoriesy 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 laboratoriesy or radiology/other services performed in conjunction with emergency services in an emergency department of a hospital.

213.510 Outpatient Hospital Benefit Limit 10-1-159-1-26

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.)**

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5. Opioid Use Disorder when Treated with MAT	**(View ICD OUD 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.~~

213.710 Fetal Non-Stress Test and Ultrasound

~~2-1-22~~9-1-26

~~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.~~The Arkansas Medicaid Program covers the fetal non-stress test and the ultrasound when performed in conjunction with maternity care.

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~~9-1-26

The certified nurse-midwife may bill Medicaid for external fetal monitoring performed in the certified nurse-midwife's office when it is medically necessary and in addition to the obstetrical office visit.~~.~~

~~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)~~Reserved

~~10-13-03~~9-1-26

~~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.~~

272.490 Obstetrical Care

~~7~~9-1-26~~5~~

Providers should bill for prenatal, delivery, and postpartum services, and remote monitoring of pregnant women separately. Effective
July 1, 2025, and thereafter, global obstetrical billing is not payable.

When billing obstetrical services, **view or print the procedure codes for Certified Nurse Midwife (CNM) services**.

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.

A. When lab tests 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

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diagnostic facilities are completely dependent on the referring certified nurse-midwife for diagnosis information necessary for reimbursement.

B. 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.

C. 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.

Certified nurse-midwives must use the appropriate procedure code with modifier **UA** to bill for one to three visits for prenatal care.

The appropriate procedure code with no modifier must be used by providers to bill four to six (6) visits for prenatal care without delivery, and the appropriate procedure code with no modifier is to be used for seven (7) or more visits without delivery.

View or print the procedure codes for Certified Nurse Midwife (CNM) services to identify which procedure codes are allowable.

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 twelve (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~~9-1-26

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.~~ Refer to the procedure code table at the above link for the appropriate CPT code. This CPT ~~procedure~~ code is only applicable ~~only~~ to internal fetal monitoring ~~during labor~~ by a consultant during the beneficiary's labor. Procedure code with modifier U1, for external fetal monitoring, is payable to the certified nurse-midwife when performed in ~~a certified nurse-midwife's~~their office or clinic. Certified nurse-midwives may not bill ~~no~~ more than one (1) unit per day of external fetal monitoring and can, ~~not to~~ exceed two (2) per pregnancy.

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

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~~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.~~

272.496 Certified Nurse-Midwives Who Are Also Supportive Maternal Care Providers or Community Health Workers **9-1-26**

A. A certified nurse-midwife (CNM) who is also a certified community-based doula may not bill for both doula services and midwife services for the same beneficiary for the same pregnancy.

B. A CNM who is also a breastfeeding and lactation consultant may bill for breastfeeding and lactation consultant services separate from the services they provide as a CNM for the same beneficiary if the services are provided on different days.

C. A CNM who is also a community health worker (CHW) may bill for CHW services separate from the services they provide as a CNM for the same beneficiary if the services are provided on different days.

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TOC not required

215.020 Benefit Limit for Non-Emergency Services

~~10-1-15~~9-1-26

A. Non-emergency outpatient hospital services are:

1. Non-emergency outpatient hospital and related physician services and
2. Outpatient hospital treatment and therapy services and related physician services.

B. Beneficiaries aged twenty-one (21) and older are limited to a total of twelve (12) non-emergency outpatient hospital visits per state fiscal year, July 1 through June 30.

1. The outpatient hospital benefit limit includes outpatient hospital services provided in an acute care/general hospital, a rehabilitative hospital, or both.
2. Treatment and therapy services are included in the non-emergency outpatient hospital services limit of twelve (12) visits per state fiscal year.
3. Separately covered Medicaid services when provided~~Services that Medicaid covers separately when furnished~~ in conjunction with one another ~~*and* that occur~~ during the same outpatient encounter are counted against the~~is~~ benefit limit as only *one* non-emergency outpatient hospital service.

C. Requests for extension of this benefit are considered for patients who require supportive treatment for maintaining life.

D. Extension of this benefit is automatic for patients whose primary diagnosis for the service furnished is in the following list:

1. Malignant neoplasm (**View ICD Codes**.)
2. HIV infection and AIDS (**View ICD Codes.**)
3. Renal failure (**View ICD Codes.**)
4. Pregnancy (**View ICD Codes.**)
5. Opioid Use Disorder when treated with MAT (**View ICD OUD Codes**.)

E. Beneficiaries under ~~age~~ twenty-one (21) years old in the Child Health Services (EPSDT) Program are not benefit-limited, except with respect to the services listed in Section 215.021.

~~*OB ultrasounds and fetal non stress tests are not exempt from Extension of Benefits. See Section 215.041 for additional coverage information.~~

215.040 Benefit Limit in Outpatient Diagnostic Laboratory and Radiology/Other Procedures

~~9~~7-1-2~~2~~6

A. Arkansas Medicaid limits claim~~s~~ payment for outpatient diagnostic laboratory services and radiology/other services ~~per~~ for beneficiar~~y~~ies twenty-one (21) years of age or older.

1. The benefit limits are based on the State Fiscal Year (SFY: July 1 through June 30).
2. Diagnostic laboratory services benefits are limited to five hundred dollars ($500) per SFY, and radiology/other services benefits are limited to five hundred dollars ($500) per SFY.
3. Radiology/other services include without limitation diagnostic X-rays, ultrasounds, and electronic monitoring or machine tests, such as electrocardiograms (ECG or EKG).

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4. 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. The benefit limits apply to claim~~s~~ payments made to the following providers, individually or in any combination: outpatient hospitals, independent laboratories, physicians, osteopaths, podiatrists, Certified Nurse-Midwives (CNMs), Nurse Practitioners (NP), and Ambulatory Surgical Centers (ASCs).

C. Requests for extensions of both benefits are considered for beneficiaries who require supportive treatment for maintaining life.

D. Extension of these benefits are automatic for patients whose primary diagnosis for the service furnished is in the following list:

1. Malignant neoplasm (**View ICD Codes**);
2. HIV infection and AIDS (**View ICD Codes**);
3. Renal failure (**View ICD Codes**);
4. Pregnancy~~*~~ (**View ICD Codes**): or
5. Opioid Use Disorder (OUD) when treated with Medication Assisted Treatment (MAT). (**View ICD OUD Codes**) Designated laboratory tests will be exempt from the laboratory services benefit limit when the diagnosis is OUD (**View Laboratory and Screening Codes**).

~~E. *Obstetric (OB) ultrasounds and fetal non stress tests have benefit limits that are not exempt from Extension of Benefits request requirements. (See Section 215.041 for additional coverage information.)~~

E~~F~~. Magnetic Resonance Imaging (MRI) is exempt from the five-hundred-dollar radiology/other services benefit limit. Medical necessity for each MRI must be documented in the beneficiary's medical record. (Refer to Section 270.000 for billing information.)

~~G~~F. Cardiac catheterization procedures are exempt from the five-hundred-dollar outpatient diagnostic laboratory services benefit limit and the five-hundred-dollar radiology/other benefit limit. Medical necessity for each procedure must be documented in the beneficiaries' medical record.

~~H~~G. There are no benefit limits on outpatient diagnostic laboratory services or radiology/other services for beneficiaries under twenty-one (21) in the Child Health Services/Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Program~~, except for the limitations on fetal echography (ultrasound) and fetal non-stress tests~~.

~~*OB ultrasounds and fetal non stress tests are not exempt from Extension of Benefits. See Section 215.041 for additional coverage information.~~

215.041 ~~Benefit Limits for Fetal Non-Stress Test and Fetal Ultrasound~~Reserved

~~10-13-03~~9-1-26

~~A. Fetal echography (ultrasound) is limited to two (2) per pregnancy.~~

~~B. Fetal non-stress test is limited to two (2) per pregnancy.~~

~~C. Extension of benefits for these procedures will be considered for reasons of medical necessity.~~

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215.100 Benefit Extension Requests 97-1-226

A. The Medicaid Program's diagnostic laboratory services and radiology/other services benefit limits 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. Requests to extend benefits for outpatient hospital visits and diagnostic laboratory or X-ray services~~, including those for fetal ultrasounds and fetal non-stress tests,~~ must be submitted to DHS or its designated vendor.

View or print contact information to obtain instructions for submitting the benefit extension request.

Benefit extension requests are considered only after a claim has been filed and denied because the benefit is exhausted.

C. Submit a copy of the Medical Assistance Remittance and Status Report that reflects the claim's denial ~~for~~ of exhausted benefits with the request. Do not send a claim.

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

E. 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.

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

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TOC not required

214.510 Diagnostic Laboratory and Radiology/Other Services Benefit Limits 97-1-262

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

1. Radiology/other services include without limitation diagnostic X-rays, ultrasounds, and electronic monitoring/machine tests, such as electrocardiograms (ECG or EKG).
2. All the benefit limits in this section are calculated per State Fiscal Year (SFY: July 1 through June 30).
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. Medicaid established a maximum amount (benefit limit) of five hundred dollars ($500) per SFY for diagnostic laboratory services and five hundred dollars ($500) per SFY for radiology/other services for beneficiaries twenty-one (21) years of age and older. Exceptions are listed below:

1. There is no diagnostic laboratory services benefit limit or and the radiology/other services benefit limit do not apply for beneficiaries under twenty-one (21) years of age.
2. There is no benefit limit on diagnostic laboratory services related to family planning does not apply. (Refer to Section 252.431 of this manual for the family planning-related clinical laboratory procedures.)
3. There are no bBenefit limits do not apply for on diagnostic laboratory services or radiology/other services that are performed as emergency services and approved by DHS or its designated vendor for payment as emergency services.

   View or print contact information to obtain the DHS or designated vendor step-by-step process for requesting extension of benefits.
4. Claims with the following primary diagnoses are exempt from diagnostic laboratory services or radiology/other services benefit limits:
   a. Malignant Neoplasm (**View ICD Codes**);
   b. HIV disease and AIDS (**View ICD Codes**);
   c. Renal failure (**View ICD Codes**);
   d. Pregnancy* (**View ICD Codes**); or
   e. Opioid Use Disorder (OUD) when treated with Medication Assisted Treatment (MAT). (**View ICD OUD Codes.**) Designated diagnostic laboratory tests will be exempt from the diagnostic laboratory services benefit limit when the diagnosis is OUD. (**View Laboratory and Screening Codes.**)

C. *Obstetric (OB) ultrasounds and fetal non-stress tests have benefit limits and are not exempt from Extension of Benefits request requirements. (See Section 214.630 for additional coverage information.)

DC. Extension of benefit requests are considered for clients who require supportive treatment, such as dialysis, radiation therapy, or chemotherapy for maintaining life.

ED. Benefits may be extended for other conditions documented as medically necessary.

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214.600 Obstetrical Services ~~79~~-1-26~~5~~

The Arkansas Medicaid Program covers obstetrical services including prenatal services, delivery, and postpartum care, and remote monitoring of pregnant women for Medicaid-eligible ~~clients~~ beneficiaries in *full* coverage aid categories with a medically verified pregnancy.

Aid category 61, PW clients are eligible for full range Medicaid coverage. Aid category 61, PW pregnant women's eligibility ends on the last day of the month in which the 60th postpartum day falls.

Medicaid provides temporary Aid Category 62, Presumptive Eligibility Pregnant Woman (PE-PW). Coverage is restricted to prenatal services and services for conditions that may complicate the pregnancy. These services are further limited to the outpatient setting only.

214.630 ~~Fetal Non-Stress Test~~Reserved ~~2-1-22~~9-1-26

~~The fetal non-stress test is *limited to 2 per pregnancy per beneficiary*. If it is necessary to exceed this limit, the nurse practitioner must request an extension of benefits and submit documentation that establishes medical necessity. Refer to Section 214.900 of this manual for procedures to request extension of benefits. Refer to **Section 252.451** of this manual for billing instructions and the procedure code.~~

~~The post-procedural visits are covered within the 10-day period following the fetal non-stress test.~~

214.930 Documentation Requirements ~~79~~-1-26~~2~~

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 extension of benefits for any services with benefit limits, a~~All applicable records that support the medical necessity of extended benefits are required to request extension of benefits.

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, and emergency room records for 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 the obstetrical record related to a current pregnancy when applicable; and
   g. Include clinical indication for diagnostic laboratory and radiology/other services

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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.

252.451 **~~Fetal Non-Stress Test~~Reserved** **~~2-1-22~~9-1-26**

~~The Fetal Non-Stress Test (procedure code) is limited to 2 per pregnancy. If it is necessary to exceed this limit, the nurse practitioner must request an extension of benefits and submit documentation that establishes medical necessity.~~

~~**View or print the procedure codes for Nurse Practitioner services.**~~

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TOC required

222.000 Fetal Non-Stress Test and Ultrasound ~~Benefit Limits~~ ~~2-1-22~~9-1-26

The Arkansas Medicaid Program covers the ~~F~~fetal ~~N~~non-~~S~~stress ~~T~~test and the ~~U~~ultrasound when performed in conjunction with maternity care. Refer to **Section 292.673** of this manual for procedure codes.

~~A. The Ultrasound and Fetal Non-Stress Test have a benefit limit of two (2) per pregnancy.~~

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

~~If it is necessary to exceed the Medicaid established benefit limits, the physician must request extension of the benefit with documentation that justifies the need for additional tests and establishes medical necessity.~~

225.100 Diagnostic Laboratory and Radiology/Other Services ~~9~~7-1-26~~2~~

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

1. Radiology/other services include without limitation diagnostic X-rays, ultrasounds, and electronic monitoring or machine tests, such as electrocardiograms (ECG).
2. All benefit limits in this section are calculated ~~per~~ by State Fiscal Year (SFY: July 1 through June 30).
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. Medicaid has an established ~~a~~ maximum amount (benefit limit) of five hundred dollars ($500) per SFY for diagnostic laboratory services and five hundred dollars ($500) per SFY for radiology/other services, for clients twenty-one (21) years of age and older.

1. ~~There are n~~No laboratory or radiology/other benefit limits apply for clients under twenty-one (21) years of age~~, except for the limitations on fetal echography (ultrasound) and fetal non-stress tests~~.
2. ~~There is n~~No benefit limits apply on professional components of laboratory or radiology/other services for hospital inpatient treatment.
3. ~~There is n~~No benefit limits apply on laboratory services related to family planning. See Section 292.552 for the family-planning-related clinical laboratory procedures exempt from the laboratory services benefit limit.
4. ~~There is n~~No benefit limits apply on laboratory services or radiology/other services performed as emergency services.

C. Extension-of-benefit requests are considered for ~~medically necessary~~ services deemed medically necessary.

1. Claims with any of the following primary diagnoses are exempt from laboratory services or radiology/other benefit limits:
   a. Malignant neoplasm (**View ICD Codes**);
   b. HIV infection and AIDS (**View ICD Codes**);
   c. Renal failure (**View ICD Codes**);

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d. Pregnancy (View ICD Codes); or

e. Opioid Use Disorder (OUD) when treated with Medication Assisted Treatment (MAT) (View ICD OUD Codes). Designated laboratory tests will be exempt from the laboratory services benefit limit when the diagnosis is OUD. (View Laboratory and Screening Codes).

2. Benefits may be extended for other conditions based on documented reasons of medical necessity. Providers may request extensions of benefits according to instructions in Section 229.100 of this manual.

D. Magnetic resonance imaging (MRI) services are exempt from the five-hundred-dollar ($500) outpatient radiology/other benefit limit. Medical necessity for each MRI must be documented in the client's medical record.

E. Cardiac catheterization procedures are exempt from the five-hundred-dollar ($500) SFY benefit limit (each) for outpatient laboratory services and for radiology/other services. Medical necessity for each procedure must be documented in the client's medical record.

226.000 Physician Services Benefit Limit ~~79~~-1-26~~2~~

Physician Program

A. For clients twenty-one (21) years of age or older, services provided in a physician's office, an advanced practice registered nurse's (APRN) office, a patient's home, or a nursing home are limited to sixteen (16) visits per state fiscal year (July 1 through June 30).

Clients under twenty-one (21) years of age in the Child Health Services/Early and Periodic, Screening, Diagnosis, and Treatment (EPSDT) Program are not subject to this benefit limit.

The following services are counted toward the service benefit limits:

1. Services of physicians in the office, client's home, or nursing facility.
2. Medical services provided by a dentist.
3. Medical services furnished by an optometrist.
4. Certified nurse-midwife services.
5. APRN services in the office, client's home, or nursing facility.
6. Rural health clinic (RHC) encounters.
7. Federally qualified health center (FQHC) encounters.

B. Extensions of this benefit are considered when documentation verifies medical necessity. Refer to Sections 229.100 through 229.120 of the manual for procedures on obtaining extension of benefits for Primary Care Provider (PCP) services.

C. The Arkansas Medicaid Program exempts the following diagnoses from the extension of benefit requirements when the diagnosis is entered as the primary diagnosis:

1. Malignant neoplasm (View ICD Codes.).
2. HIV infection or AIDS (View ICD Codes.).
3. Renal failure (View ICD Codes.).
4. Pregnancy~~*~~ (View ICD Codes.).
5. Opioid Use Disorder when treated with MAT (View ICD OUD Codes.)

When a Medicaid client's primary diagnosis is one (1) of those listed above and the client has exhausted the Medicaid established benefit for physician, APRN, and physician assistant

MARKUP

services, outpatient hospital services, ~~or~~ laboratory and X-ray services, a request for extension of benefits is not required.

~~*OB ultrasounds and fetal non-stress tests are not exempt from Extension of Benefits. See Section 292.673 for additional coverage information.~~

247.000 Obstetrical Services

9~~7~~-1-26~~5~~

The Arkansas Medicaid Program covers obstetrical services for Medicaid-eligible beneficiaries. These services include prenatal services, delivery, and postpartum care, and remote monitoring of pregnant women. Please refer to Sections 292.670 through 292.675 of this manual for special billing instructions for pregnancy-related services.

292.673 Fetal Non-Stress Test and Ultrasound

9-1-26~~2-1-22~~

The Arkansas Medicaid Program covers ~~the~~ fetal non-stress test and ~~the~~ ultrasound when performed in conjunction with maternity care.

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

~~Arkansas Medicaid imposes a benefit limit of two medically necessary fetal non-stress test procedures per pregnancy. Fetal ultrasound is limited to two per pregnancy. If it is necessary to exceed these limits, the physician must request benefit extensions, when applicable, in accordance with benefit extension request instructions in this provider manual.~~

292.674 External Fetal Monitoring

9~~7~~-1-26~~5~~

~~Procedure code must be used exclusively for external fetal monitoring when performed in a physician's office or clinic with National Place of Service code **"11".**~~ Physicians may bill for ~~one unit per day of external fetal monitoring. Physicians may bill for medically necessary fetal monitoring in addition to obstetric office visits~~ external fetal monitoring when it is medically necessary and in addition to the obstetrical office visit. The procedure code listed in the **physician's procedure code table** must be used exclusively for external fetal monitoring when performed in a physician's office or clinic with National Place of Service code "11".

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

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TOC not required

214.300 Diagnostic Laboratory and Radiology/Other Services 97-1-262

A. Diagnostic laboratory services and radiology/other services provided by a podiatrist will be included in the benefit limits for outpatient diagnostic laboratory services and outpatient radiology/other services for individuals twenty-one (21) years of age and over.

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 benefits limit for individuals under twenty-one (21) years of age~~, except for the limitations on fetal echography (ultrasound) and fetal non-stress tests~~.

C. Benefit extensions may be granted in cases of documented medical necessity.

D. Section 242.130 contains procedure codes payable for diagnostic laboratory and radiology/other services.

MARKUP

TOC not required

212.204 (DME) Electronic Blood Pressure Monitor and Cuff for Beneficiaries of All Ages

~~8-1-21~~9-1-26

Arkansas Medicaid covers the automatic electronic blood pressure monitor for beneficiaries of all ages as a rental ~~only~~ item. A provider must substantiate that an accurate blood pressure reading cannot be obtained by using a regular blood pressure monitor. Providers must also supply one (1) disposable blood pressure cuff each month. Effective 3/1/26, Medicaid covers purchase of one automatic electronic blood pressure monitor and replacement cuff for beneficiaries with a high-risk pregnancy. Medicaid coverage is limited to the purchase of one monitor and one replacement cuff per pregnancy.

Prior authorization is required for the use of this item. Providers may request prior authorization by submitting form DMS-679A, Prescription & Prior Authorization Request for Medical Equipment Excluding Wheelchairs & Wheelchair Components to DHS or its designated vendor. **View or print form DMS-679A and instructions for completion.** **View or print contact information for how to submit the request**.

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SECTION II – SUPPORTIVE MATERNAL CARE

CONTENTS

TOC required

200.000 SUPPORTIVE MATERNAL CARE GENERAL INFORMATION

200.100 Definitions 9-1-26

As used in this manual:

A. "Breastfeeding and lactation consultant" means:

1. An International Board-Certified Lactation Consultant certified by the International Board of Lactation Consultant Examiners;
2. A Certified Breastfeeding Counselor certified by the International Breastfeeding Institute; or
3. A Certified Lactation Counselor certified by the Academy of Lactation Policy and Practice.

A certified breastfeeding counselor or certified lactation counselor as described in subdivisions A.2. and A.3. of this section, must be supervised. "Supervision" means employed by one (1) of the following Arkansas Medicaid-enrolled providers:

a. An agency led by an International Board-Certified Lactation Consultant;
b. A physician, advanced practice nurse, or physician assistant;
c. A local health unit; or
d. A hospital;

B. "Breastfeeding and lactation consultant services" means medically appropriate outpatient services or hospital services, or both, provided by a breastfeeding and lactation consultant during pregnancy and through the first twelve (12) months of the infant's life to aid in milk expression or infant nutrition;

C. "Certified community-based doula" or "doula" means:

1. An individual who is a trained professional and provides nonclinical emotional, physical, and informational support to women before and during pregnancy and continuing through the postpartum period;
2. A doula must be certified as a community-based doula as provided in Arkansas Code § 17-108-201 et seq., and 17 CAR pt. 56; and

D. "Healthcare professional" means a person who is licensed by the laws of this state to administer health care in the ordinary course of the practice of his or her profession.

200.200 Arkansas Medicaid Participation Requirements for Supportive Maternal Care Providers 9-1-26

A. All 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:

1. Must be at least eighteen (18) years of age;
2. Obtain and maintain a National Provider Identifier;

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3. Use the taxonomy number required by the state; and

4. Hold the appropriate certification to provide that service as described in Section 200.100.

200.300 Group Providers of Supportive Maternal Care Services 9-1-26

Group providers of certified community-based doula services, breastfeeding and lactation consultant services, or both, must meet the following criteria in order to be eligible for participation in the Arkansas Medicaid Program.

If a doula or breastfeeding and lactation consultant is a member of a group of providers, each individual provider and the group must enroll according to the following criteria:

A. Each individual doula or breastfeeding and lactation consultant within the group must enroll following the criteria established in Section 200.200.

The group must complete an application and contract as an Arkansas Medicaid provider of certified community-based doula services, breastfeeding and lactation consultant services, or both, and must be approved by the Arkansas Medicaid Program.

B. The group must also be enrolled in the Title XVIII (Medicare) program. Out-of-state providers must submit proof of current Medicare enrollment.

C. All group providers are “pay to” providers only. The service must be performed and billed by a Medicaid-enrolled licensed doula or breastfeeding and lactation consultant within the group.

200.400 Administrative Reconsideration and Appeals 9-1-26

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

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

210.000 CERTIFIED COMMUNITY-BASED DOULAS

210.100 Scope 9-1-26

A. Arkansas Medicaid beneficiaries are eligible for services provided by certified community-based doulas if they are:

1. Pregnant or within sixteen (16) weeks postpartum;

2. Not enrolled in a Life 360 Home Program; and

3. Not receiving community health worker (CHW) services from a CHW employed by an obstetric (OB) clinic or provider.

B. Doula services may be provided upon the confirmation of pregnancy or delivery.

C. Doula services are available for up to sixteen (16) weeks postpartum, depending on the beneficiary’s continued Arkansas Medicaid eligibility.

D. Certified community-based doulas shall provide only the following services:

1. Childbirth education;

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2. Assistance with navigating the healthcare system;

3. Beneficiary advocacy before, during, and after the birth of a child;

4. Connection with community resources; and

5. Continuous emotional and physical support throughout labor and birth and intermittently during the prenatal and postpartum periods.

210.200 Required Recommendation for Preventative Services 9-1-26

Doula services, as preventative services, require a recommendation from an Arkansas Medicaid-enrolled physician, physician assistant, or advanced practice registered nurse, including a certified nurse midwife. DHS has obtained a statewide standing recommendation from a licensed healthcare provider for doula services for all pregnant or postpartum Medicaid beneficiaries. The statewide standing recommendation applies to Medicaid beneficiaries eligible for doula services. Separate documentation regarding the recommendation by doula providers is not required.

210.300 Covered Benefits — Benefit Limits 9-1-26

A. Doula services for the same beneficiary and pregnancy are limited to the following:

1. Up to six (6) visits during the prenatal and postpartum periods.

a. Postpartum visits must occur within sixteen (16) weeks of labor and delivery; and

2. One (1) visit for attendance at labor and delivery.

a. A qualifying visit for attendance at labor and delivery requires the doula to be physically present during labor, delivery, and the immediate postpartum period.

B. The following procedure codes may be billed by doulas:

View or print the procedure codes for doula services.

C. A prior authorization is not required to access the standard doula benefit package.

D. Medicaid beneficiaries are responsible for:

1. Payment for services beyond the established visit limits unless the Division of Medical Services (DMS) authorizes an extension of a particular benefit.

2. A request for extension of benefits may be submitted for beneficiaries with extenuating circumstances if there is need for additional visits beyond the six (6) prenatal and postpartum visits. Extension of benefits requests must be sent to the Department of Human Services (DHS)-contracted entity that processes extensions of benefits for beneficiaries.

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

For audit purposes, the extension of benefits must be in writing, placed in the beneficiary's file, and available for auditors.

3. 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.

E. Doula services are not counted against the limit of sixteen (16) provider visits per state fiscal year (July 1 through June 30) for beneficiaries twenty-one (21) years of age and older. The sixteen-visit limit does not apply to beneficiaries under age twenty-one (21) in the Child Health Services, Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Program.

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210.400 Visit Requirements 9-1-26

A. The minimum visit length for doula services is sixty (60) minutes.

B. The initial visit must be in person, and at least one (1) visit must take place in the beneficiary's home.

C. After the initial visit, subsequent prenatal and postpartum visits may be conducted in person or via telehealth.

D. Labor and delivery services may not be conducted via telehealth.

E. The doula will work with the beneficiary to determine how to utilize the visits to best meet the needs of the beneficiary, including how many visits will occur during the prenatal period or postpartum period.

1. For prenatal and postpartum visits, doulas must coordinate directly with the beneficiary to determine the most appropriate service location, including telehealth, for prenatal and postpartum visits.

2. Service locations may include the following:

a. Beneficiary's place of residence;

b. Doula's office;

c. Physician's office;

d. Hospital;

e. Homeless shelter;

f. Group home;

g. Temporary lodging;

h. Outreach site; or

i. Public health clinic.

F. The labor and delivery care visit may not occur in the beneficiary's residence.

210.500 Documentation Requirements 9-1-26

A. In addition to the conditions related to record keeping in Section 142.300, doulas performing services for Arkansas Medicaid beneficiaries must maintain the following documentation for each encounter:

1. Date of service;

2. Person or persons to whom services were rendered, including Medicaid ID number;

3. Start time and end time of services provided;

4. Description of the professional services rendered by the doula on behalf of the beneficiary, including results of assessments for health-related social needs and a birth plan;

5. Any new needs identified during the service; and

6. Original or electronic signature of the doula, including the credentials of the doula.

B. Documentation and claims may be subject to review and post-payment audit.

210.600 Reimbursement 9-1-26

A. All doula services outlined in this manual are reimbursed per the methodology established in the Arkansas Medicaid State Plan.

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B. Doulas who are also breastfeeding and lactation consultants may bill for breastfeeding and lactation services separate from the services they provide as doulas for the same beneficiary.

C. Doulas who are also certified nurse-midwives may not bill for both doula services and midwife services for the same beneficiary for the same pregnancy.

D. Healthcare professionals employing doulas may bill for services the doulas provide.

E. Doula services may be billed separately from the hospital per diem for both inpatient and outpatient visits.

F. Federally qualified health centers and rural health centers may bill for doula services outside the core encounter visit.

220.000 BREASTFEEDING AND LACTATION CONSULTANTS

220.100 Scope 9-1-26

A. Only Arkansas Medicaid beneficiaries who are pregnant or within twelve (12) months postpartum and infants up to twelve (12) months of age are eligible for breastfeeding and lactation consultant services.

B. Breastfeeding and lactation consultant services are available for twelve (12) months postpartum, depending on the beneficiary's continued Arkansas Medicaid eligibility.

C. Breastfeeding and lactation consultant services include medically appropriate outpatient services or hospital services, or both, provided by a breastfeeding and lactation consultant during pregnancy and through the postpartum period to aid in milk expression or infant nutrition.

220.200 Required Recommendation for Preventative Services 9-1-26

Breastfeeding and lactation services, as preventative services, require a recommendation from an Arkansas Medicaid-enrolled physician, physician assistant, or advanced practice registered nurse, including a certified nurse midwife. DHS has obtained a statewide standing recommendation from a licensed healthcare provider for breastfeeding and lactation consultant services for all pregnant or postpartum Medicaid beneficiaries. The statewide standing recommendation applies to Medicaid beneficiaries eligible for breastfeeding and lactation consultant services. Separate documentation regarding the recommendation by breastfeeding and lactation consultant providers is not required.

220.300 Covered Benefits — Benefit Limits 9-1-26

A. Benefit limits are as follows:

1. Breastfeeding and lactation consultant services for Medicaid beneficiaries who are pregnant or within twelve (12) months postpartum are limited to a maximum of three (3) visits for each pregnancy. No prior authorization is needed for these visits.

2. Breastfeeding and lactation consultant services for Medicaid beneficiaries who are twelve (12) months or younger are limited to a maximum of three (3) visits. No prior authorization is needed for these visits.

B. The following procedure codes may be billed by breastfeeding and lactation consultants.

View or print the procedure codes for breastfeeding and lactation consultant services.

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1. Medicaid beneficiaries are responsible for payment for services beyond the established visit limits unless the Division of Medical Services (DMS) authorizes an extension of a particular benefit.

2. A request for extension of benefits may be submitted, for beneficiaries with extenuating circumstances, if there is need for additional visits. Extension of benefits requests must be sent to the Department of Human Services (DHS)-contracted entity that processes extensions of benefits for beneficiaries.

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

For audit purposes, the extension of benefits must be in writing, placed in the beneficiary's file, and available for auditors. Extension of benefits should contain the medical reason for additional services and be signed by the supervising provider.

C. Group services may be provided but are subject to the limits described in Subsection A of this section. When providing services in a group setting, the number of participants must be at least two (2) participants and no more than eight (8) participants.

D. Breastfeeding and lactation consultant services are not counted against the limit of sixteen (16) visits per state fiscal year (July 1 through June 30) for beneficiaries twenty-one (21) years of age and older. The sixteen-visit limit does not apply to beneficiaries under age twenty-one (21) in the Child Health Services, Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Program.

220.400 Visit Requirements 9-1-26

A The minimum visit length for breastfeeding and lactation consultant services is fifteen (15) minutes.

The maximum visit length is ninety (90) minutes.

B. The initial visit must be in person. After the initial visit, subsequent visits may be conducted in person or via telehealth.

C. Services provided in a group setting must be in person.

D. The breastfeeding and lactation consultant will work with the beneficiary or the beneficiary's mother to determine how to utilize the visits to best meet the needs of the beneficiary.

E. Breastfeeding and lactation consultants must coordinate directly with the beneficiary or the beneficiary's mother to determine the most appropriate service location.

F. Service locations may include the following:

1. Beneficiary's place of residence;

2. Breastfeeding and lactation consultant's office;

3. Office of supervising physician, advanced practice nurse, or physician assistant;

4. A local health unit or a Women, Infants and Children's office operated by the Arkansas Department of Health; or

5. Hospital.

220.500 Documentation Requirements 9-1-26

A. In addition to the conditions related to record keeping in Section 142.300, breastfeeding and lactation consultants performing services for Arkansas Medicaid beneficiaries must maintain the following documentation:

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1. Date of service;
2. Person or persons to whom services were rendered, including Medicaid ID number;
3. Start time and end time of services provided;
4. Treatment plan, including problems, goals, and objectives, as appropriate, and updates;
5. Method or methods used or to be used to address the identified problems, goals, and objectives;
6. Progress made;
8. Any new problems, goals, or objectives identified during the service; and
9. Original or electronic signature of the breastfeeding and lactation consultant, including the credentials of the breastfeeding and lactation consultant.

B. Documentation and claims may be subject to review and post-payment audit.

220.600 Reimbursement 9-1-26

A. All breastfeeding and lactation consultant services outlined in this manual are reimbursed per the methodology established in the Arkansas Medicaid State Plan.

B. Breastfeeding and lactation consultants who are also doulas may bill for breastfeeding and lactation services separate from the services they provide as doulas for the same beneficiary.

C. Breastfeeding and lactation consultants who are also community health workers (CHWs) may bill for breastfeeding and lactation services separate from the services they provide as CHWs for the same beneficiary.

D. Breastfeeding and lactations consultants who are also certified nurse-midwives (CNMs) may bill for breastfeeding and lactation consultant services separate from the services they provide as a CNM for the same beneficiary if the services are provided on different days.

E. Healthcare professionals employing breastfeeding and lactation consultants may bill for the services the consultants provide.

F. During an inpatient hospital stay, breastfeeding and lactation consultant services cannot be billed separately from the hospital per diem. Breastfeeding and lactation consultant services provided in an outpatient hospital setting may be billed separately.

G. Federally qualified health centers and rural health centers may bill for breastfeeding and lactation consultant services outside the core encounter visit.

230.000 BILLING PROCEDURES

230.100 Introduction to Billing 9-1-26

Doulas and breastfeeding and lactation consultants use the CMS-1500 form to bill the Arkansas Medicaid Program on paper for services provided for eligible Medicaid beneficiaries. Section III of this manual contains information about available options for electronic claims submission.

Each claim may contain charges for only one (1) beneficiary.

Procedure codes payable to doulas and breastfeeding and lactation consultants do not require modifiers unless specified in the policy.

230.200 National Place of Service (POS) Codes 9-1-26

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

Place of Service	POS Codes
Telehealth Provided Other than in Patient's Home	02
Homeless Shelter	04
Telehealth Provided in Patient's Home	10
Group Home	14
Mobile Unit	15
Temporary Lodging	16
Inpatient Hospital	21
Outpatient Hospital	22
Outreach Site	27
Provider's Office	11
Patient's Home	12
Public Health Clinic	71
Other Locations	99

230.300 Billing Instructions 9-1-26

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.

230.300 Completion of CMS-1500 Claim Form 9-1-26

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.

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Field Name and Number	Instructions for Completion
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.
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.

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Field Name and Number	Instructions for Completion
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.
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.

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Field Name and Number	Instructions for Completion
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.
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.

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Field Name and Number	Instructions for Completion
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 ORIGINAL REF. NO.	Reserved for future use. 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.
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.

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Field Name and Number	Instructions for Completion
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.
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.

MARKUP

Field Name and Number	Instructions for Completion
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.

230.400 Clinic or Group Billing 9-1-26

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.

MARKUP

Revision: HCFA-Region VI
November 1990
Revised: ~~March 1, 1994~~March 1, 2026

AMOUNT, DURATION, AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY SERVICES PROVIDED

b. Screening Services

___ Provided ___No Limitations ___ With Limitations* _X_ Not Provided

c. Preventive services

_X_ Provided ___No Limitations _X_ With Limitations* _~~X~~_ Not Provided

d. Rehabilitative services

_X_ Provided ___No Limitations _X_ With Limitations* ___ Not Provided

14. Services for individuals age 65 or older in institutions for mental diseases

a. Inpatient hospital services

___ Provided ___No Limitations ___ With Limitations* _X_ Not Provided

b. Nursing facility services

c. ___ Provided ___No Limitations ___ With Limitations* _X_ Not Provided

*Description provided on attachment

MARKUP

AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED

Revised: March 1, 2026

CATEGORICALLY NEEDY

13. Other diagnostic, screening, preventive and rehabilitative services, i.e., other than those provided elsewhere in this plan. (Continued)

a. Diagnostic services – Not Provided.
b. Screening services - Not Provided.
c. Preventive services - Provided, with limitation.

Vaccines:

Arkansas covers vaccines and vaccine administration which includes approved vaccines recommended by the Advisory Committee on Immunization Practices (an advisory committee established by the Secretary, acting through the Director of the Centers for Disease Control and Prevention).

~~d. Rehabilitative Services~~ **<This section moved without change to 3.1-A, page 6a1G>**

~~1. Rehabilitative Services for Persons with Mental Illness (RSPMI)~~

~~**A comprehensive system of care for behavioral health services has been developed for use by RSPMI providers. The changes to the program were developed in coordination with providers, representatives of the Arkansas System of Care and other key stakeholders.**~~

~~**DMS is seeking first to revise service definitions and methods within this program to meet the needs of persons whose illnesses meet the definitions outlined in the American Psychiatric Association Diagnostic and Statistical Manual.**~~

~~**Covered mental health services do not include services provided to individuals aged 21 to 65 who reside in facilities that meet the Federal definition of an institution for mental disease. Coverage of RSPMI services within the rehabilitation section of Arkansas' state plan that are provided in IMD's will be discontinued as of September 1, 2011.**~~

~~**A. Scope**~~

~~**A range of mental health rehabilitative or palliative services is provided by a duly certified RSPMI provider to Medicaid-eligible beneficiaries suffering from mental illness, as described in the American Psychiatric Association Diagnostic and Statistical Manual (DSM-IV and subsequent revisions).**~~

~~**DMS has set forth in policy the settings in which each individual service may be provided. Each service shown below includes the place of service allowable for that procedure.**~~

~~**Services:**~~

- ~~**SERVICE: Mental Health Evaluation/Diagnosis**~~
  ~~**DEFINITION: The cultural, developmental, age and disability -relevant clinical evaluation and determination of a beneficiary's mental status; functioning in various life domains; and an axis five DSM diagnostic**~~

MARKUP

CATEGORICALLY NEEDY

13. Other diagnostic, screening, preventive and rehabilitative services, i.e., other than those provided elsewhere in this plan. (Continued)

c. Preventive Services—Provided with Limitation (continued)

Certified Community-based Doulas:

A Certified Community-based Doula is a trained professional who provides emotional, physical, and informational support during the prenatal, labor, delivery, and postpartum periods. Certified Community-based Doula services must be recommended by a physician or other licensed practitioner of the healing arts~~.~~ acting within their scope of practice under state law.~~—~~;

Certified community-based doulas shall provide only the following services:

1. Childbirth~~,~~ ~~-~~education;
2. Assistance with navigating the healthcare system;
3. Client advocacy before, during, and after the birth of a child;
4. Connection with community resources; and
5. Continuous emotional and physical support throughout labor and birth and intermittently during the prenatal and postpartum periods.

Services shall include support during a hospital delivery and during the prenatal and postpartum periods as defined through rules established by the Arkansas Department of Human Services.

To be eligible to provide services, Doulas must be:

(1) Certified by the Department of Health in accordance with state law; and
(2) At least eighteen (18) years of age and have an NPI number.

MARKUP

CATEGORICALLY NEEDY

13. Other diagnostic, screening, preventive and rehabilitative services, i.e., other than those provided elsewhere in this plan. (Continued)

c. Preventive Services—Provided with Limitation (continued)

Breastfeeding and Lactation Consultants:

A breastfeeding and lactation consultant is a trained professional specializing in providing medically appropriate care to aid in milk expression or infant nutrition-. Breastfeeding and Lactation Consultant services must be recommended by a physician or other licensed practitioner of the healing arts acting within their scope of practice under state law.

Breastfeeding and lactation consultant services are medically appropriate outpatient services or hospital services, or both, provided by a breastfeeding and lactation consultant during pregnancy and through the extended postpartum period to aid in milk expression or infant nutrition. Components of Breastfeeding and Lactation Consultant services include individual outpatient consultation and group classes.

To be eligible to provide services, Breastfeeding and Lactation Consultants must:

- Be at least eighteen (18) years of age and have an NPI number; and
- Have one of the following certifications:
  1. An International Board-Certified Lactation Consultant; or
  2. A Certified Lactation Counselor;
     - Certified Lactation Counselors must be certified by either the (1) International Breastfeeding Institute or (2) Academy of Lactation Policy and Practice;
     - Certified Lactation Counselors are required to be supervised by a Medicaid enrolled healthcare provider to receive reimbursement. Supervision is defined as being employed by one of the following:
       - A. An agency led by an International Board-Certified Lactation Consultant;
       - B. A physician, advanced practice nurse, or physician assistant
       - C. A local health unit or
       - D. A hospital

MARKUP

Added new page.

13. Other diagnostic, screening, preventive and rehabilitative services, i.e., other than those provided elsewhere in this plan. (Continued)

d. Rehabilitative Services

1. Rehabilitative Services for Persons with Mental Illness (RSPMI)

A comprehensive system of care for behavioral health services has been developed for use by RSPMI providers. The changes to the program were developed in coordination with providers, representatives of the Arkansas System of Care and other key stakeholders.

DMS is seeking first to revise service definitions and methods within this program to meet the needs of persons whose illnesses meet the definitions outlined in the American Psychiatric Association Diagnostic and Statistical Manual.

Covered mental health services do not include services provided to individuals aged 21 to 65 who reside in facilities that meet the Federal definition of an institution for mental disease. Coverage of RSPMI services within the rehabilitation section of Arkansas' state plan that are provided in IMD's will be discontinued as of September 1, 2011.

A. Scope

A range of mental health rehabilitative or palliative services is provided by a duly certified RSPMI provider to Medicaid-eligible beneficiaries suffering from mental illness, as described in the American Psychiatric Association Diagnostic and Statistical Manual (DSM-IV and subsequent revisions).

DMS has set forth in policy the settings in which each individual service may be provided. Each service shown below includes the place of service allowable for that procedure.

Services:

- SERVICE: Mental Health Evaluation/Diagnosis
  DEFINITION: The cultural, developmental, age and disability -relevant clinical evaluation and determination of a beneficiary's mental status; functioning in various life domains; and an axis five DSM diagnostic

MARKUP

AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED

Revised: ~~October 1,~~ ~~2023~~March 1, 2026

MEDICALLY NEEDY

13. Other diagnostic, screening, preventive and rehabilitative services, i.e., other than those provided elsewhere in this plan. (Continued)

a. Diagnostic services – Not Provided.
b. Screening services - Not Provided.
c. Preventive services - **Provided, with limitation**

Vaccines:

Arkansas covers vaccines and vaccine administration which includes approved vaccines recommended by the Advisory Committee on Immunization Practices (an advisory committee established by the Secretary, acting through the Director of the Centers for Disease Control and Prevention).

~~d. Rehabilitative Services~~ **<This section moved without change to 3.1-B, page 5d1G>**

~~1. Rehabilitative Services for Persons with Mental Illness (RSPMI)~~

~~A comprehensive system of care for behavioral health services has been developed for use by RSPMI providers. The changes to the program were developed in coordination with providers, representatives of the Arkansas System of Care and other key stakeholders.~~

~~DMS is seeking first to revise service definitions and methods within this program to meet the needs of persons whose illnesses meet the definitions outlined in the American Psychiatric Association Diagnostic and Statistical Manual.~~

~~Covered mental health services do not include services provided to individuals aged 21 to 65 who reside in facilities that meet the Federal definition of an institution for mental disease. Coverage of RSPMI services within the rehabilitation section of Arkansas' state plan that are provided in IMD's will be discontinued as of September 1, 2011.~~

~~**A.** Scope~~

~~A range of mental health rehabilitative or palliative services is provided by a duly certified RSPMI provider to Medicaid-eligible beneficiaries suffering from mental illness, as described in the American Psychiatric Association Diagnostic and Statistical Manual (DSM-IV and subsequent revisions).~~

~~DMS has set forth in policy the settings in which each individual service may be provided. Each service shown below includes the place of service allowable for that procedure.~~

~~Services:~~

~~SERVICE: Mental Health Evaluation/Diagnosis~~
~~DEFINITION: The cultural, developmental, age and disability-relevant clinical evaluation and determination of a beneficiary's mental status; functioning in various life domains; and an axis five DSM diagnostic~~

MARKUP

13. Other diagnostic, screening, preventive and rehabilitative services, i.e., other than those provided elsewhere in this plan. (Continued)

c. Preventive Services—Provided with Limitation (continued)

Certified Community-based Doulas:

A Certified Community-based Doula -is a trained professional who provides emotional, physical, and informational support during the prenatal, labor, delivery, and postpartum periods. Certified Community-based Doula services must be recommended by a physician or other licensed practitioner of the healing arts acting within their scope of practice under state law.

Certified community-based doulas shall provide only the following services:

1. Childbirth,- education;
2. Assistance with navigating the healthcare system;
3. Client advocacy before, during, and after the birth of a child;
4. Connection with community resources; and
5. Continuous emotional and physical support throughout labor and birth and intermittently during the prenatal and postpartum periods.

Services shall include support during a hospital delivery and during the prenatal and postpartum periods as defined through rules established by the Arkansas Department of Human Services.

To be eligible to provide services, Doulas must be:

(1) Certified by the Department of Health as provided in accordance with state law;

(2) At least eighteen (18) years of age and have an NPI number.

MARKUP

MEDICALLY NEEDY

13. Other diagnostic, screening, preventive and rehabilitative services, i.e., other than those provided elsewhere in this plan. (Continued)

c. Preventive Services—Provided with Limitation (continued)

Breastfeeding and Lactation Consultants:

A breastfeeding and lactation consultant is a trained professional specializing in providing medically appropriate care to aid in milk expression or infant nutrition. Breastfeeding and Lactation Consultant services must be recommended by a physician or other licensed practitioner of the healing arts acting within their scope of practice under state law.

Breastfeeding and lactation consultant services are medically appropriate outpatient services or hospital services, or both, provided by a breastfeeding and lactation consultant during pregnancy and through the extended postpartum period to aid in milk expression or infant nutrition. Components of Breastfeeding and Lactation Consultant services include individual outpatient consultation and group classes.

To be eligible to provide services, Breastfeeding and Lactation Consultants must:

- Be at least eighteen (18) years of age and have an NPI number and
- Have one of the following certifications:
  1. An International Board-Certified Lactation Consultant; or
  2. A Certified Lactation Counselor;
     - Certified Lactation Counselors must be certified by the (1) International Breastfeeding Institute or (2) Academy of Lactation Policy and Practice.
     - Certified Lactation Counselors are required to be supervised by a Medicaid enrolled healthcare provider to receive reimbursement. Supervision is defined as being employed by one of the following:
       - A. An agency led by an International Board-Certified Lactation Consultant;
       - B. A physician, advanced practice nurse, or physician assistant
       - C. A local health unit or
       - D. A hospital

MARKUP

MEDICALLY NEEDY

13. Other diagnostic, screening, preventive and rehabilitative services, i.e., other than those provided elsewhere in this plan. (Continued)

d. Rehabilitative Services

1. Rehabilitative Services for Persons with Mental Illness (RSPMI)

A comprehensive system of care for behavioral health services has been developed for use by RSPMI providers. The changes to the program were developed in coordination with providers, representatives of the Arkansas System of Care and other key stakeholders.

DMS is seeking first to revise service definitions and methods within this program to meet the needs of persons whose illnesses meet the definitions outlined in the American Psychiatric Association Diagnostic and Statistical Manual.

Covered mental health services do not include services provided to individuals aged 21 to 65 who reside in facilities that meet the Federal definition of an institution for mental disease. Coverage of RSPMI services within the rehabilitation section of Arkansas' state plan that are provided in IMD's will be discontinued as of September 1, 2011.

A. Scope

A range of mental health rehabilitative or palliative services is provided by a duly certified RSPMI provider to Medicaid-eligible beneficiaries suffering from mental illness, as described in the American Psychiatric Association Diagnostic and Statistical Manual (DSM-IV and subsequent revisions).

DMS has set forth in policy the settings in which each individual service may be provided. Each service shown below includes the place of service allowable for that procedure.

Services:

- SERVICE: Mental Health Evaluation/Diagnosis
  DEFINITION: The cultural, developmental, age and disability -relevant clinical evaluation and determination of a beneficiary's mental status; functioning in various life domains; and an axis five DSM diagnostic

MARKUP

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES -
OTHER TYPES OF CARE

Revised: ~~October 1, 2023~~March 1, 2026

12. Prescribed drugs, dentures, and prosthetic devices; and eyeglasses prescribed by a physician skilled in diseases of the eye or by an optometrist (Continued)

d. Eyeglasses

~~Negotiated statewide contract bid.~~ Arkansas provides eyeglasses when prescribed for vision correction through a competitively bid contract with an optical supply vendor.

13. Other diagnostic, screening, preventive and rehabilitative services, i.e., other than those provided elsewhere in this plan

a. Diagnostic Services - Not provided.
b. Screening Services - Not provided.
c. Preventive Services - Provided with limitations.

Arkansas covers vaccines and vaccine administration which includes approved vaccines recommended by the Advisory Committee on Immunization Practices (an advisory committee established by the Secretary, acting through the Director of the Centers for Disease Control and Prevention).

For dates of service on or after March 1, 2026, Arkansas reimburses certified community-based doulas and lactation and breastfeeding consultant services authorized under Section 13 of Attachments 3.1-A and 3.1-B using a state-developed fee schedule.

DHS selected Oklahoma doula rates in place prior to April 2025, including procedure codes and modifier structure. This selection is based on similar rural geography, established doula services programming, and similar payment rates to a neighboring state, Louisiana. While the billing rate basis varied across the comparator states did not allow for calculation of a specific common statistic, DHS reviewed the comparator state payment rates to assess for reasonableness.

For Lactation and breastfeeding services, DHS reviewed comparable state service rates. While the variation in the billing rate basis across the comparator states did not allow for calculation of a specific common statistic, DHS reviewed the comparator state payment rates to assess for reasonableness. DHS selected a rate between the rates of neighboring states, Missouri and Louisiana. The selected is also within the range of Illinois lactation services. All three comparison states are similar in rural versus urban geography and established lactation and breastfeeding counseling programming. Group rates were established based on an average group size of three.

Except as otherwise noted in the State Plan, fee schedule rates are the same for governmental and private providers. The agency's fee schedule was set as of March 1, ~~2026~~2026, and is effective for services furnished on or after March 1, 2026. All rates are published on the agency's website ~~at :~~at: https://humanservices.arkansas.gov/divisions-shared-services/medical-services/helpful-information-for-providers/fee-schedules/

d. Rehabilitative Services

1. Rehabilitative Services for Persons with Mental Illness (RSPMI)

Reimbursement is based on the lower of the amount billed or the Title XIX (Medicaid) maximum allowable. Except as otherwise noted in the state plan, state developed fee schedule rates are the same for both governmental and private providers of RSPMI services. The agency's fee schedule rates were set as of April 1, ~~1988~~1988, and are effective for services provided on or after that date. All rates are published on the agency's website at: https://humanservices.arkansas.gov/divisions-shared-services/medical-services/helpful-information-for-providers/fee-schedules/ ~~www.medicaid.state.ar.us~~.

Effective for dates of service on or after April 1, 2004, reimbursement rates (payments) for inpatient visits in acute care hospitals by board certified psychiatrists shall be as ordered by the United States District Court for the Eastern District of Arkansas in the case of Arkansas Medical Society v. Reynolds. Refer to Attachment 4.19-B, Item 5, for physician reimbursement.

The State shall not claim FFP for any ~~non institutional~~non-institutional service provided to individuals who are residents of facilities that meet the Federal definition of an institution for mental diseases or a psychiatric residential treatment facility as described in Federal regulations at 42 CFR 1440 and 14460 and 42 CFR 441 Subparts C and D. Reimbursement of RSPMI services that are provided in IMD's will be discontinued for services provided on or after September 1, 2011.
For RSPMI services provided in clinics operated by State operated teaching hospitals.

Effective for claims with dates of service on or after March 1, 2002, Arkansas State Operated Teaching Hospital psychiatric clinics that are not part of a hospital outpatient department shall be reimbursed based on reasonable costs. Medicaid shall issue interim payments at the established fee schedule rates. A year-end cost settlement shall be performed to reconcile interim payments with the provider's reasonable costs. ~~with interim payments at the RSPMI fee schedule rates and a year-end cost settlement.~~ The state will return to CMS the federal share of reconciled payments recouped from provider overpayments consistent with 42 CFR 433 Subpart F.
The provider will be paid the lesser of actual costs identified using a CMS approved cost report or customary charges. Each Arkansas State Operated Teaching Hospital with qualifying psychiatric clinics shall submit an annual cost report. Said cost report shall be submitted within five (5) months after the close of the hospital's fiscal year. Failure to file the cost report within the prescribed period, except as expressly extended by the State Medicaid Agency, ~~may~~will result in suspension of reimbursement until the cost report is filed. The State Medicaid Agency will review the submitted cost report and make a tentative settlement within 60 days of the receipt of the cost report and will make final settlement in the following year after all Medicaid charges and payments have been processed. The final settlement will be calculated and made at the same time as the next year's tentative settlement is calculated and made.

Medical professionals affiliated with Arkansas State Operated Teaching Hospitals are not eligible for additional reimbursement for services provided in these clinics.

MARKUP

TOC required

215.110 Benefit Limits for Diagnostic Laboratory and Radiology/Other Services 9-1-26

A. Both diagnostic laboratory and radiology/other services in all settings, including ASCs, are subject to a benefit limit.

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. Magnetic resonance imaging (MRI) services are exempt from the radiology/other services benefit limit per SFY.

C. Individuals under twenty-one (21) years of age are not subject to the diagnostic laboratory services benefit limit or to the radiology/other services benefit limit.

215.111 Reserved 9-1-26

PROPOSED

TOC not required

212.000 Coverage of Chiropractic Services 9-1-26

A. Chiropractic services must be administered by a licensed chiropractor, meeting minimum standards promulgated by the Secretary of Health and Human Services under Title XVIII of the Social Security Act. Manipulation of the spine for the treatment of subluxation is the **only** chiropractic service covered by Medicaid.

B. Benefits.

1. Benefits are not limited for beneficiaries under twenty-one (21) years of age (in the Child Health Services/Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Program).
2. Medicaid covers chiropractic services for beneficiaries twenty-one (21) years of age and older, with a benefit limit of twelve (12) visits per State Fiscal Year (SFY: July 1 through June 30).
3. Two (2) chiropractic X-rays per SFY are covered by Medicaid. However, an X-ray is not required for treatment.
4. Chiropractic X-rays count against the five-hundred-dollar per SFY radiology/other services benefit limit.

   Radiology/other services include without limitation diagnostic X-rays, ultrasounds, and electronic monitoring/machine tests, such as electrocardiograms (ECG or EKG).
5. The radiology/other services benefit may be extended when medically necessary (see Section 214.000). All X-rays and documentation must be kept in the beneficiary's medical record for a period of five (5) years for audit purposes. Chiropractic services may be provided in the provider's office, the patient's home, a nursing home, or another appropriate place.

C. For beneficiaries who are eligible for Medicare and Medicaid, see Section I of this manual for additional coinsurance and deductible information. See **Section III** for instructions on filing joint Medicare/Medicaid claims.

PROPOSED

TOC not required

213.410 Diagnostic Laboratory and Radiology Other Services Benefit Limits 9-1-26

A. Medicaid established maximum amounts (benefit limits) for outpatient diagnostic laboratories 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.

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 laboratories or radiology/other services performed in conjunction with emergency services in an emergency department of a hospital.

213.510 Outpatient Hospital Benefit Limit 9-1-26

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.

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.)**
5. Opioid Use Disorder when Treated with MAT	**(View ICD OUD Codes.)**

PROPOSED

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.

213.710 Fetal Non-Stress Test and Ultrasound 9-1-26

The Arkansas Medicaid Program covers the fetal non-stress test and the ultrasound when performed in conjunction with maternity care.

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 9-1-26

The certified nurse-midwife may bill Medicaid for external fetal monitoring performed in the certified nurse-midwife's office when it is medically necessary and in addition to the obstetrical office visit.

213.730 Reserved 9-1-26

272.490 Obstetrical Care 9-1-26

Providers should bill for prenatal, delivery, and postpartum services, and remote monitoring of pregnant women separately. Effective July 1, 2025, and thereafter, global obstetrical billing is not payable.

When billing obstetrical services, **view or print the procedure codes for Certified Nurse Midwife (CNM) services**.

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.

A. When lab tests 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.

B. 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.

C. 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.

Certified nurse-midwives must use the appropriate procedure code with modifier **UA** to bill for one to three visits for prenatal care.

The appropriate procedure code with no modifier must be used by providers to bill four to six (6) visits for prenatal care without delivery, and the appropriate procedure code with no modifier is to be used for seven (7) or more visits without delivery.

PROPOSED

View or print the procedure codes for Certified Nurse Midwife (CNM) services to identify which procedure codes are allowable.

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 twelve (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 9-1-26

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

Refer to the procedure code table at the above link for the appropriate CPT code. This CPT code is only applicable to internal fetal monitoring by a consultant during the beneficiary's labor. Procedure code with modifier U1, for external fetal monitoring, is payable to the certified nurse-midwife when performed in their office or clinic. Certified nurse-midwives may not bill more than one (1) unit per day of external fetal monitoring and cannot exceed two (2) per pregnancy.

272.496 Certified Nurse-Midwives Who Are Also Supportive Maternal Care Providers or Community Health Workers 9-1-26

A. A certified nurse-midwife (CNM) who is also a certified community-based doula may not bill for both doula services and midwife services for the same beneficiary for the same pregnancy.

B. A CNM who is also a breastfeeding and lactation consultant may bill for breastfeeding and lactation consultant services separate from the services they provide as a CNM for the same beneficiary if the services are provided on different days.

C. A CNM who is also a community health worker (CHW) may bill for CHW services separate from the services they provide as a CNM for the same beneficiary if the services are provided on different days.

PROPOSED

TOC not required

215.020 Benefit Limit for Non-Emergency Services 9-1-26

A. Non-emergency outpatient hospital services are:

1. Non-emergency outpatient hospital and related physician services and
2. Outpatient hospital treatment and therapy services and related physician services.

B. Beneficiaries aged twenty-one (21) and older are limited to a total of twelve (12) non-emergency outpatient hospital visits per state fiscal year, July 1 through June 30.

1. The outpatient hospital benefit limit includes outpatient hospital services provided in an acute care/general hospital, a rehabilitative hospital, or both.
2. Treatment and therapy services are included in the non-emergency outpatient hospital services limit of twelve (12) visits per state fiscal year.
3. Separately covered Medicaid services when provided in conjunction with one another during the same outpatient encounter are counted against the benefit limit as only *one* non-emergency outpatient hospital service.

C. Requests for extension of this benefit are considered for patients who require supportive treatment for maintaining life.

D. Extension of this benefit is automatic for patients whose primary diagnosis for the service furnished is in the following list:

1. Malignant neoplasm (**View ICD Codes**.)
2. HIV infection and AIDS (**View ICD Codes.**)
3. Renal failure (**View ICD Codes.**)
4. Pregnancy (**View ICD Codes.**)
5. Opioid Use Disorder when treated with MAT (**View ICD OUD Codes**.)

E. Beneficiaries under twenty-one (21) years old in the Child Health Services (EPSDT) Program are not benefit-limited, except with respect to the services listed in Section 215.021.

215.040 Benefit Limit in Outpatient Diagnostic Laboratory and Radiology/Other Procedures 9-1-26

A. Arkansas Medicaid limits claim payment for outpatient diagnostic laboratory services and radiology/other services for beneficiaries twenty-one (21) years of age or older.

1. The benefit limits are based on the State Fiscal Year (SFY: July 1 through June 30).
2. Diagnostic laboratory services benefits are limited to five hundred dollars ($500) per SFY, and radiology/other services benefits are limited to five hundred dollars ($500) per SFY.
3. Radiology/other services include without limitation diagnostic X-rays, ultrasounds, and electronic monitoring or machine tests, such as electrocardiograms (ECG or EKG).
4. 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.

PROPOSED

B. The benefit limits apply to claim payments made to the following providers, individually or in any combination: outpatient hospitals, independent laboratories, physicians, osteopaths, podiatrists, Certified Nurse-Midwives (CNMs), Nurse Practitioners (NP), and Ambulatory Surgical Centers (ASCs).

C. Requests for extensions of both benefits are considered for beneficiaries who require supportive treatment for maintaining life.

D. Extension of these benefits are automatic for patients whose primary diagnosis for the service furnished is in the following list:

1. Malignant neoplasm (**View ICD Codes**);
2. HIV infection and AIDS (**View ICD Codes**);
3. Renal failure (**View ICD Codes**);
4. Pregnancy (**View ICD Codes**): or
5. Opioid Use Disorder (OUD) when treated with Medication Assisted Treatment (MAT). (**View ICD OUD Codes**) Designated laboratory tests will be exempt from the laboratory services benefit limit when the diagnosis is OUD (**View Laboratory and Screening Codes**).

E. Magnetic Resonance Imaging (MRI) is exempt from the five-hundred-dollar radiology/other services benefit limit. Medical necessity for each MRI must be documented in the beneficiary's medical record. (Refer to Section 270.000 for billing information.)

F. Cardiac catheterization procedures are exempt from the five-hundred-dollar outpatient diagnostic laboratory services benefit limit and the five-hundred-dollar radiology/other benefit limit. Medical necessity for each procedure must be documented in the beneficiaries' medical record.

G. There are no benefit limits on outpatient diagnostic laboratory services or radiology/other services for beneficiaries under twenty-one (21) in the Child Health Services/Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Program.

215.041 Reserved 9-1-26

215.100 Benefit Extension Requests 9-1-26

A. The Medicaid Program's diagnostic laboratory services and radiology/other services benefit limits 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. Requests to extend benefits for outpatient hospital visits and diagnostic laboratory or X-ray services must be submitted to DHS or its designated vendor.

View or print contact information to obtain instructions for submitting the benefit extension request.

PROPOSED

Benefit extension requests are considered only after a claim has been filed and denied because the benefit is exhausted.

C. Submit a copy of the Medical Assistance Remittance and Status Report that reflects the claim's denial of exhausted benefits with the request. Do not send a claim.

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

E. 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.

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

PROPOSED

TOC not required

214.510 Diagnostic Laboratory and Radiology/Other Services Benefit Limits 9-1-26

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

1. Radiology/other services include without limitation diagnostic X-rays, ultrasounds, and electronic monitoring/machine tests, such as electrocardiograms (ECG or EKG).
2. All the benefit limits in this section are calculated per State Fiscal Year (SFY: July 1 through June 30).
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 annual caps.

View or print the essential health benefit procedure codes.

B. Medicaid established a maximum amount (benefit limit) of five hundred dollars ($500) per SFY for diagnostic laboratory services and five hundred dollars ($500) per SFY for radiology/other services for beneficiaries twenty-one (21) years of age and older. Exceptions are:

1. The diagnostic laboratory services benefit limit and the radiology/other services benefit limit do not apply for beneficiaries under twenty-one (21) years of age.
2. The benefit limit on diagnostic laboratory services related to family planning does not apply. (Refer to Section 252.431 of this manual for the family planning-related clinical laboratory procedures.)
3. Benefit limits do not apply for diagnostic laboratory services or radiology/other services performed as emergency services and approved by DHS or its designated vendor for payment as emergency services.

   View or print contact information to obtain the DHS or designated vendor step-by-step process for requesting extension of benefits.
4. Claims with the following primary diagnoses are exempt from diagnostic laboratory services or radiology/other services benefit limits:
   a. Malignant Neoplasm (**View ICD Codes**);
   b. HIV disease and AIDS (**View ICD Codes**);
   c. Renal failure (**View ICD Codes**);
   d. Pregnancy* (**View ICD Codes**); or
   e. Opioid Use Disorder (OUD) when treated with Medication Assisted Treatment (MAT). (**View ICD OUD Codes.**) Designated diagnostic laboratory tests will be exempt from the diagnostic laboratory services benefit limit when the diagnosis is OUD. (**View Laboratory and Screening Codes.**)

C. Extension of benefit requests are considered for clients who require supportive treatment, such as dialysis, radiation therapy, or chemotherapy for maintaining life.

D. Benefits may be extended for other conditions documented as medically necessary.

214.600 Obstetrical Services 9-1-26

The Arkansas Medicaid Program covers obstetrical services including prenatal services, delivery, and postpartum care, and remote monitoring of pregnant women for Medicaid-eligible beneficiaries in *full* coverage aid categories with a medically verified pregnancy.

PROPOSED

Aid category 61, PW clients are eligible for full range Medicaid coverage. Aid category 61, PW pregnant women's eligibility ends on the last day of the month in which the 60th postpartum day falls.

Medicaid provides temporary Aid Category 62, Presumptive Eligibility Pregnant Woman (PE-PW). Coverage is restricted to prenatal services and services for conditions that may complicate the pregnancy. These services are further limited to the outpatient setting only.

214.630 Reserved 9-1-26

214.930 Documentation Requirements 9-1-26

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 annual caps.

B. All applicable records that support the medical necessity of extended benefits are required to request extension of benefits.

C. Documentation requirements are:

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, and emergency room records for 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 the obstetrical record 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.

252.451 Reserved 9-1-26

PROPOSED

TOC required

222.000 Fetal Non-Stress Test and Ultrasound 9-1-26

The Arkansas Medicaid Program covers the fetal non-stress test and the ultrasound when performed in conjunction with maternity care. Refer to **Section 292.673** of this manual for procedure codes.

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

225.100 Diagnostic Laboratory and Radiology/Other Services 9-1-26

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

1. Radiology/other services include without limitation diagnostic X-rays, ultrasounds, and electronic monitoring or machine tests, such as electrocardiograms (ECG).
2. All benefit limits in this section are calculated by State Fiscal Year (SFY: July 1 through June 30).
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 annual caps.

View or print the essential health benefit procedure codes.

B. Medicaid has an established maximum amount (benefit limit) of five hundred dollars ($500) per SFY for diagnostic laboratory services and five hundred dollars ($500) per SFY for radiology/other services, for clients twenty-one (21) years of age and older.

1. No laboratory or radiology/other benefit limits apply for clients under twenty-one (21) years of age.
2. No benefit limits apply on professional components of laboratory or radiology/other services for hospital inpatient treatment.
3. No benefit limits apply on laboratory services related to family planning. See Section 292.552 for the family-planning-related clinical laboratory procedures exempt from the laboratory services benefit limit.
4. No benefit limits apply on laboratory services or radiology/other services performed as emergency services.

C. Extension-of-benefit requests are considered for services deemed medically necessary.

1. Claims with any of the following primary diagnoses are exempt from laboratory services or radiology/other benefit limits:
   a. Malignant neoplasm (**View ICD Codes**);
   b. HIV infection and AIDS (**View ICD Codes**);
   c. Renal failure (**View ICD Codes**);
   d. Pregnancy (**View ICD Codes**); or
   e. Opioid Use Disorder (OUD) when treated with Medication Assisted Treatment (MAT) (**View ICD OUD Codes**). Designated laboratory tests will be exempt from the laboratory services benefit limit when the diagnosis is OUD. (**View Laboratory and Screening Codes**).
2. Benefits may be extended for other conditions based on documented reasons of medical necessity. Providers may request extensions of benefits according to instructions in Section 229.100 of this manual.

PROPOSED

D. Magnetic resonance imaging (MRI) services are exempt from the five-hundred-dollar ($500) outpatient radiology/other benefit limit. Medical necessity for each MRI must be documented in the client's medical record.

E. Cardiac catheterization procedures are exempt from the five-hundred-dollar ($500) SFY benefit limit (each) for outpatient laboratory services and for radiology/other services. Medical necessity for each procedure must be documented in the client's medical record.

226.000 Physician Services Benefit Limit 9-1-26

Physician Program

A. For clients twenty-one (21) years of age or older, services provided in a physician's office, an advanced practice registered nurse's (APRN) office, a patient's home, or a nursing home are limited to sixteen (16) visits per state fiscal year (July 1 through June 30).

Clients under twenty-one (21) years of age in the Child Health Services/Early and Periodic, Screening, Diagnosis, and Treatment (EPSDT) Program are not subject to this benefit limit.

The following services are counted toward the service benefit limits:

1. Services of physicians in the office, client's home, or nursing facility.
2. Medical services provided by a dentist.
3. Medical services furnished by an optometrist.
4. Certified nurse-midwife services.
5. APRN services in the office, client's home, or nursing facility.
6. Rural health clinic (RHC) encounters.
7. Federally qualified health center (FQHC) encounters.

B. Extensions of this benefit are considered when documentation verifies medical necessity. Refer to Sections 229.100 through 229.120 of the manual for procedures on obtaining extension of benefits for Primary Care Provider (PCP) services.

C. The Arkansas Medicaid Program exempts the following diagnoses from the extension of benefit requirements when the diagnosis is entered as the primary diagnosis:

1. Malignant neoplasm (**View ICD Codes.**).
2. HIV infection or AIDS (**View ICD Codes.**).
3. Renal failure (**View ICD Codes.**).
4. Pregnancy (**View ICD Codes.**).
5. Opioid Use Disorder when treated with MAT (**View ICD OUD Codes.**)

When a Medicaid client's primary diagnosis is one (1) of those listed above and the client has exhausted the Medicaid established benefit for physician, APRN, and physician assistant services, outpatient hospital services, laboratory and X-ray services, a request for extension of benefits is not required.

247.000 Obstetrical Services 9-1-26

The Arkansas Medicaid Program covers obstetrical services for Medicaid-eligible beneficiaries. These services include prenatal services, delivery, and postpartum care, and remote monitoring of pregnant women. Please refer to Sections 292.670 through 292.675 of this manual for special billing instructions for pregnancy-related services.

PROPOSED

292.673 Fetal Non-Stress Test and Ultrasound 9-1-26

The Arkansas Medicaid Program covers fetal non-stress test and ultrasound when performed in conjunction with maternity care.

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

292.674 External Fetal Monitoring 9-1-26

Physicians may bill for external fetal monitoring when it is medically necessary and in addition to the obstetrical office visit. The procedure code listed in the **physician's procedure code table** must be used exclusively for external fetal monitoring when performed in a physician's office or clinic with National Place of Service code "11".

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

PROPOSED

TOC not required

214.300 Diagnostic Laboratory and Radiology/Other Services 9-1-26

A. Diagnostic laboratory services and radiology/other services provided by a podiatrist will be included in the benefit limits for outpatient diagnostic laboratory services and outpatient radiology/other services for individuals twenty-one (21) years of age and over.

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 benefits limit for individuals under twenty-one (21) years of age.

C. Benefit extensions may be granted in cases of documented medical necessity.

D. Section 242.130 contains procedure codes payable for diagnostic laboratory and radiology/other services.

PROPOSED

TOC not required

212.204 (DME) Electronic Blood Pressure Monitor and Cuff for Beneficiaries of All Ages 9-1-26

Arkansas Medicaid covers the automatic electronic blood pressure monitor for beneficiaries of all ages as a rental item. A provider must substantiate that an accurate blood pressure reading cannot be obtained by using a regular blood pressure monitor. Providers must also supply one (1) disposable blood pressure cuff each month. Effective 3/1/26, Medicaid covers purchase of one automatic electronic blood pressure monitor and replacement cuff for beneficiaries with a high-risk pregnancy. Medicaid coverage is limited to the purchase of one monitor and one replacement cuff per pregnancy.

Prior authorization is required for the use of this item. Providers may request prior authorization by submitting form DMS-679A, Prescription & Prior Authorization Request for Medical Equipment Excluding Wheelchairs & Wheelchair Components to DHS or its designated vendor. **View or print form DMS-679A and instructions for completion.** **View or print contact information for how to submit the request**.

PROPOSED

SECTION II – SUPPORTIVE MATERNAL CARE

CONTENTS

TOC required

200.000 SUPPORTIVE MATERNAL CARE GENERAL INFORMATION

200.100 Definitions 9-1-26

As used in this manual:

A. "Breastfeeding and lactation consultant" means:

1. An International Board-Certified Lactation Consultant certified by the International Board of Lactation Consultant Examiners;
2. A Certified Breastfeeding Counselor certified by the International Breastfeeding Institute; or
3. A Certified Lactation Counselor certified by the Academy of Lactation Policy and Practice.

A certified breastfeeding counselor or certified lactation counselor as described in subdivisions A.2. and A.3. of this section, must be supervised. "Supervision" means employed by one (1) of the following Arkansas Medicaid-enrolled providers:

a. An agency led by an International Board-Certified Lactation Consultant;
b. A physician, advanced practice nurse, or physician assistant;
c. A local health unit; or
d. A hospital;

B. "Breastfeeding and lactation consultant services" means medically appropriate outpatient services or hospital services, or both, provided by a breastfeeding and lactation consultant during pregnancy and through the first twelve (12) months of the infant's life to aid in milk expression or infant nutrition;

C. "Certified community-based doula" or "doula" means:

1. An individual who is a trained professional and provides nonclinical emotional, physical, and informational support to women before and during pregnancy and continuing through the postpartum period;
2. A doula must be certified as a community-based doula as provided in Arkansas Code § 17-108-201 et seq., and 17 CAR pt. 56; and

D. "Healthcare professional" means a person who is licensed by the laws of this state to administer health care in the ordinary course of the practice of his or her profession.

200.200 Arkansas Medicaid Participation Requirements for Supportive Maternal Care Providers 9-1-26

A. All 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:

1. Must be at least eighteen (18) years of age;
2. Obtain and maintain a National Provider Identifier;

PROPOSED

3. Use the taxonomy number required by the state; and
4. Hold the appropriate certification to provide that service as described in Section 200.100.

200.300 Group Providers of Supportive Maternal Care Services 9-1-26

Group providers of certified community-based doula services, breastfeeding and lactation consultant services, or both, must meet the following criteria in order to be eligible for participation in the Arkansas Medicaid Program.

If a doula or breastfeeding and lactation consultant is a member of a group of providers, each individual provider and the group must enroll according to the following criteria:

A. Each individual doula or breastfeeding and lactation consultant within the group must enroll following the criteria established in Section 200.200.

The group must complete an application and contract as an Arkansas Medicaid provider of certified community-based doula services, breastfeeding and lactation consultant services, or both, and must be approved by the Arkansas Medicaid Program.

B. The group must also be enrolled in the Title XVIII (Medicare) program. Out-of-state providers must submit proof of current Medicare enrollment.

C. All group providers are “pay to” providers only. The service must be performed and billed by a Medicaid-enrolled licensed doula or breastfeeding and lactation consultant within the group.

200.400 Administrative Reconsideration and Appeals 9-1-26

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

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

210.000 CERTIFIED COMMUNITY-BASED DOULAS

210.100 Scope 9-1-26

A. Arkansas Medicaid beneficiaries are eligible for services provided by certified community-based doulas if they are:

1. Pregnant or within sixteen (16) weeks postpartum;
2. Not enrolled in a Life 360 Home Program; and
3. Not receiving community health worker (CHW) services from a CHW employed by an obstetric (OB) clinic or provider.

B. Doula services may be provided upon the confirmation of pregnancy or delivery.

C. Doula services are available for up to sixteen (16) weeks postpartum, depending on the beneficiary’s continued Arkansas Medicaid eligibility.

D. Certified community-based doulas shall provide only the following services:

1. Childbirth education;

PROPOSED

2. Assistance with navigating the healthcare system;
3. Beneficiary advocacy before, during, and after the birth of a child;
4. Connection with community resources; and
5. Continuous emotional and physical support throughout labor and birth and intermittently during the prenatal and postpartum periods.

210.200 Required Recommendation for Preventative Services 9-1-26

Doula services, as preventative services, require a recommendation from an Arkansas Medicaid-enrolled physician, physician assistant, or advanced practice registered nurse, including a certified nurse midwife. DHS has obtained a statewide standing recommendation from a licensed healthcare provider for doula services for all pregnant or postpartum Medicaid beneficiaries. The statewide standing recommendation applies to Medicaid beneficiaries eligible for doula services. Separate documentation regarding the recommendation by doula providers is not required.

210.300 Covered Benefits — Benefit Limits 9-1-26

A. Doula services for the same beneficiary and pregnancy are limited to the following:

1. Up to six (6) visits during the prenatal and postpartum periods.
   a. Postpartum visits must occur within sixteen (16) weeks of labor and delivery; and
2. One (1) visit for attendance at labor and delivery.
   a. A qualifying visit for attendance at labor and delivery requires the doula to be physically present during labor, delivery, and the immediate postpartum period.

B. The following procedure codes may be billed by doulas:

View or print the procedure codes for doula services.

C. A prior authorization is not required to access the standard doula benefit package.

D. Medicaid beneficiaries are responsible for:

1. Payment for services beyond the established visit limits unless the Division of Medical Services (DMS) authorizes an extension of a particular benefit.
2. A request for extension of benefits may be submitted for beneficiaries with extenuating circumstances if there is need for additional visits beyond the six (6) prenatal and postpartum visits. Extension of benefits requests must be sent to the Department of Human Services (DHS)-contracted entity that processes extensions of benefits for beneficiaries.

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

   For audit purposes, the extension of benefits must be in writing, placed in the beneficiary's file, and available for auditors.
3. 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.

E. Doula services are not counted against the limit of sixteen (16) provider visits per state fiscal year (July 1 through June 30) for beneficiaries twenty-one (21) years of age and older. The sixteen-visit limit does not apply to beneficiaries under age twenty-one (21) in the Child Health Services, Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Program.

PROPOSED

210.400 Visit Requirements 9-1-26

A. The minimum visit length for doula services is sixty (60) minutes.

B. The initial visit must be in person, and at least one (1) visit must take place in the beneficiary's home.

C. After the initial visit, subsequent prenatal and postpartum visits may be conducted in person or via telehealth.

D. Labor and delivery services may not be conducted via telehealth.

E. The doula will work with the beneficiary to determine how to utilize the visits to best meet the needs of the beneficiary, including how many visits will occur during the prenatal period or postpartum period.

1. For prenatal and postpartum visits, doulas must coordinate directly with the beneficiary to determine the most appropriate service location, including telehealth, for prenatal and postpartum visits.
2. Service locations may include the following:
    a. Beneficiary's place of residence;
    b. Doula's office;
    c. Physician's office;
    d. Hospital;
    e. Homeless shelter;
    f. Group home;
    g. Temporary lodging;
    h. Outreach site; or
    i. Public health clinic.

F. The labor and delivery care visit may not occur in the beneficiary's residence.

210.500 Documentation Requirements 9-1-26

A. In addition to the conditions related to record keeping in Section 142.300, doulas performing services for Arkansas Medicaid beneficiaries must maintain the following documentation for each encounter:

1. Date of service;
2. Person or persons to whom services were rendered, including Medicaid ID number;
3. Start time and end time of services provided;
4. Description of the professional services rendered by the doula on behalf of the beneficiary, including results of assessments for health-related social needs and a birth plan;
5. Any new needs identified during the service; and
6. Original or electronic signature of the doula, including the credentials of the doula.

B. Documentation and claims may be subject to review and post-payment audit.

210.600 Reimbursement 9-1-26

A. All doula services outlined in this manual are reimbursed per the methodology established in the Arkansas Medicaid State Plan.

PROPOSED

B. Doulas who are also breastfeeding and lactation consultants may bill for breastfeeding and lactation services separate from the services they provide as doulas for the same beneficiary.

C. Doulas who are also certified nurse-midwives may not bill for both doula services and midwife services for the same beneficiary for the same pregnancy.

D. Healthcare professionals employing doulas may bill for services the doulas provide.

E. Doula services may be billed separately from the hospital per diem for both inpatient and outpatient visits.

F. Federally qualified health centers and rural health centers may bill for doula services outside the core encounter visit.

220.000 BREASTFEEDING AND LACTATION CONSULTANTS

220.100 Scope 9-1-26

A. Only Arkansas Medicaid beneficiaries who are pregnant or within twelve (12) months postpartum and infants up to twelve (12) months of age are eligible for breastfeeding and lactation consultant services.

B. Breastfeeding and lactation consultant services are available for twelve (12) months postpartum, depending on the beneficiary's continued Arkansas Medicaid eligibility.

C. Breastfeeding and lactation consultant services include medically appropriate outpatient services or hospital services, or both, provided by a breastfeeding and lactation consultant during pregnancy and through the postpartum period to aid in milk expression or infant nutrition.

220.200 Required Recommendation for Preventative Services 9-1-26

Breastfeeding and lactation services, as preventative services, require a recommendation from an Arkansas Medicaid-enrolled physician, physician assistant, or advanced practice registered nurse, including a certified nurse midwife. DHS has obtained a statewide standing recommendation from a licensed healthcare provider for breastfeeding and lactation consultant services for all pregnant or postpartum Medicaid beneficiaries. The statewide standing recommendation applies to Medicaid beneficiaries eligible for breastfeeding and lactation consultant services. Separate documentation regarding the recommendation by breastfeeding and lactation consultant providers is not required.

220.300 Covered Benefits — Benefit Limits 9-1-26

A. Benefit limits are as follows:

1. Breastfeeding and lactation consultant services for Medicaid beneficiaries who are pregnant or within twelve (12) months postpartum are limited to a maximum of three (3) visits for each pregnancy. No prior authorization is needed for these visits.
2. Breastfeeding and lactation consultant services for Medicaid beneficiaries who are twelve (12) months or younger are limited to a maximum of three (3) visits. No prior authorization is needed for these visits.

B. The following procedure codes may be billed by breastfeeding and lactation consultants.

View or print the procedure codes for breastfeeding and lactation consultant services.

PROPOSED

1. Medicaid beneficiaries are responsible for payment for services beyond the established visit limits unless the Division of Medical Services (DMS) authorizes an extension of a particular benefit.
2. A request for extension of benefits may be submitted, for beneficiaries with extenuating circumstances, if there is need for additional visits. Extension of benefits requests must be sent to the Department of Human Services (DHS)-contracted entity that processes extensions of benefits for beneficiaries.

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

For audit purposes, the extension of benefits must be in writing, placed in the beneficiary's file, and available for auditors. Extension of benefits should contain the medical reason for additional services and be signed by the supervising provider.

C. Group services may be provided but are subject to the limits described in Subsection A of this section. When providing services in a group setting, the number of participants must be at least two (2) participants and no more than eight (8) participants.

D. Breastfeeding and lactation consultant services are not counted against the limit of sixteen (16) visits per state fiscal year (July 1 through June 30) for beneficiaries twenty-one (21) years of age and older. The sixteen-visit limit does not apply to beneficiaries under age twenty-one (21) in the Child Health Services, Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Program.

220.400 Visit Requirements 9-1-26

A The minimum visit length for breastfeeding and lactation consultant services is fifteen (15) minutes.

The maximum visit length is ninety (90) minutes.

B. The initial visit must be in person. After the initial visit, subsequent visits may be conducted in person or via telehealth.

C. Services provided in a group setting must be in person.

D. The breastfeeding and lactation consultant will work with the beneficiary or the beneficiary's mother to determine how to utilize the visits to best meet the needs of the beneficiary.

E. Breastfeeding and lactation consultants must coordinate directly with the beneficiary or the beneficiary's mother to determine the most appropriate service location.

F. Service locations may include the following:

1. Beneficiary's place of residence;
2. Breastfeeding and lactation consultant's office;
3. Office of supervising physician, advanced practice nurse, or physician assistant;
4. A local health unit or a Women, Infants and Children's office operated by the Arkansas Department of Health; or
5. Hospital.

220.500 Documentation Requirements 9-1-26

A. In addition to the conditions related to record keeping in Section 142.300, breastfeeding and lactation consultants performing services for Arkansas Medicaid beneficiaries must maintain the following documentation:

PROPOSED

1. Date of service;
2. Person or persons to whom services were rendered, including Medicaid ID number;
3. Start time and end time of services provided;
4. Treatment plan, including problems, goals, and objectives, as appropriate, and updates;
5. Method or methods used or to be used to address the identified problems, goals, and objectives;
6. Progress made;
8. Any new problems, goals, or objectives identified during the service; and
9. Original or electronic signature of the breastfeeding and lactation consultant, including the credentials of the breastfeeding and lactation consultant.

B. Documentation and claims may be subject to review and post-payment audit.

220.600 Reimbursement 9-1-26

A. All breastfeeding and lactation consultant services outlined in this manual are reimbursed per the methodology established in the Arkansas Medicaid State Plan.

B. Breastfeeding and lactation consultants who are also doulas may bill for breastfeeding and lactation services separate from the services they provide as doulas for the same beneficiary.

C. Breastfeeding and lactation consultants who are also community health workers (CHWs) may bill for breastfeeding and lactation services separate from the services they provide as CHWs for the same beneficiary.

D. Breastfeeding and lactations consultants who are also certified nurse-midwives (CNMs) may bill for breastfeeding and lactation consultant services separate from the services they provide as a CNM for the same beneficiary if the services are provided on different days.

E. Healthcare professionals employing breastfeeding and lactation consultants may bill for the services the consultants provide.

F. During an inpatient hospital stay, breastfeeding and lactation consultant services cannot be billed separately from the hospital per diem. Breastfeeding and lactation consultant services provided in an outpatient hospital setting may be billed separately.

G. Federally qualified health centers and rural health centers may bill for breastfeeding and lactation consultant services outside the core encounter visit.

230.000 BILLING PROCEDURES

230.100 Introduction to Billing 9-1-26

Doulas and breastfeeding and lactation consultants use the CMS-1500 form to bill the Arkansas Medicaid Program on paper for services provided for eligible Medicaid beneficiaries. Section III of this manual contains information about available options for electronic claims submission.

Each claim may contain charges for only one (1) beneficiary.

Procedure codes payable to doulas and breastfeeding and lactation consultants do not require modifiers unless specified in the policy.

230.200 National Place of Service (POS) Codes 9-1-26

PROPOSED

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

Place of Service	POS Codes
Telehealth Provided Other than in Patient's Home	02
Homeless Shelter	04
Telehealth Provided in Patient's Home	10
Group Home	14
Mobile Unit	15
Temporary Lodging	16
Inpatient Hospital	21
Outpatient Hospital	22
Outreach Site	27
Provider's Office	11
Patient's Home	12
Public Health Clinic	71
Other Locations	99

230.300 Billing Instructions 9-1-26

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.

230.300 Completion of CMS-1500 Claim Form 9-1-26

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.

PROPOSED

Field Name and Number		Instructions for Completion
	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.
	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.

PROPOSED

Field Name and Number			Instructions for Completion
	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.
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.

PROPOSED

Field Name and Number		Instructions for Completion
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.
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.

PROPOSED

Field Name and Number			Instructions for Completion
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 ORIGINAL REF. NO.		Reserved for future use. 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.
	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.

PROPOSED

Field Name and Number			Instructions for Completion
	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.
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.

PROPOSED

Field Name and Number		Instructions for Completion
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.

230.400 Clinic or Group Billing 9-1-26

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.

PROPOSED

Revision: HCFA-Region VI
November 1990
Revised: March 1, 2026

**AMOUNT, DURATION, AND SCOPE OF MEDICAL
AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY SERVICES PROVIDED**

b. Screening Services

___ Provided ___No Limitations ___ With Limitations* _X_ Not Provided

c. Preventive services

_X_ Provided ___No Limitations _X_ With Limitations* _ _ Not Provided

d. Rehabilitative services

_X_ Provided ___No Limitations _X_ With Limitations* ___ Not Provided

14. Services for individuals age 65 or older in institutions for mental diseases

a. Inpatient hospital services

___ Provided ___No Limitations ___ With Limitations* _X_ Not Provided

b. Nursing facility services

c. ___ Provided ___No Limitations ___ With Limitations* _X_ Not Provided

*Description provided on attachment

PROPOSED

AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED

Revised: March 1, 2026

CATEGORICALLY NEEDY

13. Other diagnostic, screening, preventive and rehabilitative services, i.e., other than those provided elsewhere in this plan. (Continued)

a. Diagnostic services – Not Provided.
b. Screening services - Not Provided.
c. Preventive services - Provided, with limitation.

Vaccines:

Arkansas covers vaccines and vaccine administration which includes approved vaccines recommended by the Advisory Committee on Immunization Practices (an advisory committee established by the Secretary, acting through the Director of the Centers for Disease Control and Prevention).

PROPOSED

13. Other diagnostic, screening, preventive and rehabilitative services, i.e., other than those provided elsewhere in this plan. (Continued)

c. Preventive Services—Provided with Limitation (continued)

Certified Community-based Doulas:

A Certified Community-based Doula is a trained professional who provides emotional, physical, and informational support during the prenatal, labor, delivery, and postpartum periods. Certified Community-based Doula services must be recommended by a physician or other licensed practitioner of the healing arts acting within their scope of practice under state law.

Certified community-based doulas shall provide only the following services:

1. Childbirth education;
2. Assistance with navigating the healthcare system;
3. Client advocacy before, during, and after the birth of a child;
4. Connection with community resources; and
5. Continuous emotional and physical support throughout labor and birth and intermittently during the prenatal and postpartum periods.

Services shall include support during a hospital delivery and during the prenatal and postpartum periods as defined through rules established by the Arkansas Department of Human Services.

To be eligible to provide services, Doulas must be:

(1) Certified by the Department of Health in accordance with state law; and (2) At least eighteen (18) years of age and have an NPI number.

PROPOSED

13. Other diagnostic, screening, preventive and rehabilitative services, i.e., other than those provided elsewhere in this plan. (Continued)

c. Preventive Services—Provided with Limitation (continued)

Breastfeeding and Lactation Consultants:

A breastfeeding and lactation consultant is a trained professional specializing in providing medically appropriate care to aid in milk expression or infant nutrition. Breastfeeding and Lactation Consultant services must be recommended by a physician or other licensed practitioner of the healing arts acting within their scope of practice under state law.

Breastfeeding and lactation consultant services are medically appropriate outpatient services or hospital services, or both, provided by a breastfeeding and lactation consultant during pregnancy and through the extended postpartum period to aid in milk expression or infant nutrition. Components of Breastfeeding and Lactation Consultant services include individual outpatient consultation and group classes.

To be eligible to provide services, Breastfeeding and Lactation Consultants must:

- Be at least eighteen (18) years of age and have an NPI number; and
- Have one of the following certifications:
  1. An International Board-Certified Lactation Consultant; or
  2. A Certified Lactation Counselor;
     - Certified Lactation Counselors must be certified by either the (1) International Breastfeeding Institute or (2) Academy of Lactation Policy and Practice;
     - Certified Lactation Counselors are required to be supervised by a Medicaid enrolled healthcare provider to receive reimbursement. Supervision is defined as being employed by one of the following:
       A. An agency led by an International Board-Certified Lactation Consultant;
       B. A physician, advanced practice nurse, or physician assistant
       C. A local health unit or
       D. A hospital

PROPOSED

13. Other diagnostic, screening, preventive and rehabilitative services, i.e., other than those provided elsewhere in this plan. (Continued)

d. Rehabilitative Services

1. Rehabilitative Services for Persons with Mental Illness (RSPMI)

A comprehensive system of care for behavioral health services has been developed for use by RSPMI providers. The changes to the program were developed in coordination with providers, representatives of the Arkansas System of Care and other key stakeholders.

DMS is seeking first to revise service definitions and methods within this program to meet the needs of persons whose illnesses meet the definitions outlined in the American Psychiatric Association Diagnostic and Statistical Manual.

Covered mental health services do not include services provided to individuals aged 21 to 65 who reside in facilities that meet the Federal definition of an institution for mental disease. Coverage of RSPMI services within the rehabilitation section of Arkansas' state plan that are provided in IMD's will be discontinued as of September 1, 2011.

A. Scope

A range of mental health rehabilitative or palliative services is provided by a duly certified RSPMI provider to Medicaid-eligible beneficiaries suffering from mental illness, as described in the American Psychiatric Association Diagnostic and Statistical Manual (DSM-IV and subsequent revisions).

DMS has set forth in policy the settings in which each individual service may be provided. Each service shown below includes the place of service allowable for that procedure.

Services:

- SERVICE: Mental Health Evaluation/Diagnosis
  DEFINITION: The cultural, developmental, age and disability -relevant clinical evaluation and determination of a beneficiary's mental status; functioning in various life domains; and an axis five DSM diagnostic

PROPOSED

AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED

Revised: March 1, 2026

MEDICALLY NEEDY

13. Other diagnostic, screening, preventive and rehabilitative services, i.e., other than those provided elsewhere in this plan. (Continued)

a. Diagnostic services – Not Provided.
b. Screening services - Not Provided.
c. Preventive services - Provided, with limitation

Vaccines:

Arkansas covers vaccines and vaccine administration which includes approved vaccines recommended by the Advisory Committee on Immunization Practices (an advisory committee established by the Secretary, acting through the Director of the Centers for Disease Control and Prevention).

PROPOSED

13. Other diagnostic, screening, preventive and rehabilitative services, i.e., other than those provided elsewhere in this plan. (Continued)

c. Preventive Services—Provided with Limitation (continued)

Certified Community-based Doulas:

A Certified Community-based Doula is a trained professional who provides emotional, physical, and informational support during the prenatal, labor, delivery, and postpartum periods. Certified Community-based Doula services must be recommended by a physician or other licensed practitioner of the healing arts acting within their scope of practice under state law.

Certified community-based doulas shall provide only the following services:

1. Childbirth education;
2. Assistance with navigating the healthcare system;
3. Client advocacy before, during, and after the birth of a child;
4. Connection with community resources; and
5. Continuous emotional and physical support throughout labor and birth and intermittently during the prenatal and postpartum periods.

Services shall include support during a hospital delivery and during the prenatal and postpartum periods as defined through rules established by the Arkansas Department of Human Services.

To be eligible to provide services, Doulas must be**:**

(1) Certified by the Department of Health as provided in accordance with state law;
(2) At least eighteen (18) years of age and have an NPI number.

PROPOSED

13. Other diagnostic, screening, preventive and rehabilitative services, i.e., other than those provided elsewhere in this plan. (Continued)

c. Preventive Services—Provided with Limitation (continued)

Breastfeeding and Lactation Consultants:

A breastfeeding and lactation consultant is a trained professional specializing in providing medically appropriate care to aid in milk expression or infant nutrition. Breastfeeding and Lactation Consultant services must be recommended by a physician or other licensed practitioner of the healing arts acting within their scope of practice under state law.
Breastfeeding and lactation consultant services are medically appropriate outpatient services or hospital services, or both, provided by a breastfeeding and lactation consultant during pregnancy and through the extended postpartum period to aid in milk expression or infant nutrition. Components of Breastfeeding and Lactation Consultant services include individual outpatient consultation and group classes.

To be eligible to provide services, Breastfeeding and Lactation Consultants must**:**

- Be at least eighteen (18) years of age and have an NPI number and
- Have one of the following certifications:
  1. An International Board-Certified Lactation Consultant; or
  2. A Certified Lactation Counselor;
     - Certified Lactation Counselors must be certified by the (1) International Breastfeeding Institute or (2) Academy of Lactation Policy and Practice.
     - Certified Lactation Counselors are required to be supervised by a Medicaid enrolled healthcare provider to receive reimbursement. Supervision is defined as being employed by one of the following:
       A. An agency led by an International Board-Certified Lactation Consultant;
       B. A physician, advanced practice nurse, or physician assistant
       C. A local health unit or
       D. A hospital

PROPOSED

MEDICALLY NEEDY

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13. Other diagnostic, screening, preventive and rehabilitative services, i.e., other than those provided elsewhere in this plan. (Continued)

d. Rehabilitative Services

1. Rehabilitative Services for Persons with Mental Illness (RSPMI)

A comprehensive system of care for behavioral health services has been developed for use by RSPMI providers. The changes to the program were developed in coordination with providers, representatives of the Arkansas System of Care and other key stakeholders.

DMS is seeking first to revise service definitions and methods within this program to meet the needs of persons whose illnesses meet the definitions outlined in the American Psychiatric Association Diagnostic and Statistical Manual.

Covered mental health services do not include services provided to individuals aged 21 to 65 who reside in facilities that meet the Federal definition of an institution for mental disease. Coverage of RSPMI services within the rehabilitation section of Arkansas' state plan that are provided in IMD's will be discontinued as of September 1, 2011.

A. Scope

A range of mental health rehabilitative or palliative services is provided by a duly certified RSPMI provider to Medicaid-eligible beneficiaries suffering from mental illness, as described in the American Psychiatric Association Diagnostic and Statistical Manual (DSM-IV and subsequent revisions).

DMS has set forth in policy the settings in which each individual service may be provided. Each service shown below includes the place of service allowable for that procedure.

Services:

- SERVICE: Mental Health Evaluation/Diagnosis
  DEFINITION: The cultural, developmental, age and disability -relevant clinical evaluation and determination of a beneficiary's mental status; functioning in various life domains; and an axis five DSM diagnostic

PROPOSED

12. Prescribed drugs, dentures, and prosthetic devices; and eyeglasses prescribed by a physician skilled in diseases of the eye or by an optometrist (Continued)

d. Eyeglasses

Arkansas provides eyeglasses when prescribed for vision correction through a competitively bid contract with an optical supply vendor.

13. Other diagnostic, screening, preventive and rehabilitative services, i.e., other than those provided elsewhere in this plan

a. Diagnostic Services - Not provided.
b. Screening Services - Not provided.
c. Preventive Services - Provided with limitations.

Arkansas covers vaccines and vaccine administration which includes approved vaccines recommended by the Advisory Committee on Immunization Practices (an advisory committee established by the Secretary, acting through the Director of the Centers for Disease Control and Prevention).

For dates of service on or after March 1, 2026, Arkansas reimburses certified community-based doulas and lactation and breastfeeding consultant services authorized under Section 13 of Attachments 3.1-A and 3.1-B using a state-developed fee schedule.

DHS selected Oklahoma doula rates in place prior to April 2025, including procedure codes and modifier structure. This selection is based on similar rural geography, established doula services programming, and similar payment rates to a neighboring state, Louisiana. While the billing rate basis varied across the comparator states did not allow for calculation of a specific common statistic, DHS reviewed the comparator state payment rates to assess for reasonableness.

For Lactation and breastfeeding services, DHS reviewed comparable state service rates. While the variation in the billing rate basis across the comparator states did not allow for calculation of a specific common statistic, DHS reviewed the comparator state payment rates to assess for reasonableness. DHS selected a rate between the rates of neighboring states, Missouri and Louisiana. The selected is also within the range of Illinois lactation services. All three comparison states are similar in rural versus urban geography and established lactation and breastfeeding counseling programming. Group rates were established based on an average group size of three.

Except as otherwise noted in the State Plan, fee schedule rates are the same for governmental and private providers. The agency's fee schedule was set as of March 1, 2026, and is effective for services furnished on or after March 1, 2026. All rates are published on the agency's website at: https://humanservices.arkansas.gov/divisions-shared-services/medical-services/helpful-information-for-providers/fee-schedules/

d. Rehabilitative Services

1. Rehabilitative Services for Persons with Mental Illness (RSPMI)

Reimbursement is based on the lower of the amount billed or the Title XIX (Medicaid) maximum allowable. Except as otherwise noted in the state plan, state developed fee schedule rates are the same for both governmental and private providers of RSPMI services. The agency's fee schedule rates were set as of April 1, 1988, and are effective for services provided on or after that date. All rates are published on the agency's website at: https://humanservices.arkansas.gov/divisions-shared-services/medical-services/helpful-information-for-providers/fee-schedules/ .

Effective for dates of service on or after April 1, 2004, reimbursement rates (payments) for inpatient visits in acute care hospitals by board certified psychiatrists shall be as ordered by the United States District Court for the Eastern District of Arkansas in the case of Arkansas Medical Society v. Reynolds. Refer to Attachment 4.19-B, Item 5, for physician reimbursement.

The State shall not claim FFP for any non-institutional service provided to individuals who are residents of facilities that meet the Federal definition of an institution for mental diseases or a psychiatric residential treatment facility as described in Federal regulations at 42 CFR 1440 and 14460 and 42 CFR 441 Subparts C and D. Reimbursement of RSPMI services that are provided in IMD's will be discontinued for services provided on or after September 1, 2011.
For RSPMI services provided in clinics operated by State operated teaching hospitals.

Effective for claims with dates of service on or after March 1, 2002, Arkansas State Operated Teaching Hospital psychiatric clinics that are not part of a hospital outpatient department shall be reimbursed based on reasonable costs. Medicaid shall issue interim payments at the established fee schedule rates. A year-end cost settlement shall be performed to reconcile interim payments with the provider's reasonable costs. The state will return to CMS the federal share of reconciled payments recouped from provider overpayments consistent with 42 CFR 433 Subpart F. The provider will be paid the lesser of actual costs identified using a CMS approved cost report or customary charges. Each Arkansas State Operated Teaching Hospital with qualifying psychiatric clinics shall submit an annual cost report. Said cost report shall be submitted within five (5) months after the close of the hospital's fiscal year. Failure to file the cost report within the prescribed period, except as expressly extended by the State Medicaid Agency, will result in suspension of reimbursement until the cost report is filed. The State Medicaid Agency will review the submitted cost report and make a tentative settlement within 60 days of the receipt of the cost report and will make final settlement in the following year after all Medicaid charges and payments have been processed. The final settlement will be calculated and made at the same time as the next year's tentative settlement is calculated and made.

Medical professionals affiliated with Arkansas State Operated Teaching Hospitals are not eligible for additional reimbursement for services provided in these clinics.

PROPOSED

State of Arkansas *As Engrossed: H2/13/25 S4/3/25*
95th General Assembly **A Bill**
Regular Session, 2025 HOUSE BILL 1252

By: Representative L. Johnson
By: Senator Irvin

For An Act To Be Entitled

AN ACT TO ESTABLISH THE CERTIFIED COMMUNITY-BASED DOULA CERTIFICATION ACT; TO CERTIFY BIRTH AND POSTPARTUM DOULAS IN THIS STATE TO IMPROVE MATERNAL AND INFANT OUTCOMES; AND FOR OTHER PURPOSES.

Subtitle

TO ESTABLISH THE CERTIFIED COMMUNITY-BASED DOULA CERTIFICATION ACT; AND TO CERTIFY BIRTH AND POSTPARTUM DOULAS IN THIS STATE TO IMPROVE MATERNAL AND INFANT OUTCOMES.

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

SECTION 1. Arkansas Code Title 17, is amended to add an additional chapter to read as follows:

CHAPTER 108

CERTIFIED COMMUNITY-BASED DOULA CERTIFICATION ACT

Subchapter 1 - General Provisions

17-108-101. Title.

This chapter shall be known and may be cited as the "Certified Community-Based Doula Certification Act".

17-108-102. Definitions.

As used in this chapter:

(1) "Certified community-based doula" means an individual who is a trained professional and provides nonclinical emotional, physical, and informational support to women, before and during pregnancy and continuing through the postpartum period; and

(2) "Health benefit plan" means an individual, blanket, or group plan, policy, or contract for healthcare services issued or delivered in this state by a healthcare insurer, health maintenance organization, hospital medical service corporation, or self-insured governmental or church plan in this state.

Subchapter 2 - Certification

17-108-201. Certified community-based doula — Certification.

(a) The Department of Health shall issue a certification to be a certified community-based doula to an individual who:

(1) Is eighteen (18) years of age or older;

(2) Submits evidence of:

(A) Maintaining a certification from a doula certification organization designated by the department under § 17-108-203; or

(B) Holding a certificate as a doula by the Doula Alliance of Arkansas; and

(3) Submits an application with an application fee of fifty dollars ($50.00).

(b)(1) A certification under this section is valid for two (2) years after the date of issuance.

(2) To renew a certification, a doula shall:

(A)(i) Complete ten (10) hours of professional development requirements and training over two (2) years.

(ii) The department, in conjunction with the Doula Alliance of Arkansas, may adopt rules relating to the tracking by the department of professional development and training; and

(B) Submit a renewal application with a renewal application fee as determined by the department.

(c) The department shall create and maintain a registry of certified community-based doulas to be made available to the public.

17-108-202. Suspension, revocation, nonissuance, or nonrenewal.

(a) The Department of Health may suspend, revoke, or refuse to issue or renew the certification of a certified community-based doula for:

(1) Securing a certification under this chapter through fraud or deceit;

(2) Unethical conduct, gross ignorance, or inefficiency in the conduct of his or her practice;

(3) Using a false name or an alias in his or her practice;

(4) Violating any provision of this chapter; or

(5) Failing to comply with any of the requirements for issuance of the certification.

(b) Proceedings under this section shall comply with the Arkansas Administrative Procedure Act, § 25-15-201 et seq.

17-108-203. Designated doula certification organizations.

(a) The Department of Health, in conjunction with the Doula Alliance of Arkansas, shall establish criteria for an organization to be designated as a doula certification organization.

(b)(1) The department, in conjunction with the Doula Alliance of Arkansas, shall periodically review the doula certification organizations designated by the department.

(2) The department, in conjunction with the Doula Alliance of Arkansas, may:

(A) Designate additional organizations as doula certification organizations for the purpose of certifying doulas for inclusion on the registry of certified community-based doulas; and

(B)(i) Remove the designation of a doula certification organization previously designated.

(ii) If the department removes a designation, the department shall provide notice of the removal by publication on the department's website and specify the date after which a certification by the doula certification organization no longer authorizes a doula certified by the doula certification organization to be included on the certified community-based doula registry.

(c)(1) A doula certification organization seeking designation under this section shall provide the department with evidence that the doula

certification organization satisfies designation criteria established by the department.

(2) If the department designates a doula certification organization under this section, the department shall provide notice of the designation by publication on the department's website for the certified community-based doula registry and specify the date after which a certification by the doula certification organization authorizes a doula certified by the organization to be included on the certified community-based doula registry.

(d) This section does not prohibit an individual from submitting his or her doula certification to the department without involvement of a doula certification organization.

Subchapter 3 - Miscellaneous Provisions

17-108-301. Scope of practice.

A certified community-based doula under this chapter shall perform only the following types of services:

(1) Providing childbirth education;

(2) Helping pregnant women navigate the healthcare system;

(3) Advocating for pregnant women before, during, and after the birth of a child;

(4) Connecting pregnant women with community resources; and

(5) Supporting pregnant women with continuous emotional and physical support throughout labor and birth and intermittently during the prenatal and postpartum periods.

17-108-302. Patient and personal data and information.

(a) Patient and personal data and information accessed or attained by a certified community-based doula under this chapter is exempt from disclosure under the Freedom of Information Act of 1967, § 25-19-101 et seq., and is confidential and privileged as otherwise required by federal law.

(b) If a certified community-based doula under this chapter does not maintain the confidential and privileged nature of the patient data or information, the doula shall be subject to any penalty under state and federal law for a breach of confidential patient data or information.

17-108-303. Certified community-based doula compensation.

(a) A certified community-based doula under this chapter shall receive compensation for services provided from:

(1) The Arkansas Medicaid Program; and

(2) A health benefit plan.

(b) Services described in subsection (a) of this section shall include support during a hospital delivery and during the prenatal and postpartum periods as defined through rules established by the Department of Human Services.

17-108-304. Rules.

(a) The Department of Health may promulgate rules relating to the certification and regulation of certified community-based doulas under this subchapter and relating to the designation of an organization as a doula certification organization.

(b) On or before December 31, 2025, the Department of Human Services shall promulgate rules relating to the reimbursement of doulas under the Arkansas Medicaid Program.

/s/L. Johnson

APPROVED: 4/21/25

State of Arkansas*As Engrossed: H2/3/25 H3/12/25 H3/13/25 H3/20/25 S4/2/25*
95th General Assembly
A Bill
Regular Session, 2025 HOUSE BILL 1333

By: Representatives Hudson, D. Garner, Bentley, A. Brown, K. Brown, Cavenaugh, Ennett, Gonzales Worthen, J. Mayberry, McCullough, T. Shephard, Springer, Clowney
By: Senators J. Scott, *Irvin*

For An Act To Be Entitled

AN ACT TO MANDATE COVERAGE FOR BREASTFEEDING AND LACTATION CONSULTANT SERVICES; AND FOR OTHER PURPOSES.

Subtitle

TO MANDATE COVERAGE FOR BREASTFEEDING AND LACTATION CONSULTANT SERVICES.

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

SECTION 1. Arkansas Code Title 23, Chapter 79, is amended to add an additional subchapter to read as follows:

Subchapter 29 — Coverage for Breastfeeding and Lactation Consultants

23-79-2901. Definitions.

As used in this subchapter:

(l)(A) "Breastfeeding and lactation consultant" means:

(i) An International Board Certified Lactation Consultant; and

(ii)(a) A certified lactation counselor.

(b) The individuals listed under subdivision (l)(A)(ii)(a) of this section are required to be supervised by a contracted and in-network healthcare provider to receive reimbursement.

(B) The Arkansas Medicaid Program shall reimburse the individuals listed under subdivision (l)(A) of this section for breastfeeding

and lactation consulting services if the individuals:

(i) Have a Medicaid number; or

(ii) Are otherwise compliant with all requirements for reimbursement under the Arkansas Medicaid Program; (2) "Breastfeeding and lactation consultant services" means medically appropriate *outpatient services or hospital services, or both, provided* by a breastfeeding and lactation consultant during pregnancy and through the extended postpartum *period to aid in milk expression or infant nutrition;*

(3)(A) "Enrollee" means an individual entitled to coverage of healthcare services from a healthcare insurer.

(B) "Enrollee" includes a minor child;

(4)(A) "Health benefit plan" means:

(i) An individual, blanket, or group plan or a policy or contract for healthcare services offered, issued, renewed, delivered, or extended in this state by a healthcare insurer; and

(ii) A health benefit program receiving state or federal appropriations from the State of Arkansas, including the Arkansas Medicaid *Program, ARKids First-A or First-B, and* the Arkansas Health and Opportunity for Me Program established by the Arkansas Health and Opportunity for Me Act of 2021, § 23-61-1001 et seq.

(B) "Health benefit plan" includes:

(i) Indemnity and managed care plans; and

(ii) Plans providing health benefits to state and public school employees under § 21-5-401 et seq.

(C) "Health benefit plan" does not include:

(i) A plan that provides only dental benefits or eye and vision care benefits;

(ii) A disability income plan;

(iii) A credit insurance plan;

(iv) Insurance coverage issued as a supplement to liability insurance;

(v) A medical payment under an automobile or homeowners insurance plan;

(vi) A health benefit plan provided under Arkansas Constitution, Article 5, § 32, the Workers' Compensation Law, § 11-9-101 et seq., or the Public Employee Workers' Compensation Act, § 21-5-601 et seq.;

(vii) A plan that provides only indemnity for hospital confinement;

(viii) An accident-only plan;

(ix) A specified disease plan; or

(x) A long-term-care-only plan; and

(5)(A) "Healthcare insurer" means an entity subject to the insurance laws of this state or the jurisdiction of the Insurance Commissioner that contracts or offers to contract to provide health insurance coverage, including without limitation an insurance company, a hospital and medical service corporation, a health maintenance organization, a self-insured governmental or church plan in this state, the Arkansas Medicaid Program, or a nonprofit agricultural membership organization as defined in § 23-60-104.

(B) "Healthcare insurer" does not include an entity that provides only dental benefits or eye and vision care benefits.

23-79-2902. Coverage for breastfeeding and lactation consultant services.

(a) On and after January 1, 2026, a health benefit plan that is offered, issued, renewed, delivered, or extended in this state shall provide coverage for breastfeeding and lactation consultant *services in an outpatient setting to* an enrollee.

(b) The coverage for breastfeeding and lactation consultant services under subsection (a) of this section:

(1) Is not subject to an annual deductible, copayment, or coinsurance limit as established for other covered benefits under a health benefit plan; and

(2) Does not diminish or limit benefits otherwise allowable under a health benefit plan.

23-79-2903. Rules.

(a) The Insurance Commissioner may develop and promulgate rules for the implementation and administration of this subchapter.

(b) The Secretary of the Department of Human Services may develop and promulgate rules for the implementation and administration of this subchapter that may apply to the Arkansas Medicaid Program or the Arkansas Health and

Opportunity for Me Program established by the Arkansas Health and Opportunity for Me Act of 2021, § 23-61-1001 et seq.

(c) The State Board of Finance may develop and promulgate rules for the administration of this subchapter for the plans providing health benefits to state and public school employees under § 21-5-401 et seq.

/s/Hudson

APPROVED: 4/16/25

State of Arkansas
95th General Assembly
Regular Session, 2025

A Bill

SENATE BILL 213

By: Senators Irvin, B. Davis
By: Representatives Pilkington, Wardlaw, Hudson, L. Johnson, Bentley

For An Act To Be Entitled

AN ACT TO CREATE THE HEALTHY MOMS, HEALTHY BABIES ACT; TO AMEND ARKANSAS LAW TO IMPROVE MATERNAL HEALTH IN THIS STATE; AND FOR OTHER PURPOSES.

Subtitle

TO CREATE THE HEALTHY MOMS, HEALTHY BABIES ACT; AND TO AMEND ARKANSAS LAW TO IMPROVE MATERNAL HEALTH IN THIS STATE.

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

SECTION 1. DO NOT CODIFY. Title.

This act shall be known and may be cited as the "Healthy Moms, Healthy Babies Act".

SECTION 2. Arkansas Code § 20-77-151 is repealed to be reenacted and transferred to another subchapter of the Arkansas Code.

~~20-77-151. Depression screening for pregnant women.~~

~~(a) The Arkansas Medicaid Program shall reimburse for depression screening of a pregnant woman.~~

~~(b) The Department of Human Services shall apply for any federal waiver, Medicaid state plan amendments, or other authority necessary to implement this section.~~

SECTION 3. Arkansas Code Title 20, Chapter 77, is amended to add an additional subchapter to read as follows:

Subchapter 29 — Maternal Health

20-77-2901. Depression screening for pregnant women.

(a) The Arkansas Medicaid Program shall reimburse for depression screening of a pregnant woman.

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

20-77-2902. Coverage of prenatal, delivery, and postpartum services.

(a) The Arkansas Medicaid Program shall reimburse for prenatal, delivery, and postpartum services separately in lieu of a global payment or an all-inclusive payment methodology for maternity services.

(b) Prenatal, delivery, and postpartum services include without limitation:

(1) Office visits;

(2) Laboratory fees;

(3) Physician ordered testing;

(4) Blood work;

(5) Remote monitoring;

(6) Fetal nonstress tests; and

(7) Continuous glucose monitors or other services for gestational diabetes when medically necessary.

(c) This section does not alter coverage provided through the Arkansas Health and Opportunity for Me Program or a risk-based provider organization under the Medicaid Provider-Led Organized Care Act, § 20-77-2701 et seq.

20-77-2903. Presumptive eligibility for pregnant women.

(a) The Arkansas Medicaid Program shall make presumptive eligibility determinations for pregnant women who are applying for the program to improve access to prenatal care and allow prenatal care to be delivered immediately while waiting for a full application to be processed.

(b) The program may designate one (1) or more qualified entities to screen for eligibility and immediately enroll pregnant women into the program.

20-77-2904. Blood pressure monitoring for pregnant and postpartum

women.

(a) The Arkansas Medicaid Program shall provide coverage and reimbursement for self-measurement blood pressure monitoring services for pregnant women and postpartum women.

(b) Self-measurement blood pressure monitoring services shall include:

(1) Validated blood pressure monitoring devices, such as a blood pressure cuff and replacement cuffs, as medically necessary, to diagnose or treat hypertension;

(2) Patient education and training on the set-up and use of a self-measurement blood pressure measurement device that is validated for clinical accuracy, device calibration, and the procedure for obtaining self-measurement readings; and

(3) Collection of data reports by the patient or caregiver for submission to a healthcare provider to communicate blood pressure readings and create or modify treatment plans.

20-77-2905. Reimbursement for remote ultrasound procedures.

(a)(1) The Arkansas Medicaid Program shall reimburse for medically necessary remote ultrasound procedures utilizing established Current Procedural Terminology codes for remote ultrasound procedures when the patient is in a residence or other off-site location from the healthcare provider of the patient and the same standard of care is met.

(2) Subdivision (a)(1) of this section shall apply to the fee-for-service categories of the program and any managed care plan within the program.

(b) A remote ultrasound procedure shall be reimbursable when the healthcare provider uses digital technology that:

(1) Collects medical and other forms of health data from a patient and electronically transmits the information securely to a healthcare provider in a different location for interpretation and recommendation;

(2) Is compliant with the Health Insurance Portability and Accountability Act of 1996, 42 U.S.C. § 1320d et seq., as it existed on January 1, 2025; and

(3) Is approved by the United States Food and Drug Administration.

20-77-2906. Coverage for certain services provided by doulas and community health workers.

The Arkansas Medicaid Program shall reimburse doulas and community health workers for home visitation related to prenatal care and postpartum care.

20-77-2907. Implementation and rules.

The Department of Human Services shall:

(1) Apply for any federal waiver, Medicaid state plan amendments, or other authority necessary to implement this subchapter; and

(2) Adopt rules to implement this subchapter.

SECTION 4. Arkansas Code § 16-114-203(c), concerning the statute of limitations, is amended to read as follows:

(c)(1) ~~If~~ Except as otherwise provided in this subsection, if an individual is nine (9) years of age or younger at the time of the act, omission, or failure complained of, the minor or person claiming on behalf of the minor shall have until the later of the minor's eleventh birthday or two (2) years from the act, omission, or failure in which to commence an action.

(2) ~~However, if~~ If no medical injury is known and could not reasonably have been discovered prior to the minor's eleventh birthday, then the minor or his or her representative shall have until two (2) years after the medical injury is known or reasonably could have been discovered, or until the minor's nineteenth birthday, whichever is earlier, in which to commence an action.

(3) If an alleged medical injury occurred during childbirth, the minor or his or her representative shall have until the minor's fifth birthday to commence an action.

APPROVED: 2/25/25

State of Arkansas
95th General Assembly
Regular Session, 2025

A Bill

HOUSE BILL 1427

By: Representatives Pilkington, Wardlaw, Hudson, L. Johnson, Bentley
By: Senators Irvin, B. Davis

For An Act To Be Entitled

AN ACT TO CREATE THE HEALTHY MOMS, HEALTHY BABIES ACT; TO AMEND ARKANSAS LAW TO IMPROVE MATERNAL HEALTH IN THIS STATE; AND FOR OTHER PURPOSES.

Subtitle

TO CREATE THE HEALTHY MOMS, HEALTHY BABIES ACT; AND TO AMEND ARKANSAS LAW TO IMPROVE MATERNAL HEALTH IN THIS STATE.

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(1) Office visits;

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20-77-2906. Coverage for certain services provided by doulas and community health workers.

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20-77-2907. Implementation and rules.

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SECTION 4. Arkansas Code § 16-114-203(c), concerning the statute of limitations, is amended to read as follows:

(c)(1) ~~If~~ Except as otherwise provided in this subsection, if an individual is nine (9) years of age or younger at the time of the act, omission, or failure complained of, the minor or person claiming on behalf of the minor shall have until the later of the minor's eleventh birthday or two (2) years from the act, omission, or failure in which to commence an action.

(2) ~~However, if~~ If no medical injury is known and could not reasonably have been discovered prior to the minor's eleventh birthday, then the minor or his or her representative shall have until two (2) years after the medical injury is known or reasonably could have been discovered, or until the minor's nineteenth birthday, whichever is earlier, in which to commence an action.

(3) If an alleged medical injury occurred during childbirth, the minor or his or her representative shall have until the minor's fifth birthday to commence an action.

APPROVED: 2/20/25