TOC required

213.600 Certified Nurse-Midwife Services Benefit Limit 7-1-25

Beneficiaries age twenty-one (21) and older are limited to sixteen (16) visits per state fiscal year (July 1 through June 30) for services provided by a certified nurse-midwife, physician's services, rural health clinic services, medical services furnished by a dentist, office medical services by an optometrist, services provided by an advanced nurse practitioner, or a combination of the six.

For example: A beneficiary who has had two office medical visits to the dentist, one office medical visit to an optometrist and two visits to a physician has used five of the limited sixteen (16) visits per state fiscal year.

The following services are counted toward the sixteen (16) visits per state fiscal year limit established for the Certified Nurse-Midwife Program:

A. Certified nurse-midwife services

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

C. Rural health clinic (RHC) core services

D. Medical services provided by a dentist

E. Medical services furnished by an optometrist

F. Advanced nurse practitioner services

Office visits coded with obstetrical visit procedure codes are not counted toward the visit limit. All other office visits count toward the established sixteen (16) visit limit. Extensions of the benefit limit will be considered for services beyond the established benefit limit when documentation verifies medical necessity. Refer to Section 214.000 of this manual for procedures for obtaining extension of benefits.

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

240.100 Procedure for Obtaining Prior Authorization 7-1-25

A. Certain medical and surgical procedures are not covered without prior authorization due to federal requirements, or because of the elective nature of the surgery. **View or print the procedure codes for Certified Nurse Midwife (CNM) services for a listing of codes and requirements.**

B. DHS or its designated vendor issues prior authorizations for restricted medical and surgical procedures covered by the Arkansas Medicaid Program. **View or print contact information** to obtain the DHS or designated vendor step-by-step process for requesting prior authorizations.

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

   2. Payment for prior-authorized services is in accordance with federal regulations.

C. Prior authorization of services does not guarantee eligibility for a beneficiary. Payment is subject to verification that the beneficiary is Medicaid-eligible at the time services are provided.

D. It is the responsibility of the certified nurse-midwife who will perform the procedure to initiate the prior authorization request. An electronic portal and training are available to submit requests to DHS or its designated vendor. **View or print contact information to obtain the DHS or designated vendor step-by-step process for requesting prior authorization.**

E. The provider must supply the identifying criteria for the beneficiary and provider and all medical data necessary to justify the procedures.

F. Consulting physicians or practitioners are responsible for having DHS or its designated vendor add their required or restricted procedures to the PA file. They will be given the prior authorization number at the time of contact on cases that are approved.

240.110 Post-Procedural Authorization Process 7-1-25

When a provider is unable to submit a request for required authorization prior to providing a service, a post-procedural authorization process must be followed to obtain an authorization number:

A. All requests for post-procedural authorizations for eligible beneficiaries are to be made to DHS or its designated vendor. **View or print contact information to obtain the DHS or designated vendor step-by-step process for requesting prior authorization**.

B. Out-of-state providers and others without electronic capability may call DHS or its designated vendor to obtain the dates of eligibility. **View or print contact information to obtain dates of eligibility.**

C. The provider must supply the identifying criteria for the beneficiary and provider and all medical data necessary to justify the procedures.

D. Consulting physicians or practitioners are responsible for having DHS or its designated vendor add their required or restricted procedures to the PA file. They will be given the prior authorization number at the time of contact on cases that are approved.

240.120 Post-Procedural Authorization Process for Beneficiaries who are Under Age 21 7-1-25

Providers performing surgical procedures that require prior authorization for beneficiaries under age twenty-one (21) are allowed sixty (60) days from the date of service to obtain a prior authorization number.

240.130 Post-Procedural Authorization for Beneficiaries Aged 21 and Older 7-1-25

For beneficiaries aged twenty-one (21) and older, post-procedural authorization will be granted only for emergency procedures and in cases of retroactive eligibility. Requests for post-authorization of an emergency procedure must be submitted on the first business day after the procedure is performed.

In cases of retroactive eligibility, the provider must submit the request for post-authorization within sixty (60) days of the eligibility authorization date displayed in the electronic eligibility verification response.

240.200 Prescription Prior Authorization 7-1-25

Prescription drugs are available for reimbursement under the Arkansas Medicaid Program when prescribed by a certified nurse midwife with prescriptive authority. Certain prescription drugs may require prior authorization. It is the responsibility of the prescriber to request and obtain the prior authorization. Information may be obtained from DHS or its designated vendor. **View or print contact information for DHS or designated prescription drug vendor**.

The following information is available through DHS or the designated prescription drug vendor:

A. Prescription drugs requiring prior authorization.

B. Criteria for drugs requiring prior authorization.

C. Forms to be competed for prior authorization.

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

272.470 Newborn Care 7-1-25

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

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

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

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

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

For newborn resuscitation, **use the appropriate procedure code as listed within the linked table**.

ARKids A and ARKids B beneficiary services require a CMS 1500 claim form and may be filed electronically or on paper. Please note the processing time for paper claims is extended for manual processing.

For ARKids B-beneficiaries, newborn screening codes must be billed electronically or on the paper CMS-1500 claim form. For information, call the Provider Assistance Center. **View or print the Provider Assistance Center contact information**.

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

272.490 Obstetrical Care 7-1-25

Providers should bill for prenatal, delivery, and postpartum services 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.

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.

TOC not required

220.000 Benefit Limits 7-1-25

A. Arkansas Medicaid clients aged twenty-one (21) and older are limited to sixteen (16) FQHC core service encounters per state fiscal year (SFY, July 1 through June 30).

The following services are counted toward the sixteen (16) encounters per SFY benefit limit:

1. Federally Qualified Health Center (FQHC) encounters;
2. Physician visits in the office, patient's home, or nursing facility;
3. Certified nurse-midwife visits;
4. RHC encounters;
5. Medical services provided by a dentist;
6. Medical services provided by an optometrist; and
7. Advanced practice registered nurse services in the office, patient's home, or nursing facility.

B. The following services are not counted toward the sixteen (16) encounters per SFY benefit limit:

1. FQHC inpatient hospital visits do not count against the FQHC encounter benefit limit. Medicaid covers only one (1) FQHC inpatient hospital visit per Medicaid-covered inpatient day, for clients of all ages.
2. Obstetric and gynecologic procedures reported by CPT surgical procedure code do not count against the FQHC encounter benefit limit.
3. Postpartum visits are to be billed as an encounter, with an appropriate postpartum diagnosis code. These will not count against the FQHC encounter benefit limit.
4. Family planning surgeries and encounters do not count against the FQHC encounter benefit limit.
5. Medication Assisted Treatment for Opioid Use Disorder does not count against the FQHC encounter limit when it is the primary diagnosis (**View ICD OUD Codes**).

C. Medicaid clients under the age of twenty-one (21) in the Child Health Services (EPSDT) Program are not subject to an FQHC encounter benefit limit.

TOC not required

214.210 Advanced Practice Registered Nurse (APRN) Services Benefit Limits 7-1-25

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

The following services are counted toward the Service Benefit Limits established for the state fiscal year:

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

The established benefit limit does not apply to clients under age twenty-one (21).

Office visits coded with obstetrical visit procedure codes are not counted toward the visit limit. All other office visits count toward the established sixteen (16) visit limit.

Extensions of the benefit limit will be considered for services beyond the established benefit limit when documentation verifies medical necessity. Refer to Section 214.900 of this manual for procedures for obtaining extension of benefits.

TOC required

247.000 Obstetrical Services 7-1-25

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

292.670 Obstetrical Care 7-1-25

Medicaid reimburses obstetrical care on a fee-for-service basis.

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

Providers may bill Medicaid for the delivery and postpartum care with the applicable procedure codes from the following table:

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

Non-emergency hysterectomy after C-section requires prior authorization from DHS or its designated vendor. **View or print contact information to obtain the DHS or designated vendor step-by-step process for prior authorization requests.** Refer to Section 292.580 for billing instructions for emergency and non-emergency hysterectomy after C-section.

Providers must ensure that the services are billed within the 365-day filing deadline.

Laboratory and X-ray services may be billed separately using the appropriate CPT codes. If lab tests or X-rays are pregnancy related, the referring physician must code correctly when these services are sent to the lab or X-ray facility. The diagnostic facilities are dependent on the referring physician for pregnancy related diagnosis information necessary for Medicaid reimbursement.

The obstetrical laboratory profile procedure code consists of four components: Complete Blood Count, VDRL, Rubella, and blood typing and RH. If the ASO titer is performed, the test must be billed separately using the individual code.

If a blood specimen is sent to an outside laboratory, only one collection fee may be billed. No additional fees shall be billed for other types of specimens that are sent for testing to an outside laboratory. The outside laboratory may then bill Medicaid for the laboratory procedure. Refer to Section 292.600 of this manual.

NOTE: Payment will not be made for emergency room physician charges on an OB patient admitted directly from the emergency room into the hospital for delivery.

292.674 External Fetal Monitoring 7-1-25

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.

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

292.675 Risk Management for Pregnancy 7-1-25

A physician may provide risk management services for pregnant women if he or she employs the professional staff indicated in service descriptions found in Section 247.200 of this manual. These services may be billed separately from obstetrical fees. The services in the list below are considered to be one service and are limited to 32 cumulative units. Use the modifiers when filing claims to identify the service provided.

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

For early discharge home visits, use one of the applicable CPT procedure codes.

TOC required

218.100 RHC Encounter Benefit Limits 7-1-25

A. Medicaid clients under the age of twenty-one (21) in the Child Health Services (EPSDT) Program do not have a rural health clinic RHC encounter benefit limit.

B. A benefit limit of sixteen (16) encounters per state fiscal year (SFY), July 1 through June 30, has been established for clients twenty-one (21) years or older. The following services are counted toward the benefit limit:

1. Provider visits in the office, client's home, or nursing facility;
2. Certified nurse-midwife visits;
3. RHC encounters;
4. Medical services provided by a dentist;
5. Medical services provided by an optometrist;
6. Advanced practice registered nurse (APRN) services in the office, client's home, or nursing facility; and
7. Federally qualified health center (FQHC) encounters.

Office visits coded with obstetrical visit procedure codes are not counted toward the visit limit. All other office visits count toward the established sixteen (16) visit limit.

The established benefit limit does not apply to individuals receiving Medication Assisted Treatment for Opioid Use Disorder when it is the primary diagnosis (**View ICD OUD Codes**).

Extensions of the benefit limit will be considered for services beyond the established benefit limit when documentation verifies medical necessity. Refer to Section 218.310 of this manual for procedures for obtaining extension of benefits.

5. **Physician Services (Continued)**

F. For dates of service beginning January 1, 2021, the maximum reimbursement rate for evaluation and management codes are increased by 3 percent of the 7/1/2020 fee-for-service rate for each of these codes. Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of evaluation and management services. The agency's fee schedule rate was set as of January 1, 2021, and is effective for services provided on or after that date. All rates are published on the agency's website.

G. For dates of service beginning July 1, 2025, the reimbursement rates for obstetrical care to include prenatal care, delivery, and postpartum care are increased by seventy percent. The increase is based on an analysis of private pay rates from state fiscal years 2023 and 2024, Arkansas Blue Cross Blue Shield and Centene. Except as otherwise noted in the plan, state developed fee schedule rates are the same for both governmental and private providers. All rates are published on the agency's website.

Effective for dates of service on or after July 1, 2020, the immunization administration fee for influenza will be based on the 2020 Medicare flu vaccine administration fee. All other immunization administration fees will be based on Medicare's 2020 physician fee schedule for the State of Arkansas. The rate is paid to all governmental and non-governmental providers, unless otherwise specified in the state plan. All rates are published at the agency's website.

FINANCIAL IMPACT STATEMENT

PLEASE ANSWER ALL QUESTIONS COMPLETELY.

DEPARTMENT Department of Human Services
BOARD/COMMISSION
PERSON COMPLETING THIS STATEMENT Jason Callan
TELEPHONE NO. (501) 320-6540 **EMAIL** Jason.Callan@dhs.arkansas.gov

To comply with Ark. Code Ann. § 25-15-204(e), please complete the Financial Impact Statement and email it with the questionnaire, summary, markup and clean copy of the rule, and other documents. Please attach additional pages, if necessary.

TITLE OF THIS RULE Obstetrical Professional Services Rate Increase and Unbundling

1. Does this proposed, amended, or repealed rule have a financial impact?
   Yes [✔] No [ ]

2. Is the rule based on the best reasonably obtainable scientific, technical, economic, or other evidence and information available concerning the need for, consequences of, and alternatives to the rule?
   Yes [✔] No [ ]

3. In consideration of the alternatives to this rule, was this rule determined by the agency to be the least costly rule considered? Yes [✔] No [ ]

   If no, please explain:

   (a) how the additional benefits of the more costly rule justify its additional cost;

   (b) the reason for adoption of the more costly rule;

   (c) whether the reason for adoption of the more costly rule is based on the interests of public health, safety, or welfare, and if so, how; and

   (d) whether the reason for adoption of the more costly rule is within the scope of the agency's statutory authority, and if so, how.

4. If the purpose of this rule is to implement a *federal* rule or regulation, please state the following:

   (a) What is the cost to implement the federal rule or regulation?

Current Fiscal Year		**Next Fiscal Year**	
General Revenue	$	General Revenue	$
Federal Funds	$	Federal Funds	$
Cash Funds		Cash Funds	
Special Revenue		Special Revenue	
Other (Identify)		Other (Identify)	
Total		Total	

(b) What is the additional cost of the state rule?

Current Fiscal Year		**Next Fiscal Year**	
General Revenue	$11,519,545	General Revenue	$11,702,093
Federal Funds	$26,511,307	Federal Funds	$26,328,759
Cash Funds		Cash Funds	
Special Revenue		Special Revenue	
Other (Identify)		Other (Identify)	
Total	$ 38,030,852.00	Total	$ 38,030,852.00

5. What is the total estimated cost by fiscal year to any private individual, private entity, or private business subject to the proposed, amended, or repealed rule? Please identify those subject to the rule, and explain how they are affected.

Current Fiscal Year $_____ **Next Fiscal Year** $_____

6. What is the total estimated cost by fiscal year to a state, county, or municipal government to implement this rule? Is this the cost of the program or grant? Please explain how the government is affected.

Current Fiscal Year $ 11,519,545.00 **Next Fiscal Year** $ 11,702,093.00

7. With respect to the agency's answers to Questions #5 and #6 above, is there a new or increased cost or obligation of at least one hundred thousand dollars ($100,000) per year to a private individual, private entity, private business, state government, county government, municipal government, or to two (2) or more of those entities combined?

Yes ☑ No ☐

If yes, the agency is required by Ark. Code Ann. § 25-15-204(e)(4) to file written findings at the time of filing the financial impact statement. The written findings shall be filed simultaneously with the financial impact statement and shall include, without limitation, the following:

(1) a statement of the rule's basis and purpose; The Department of Humans Services (DHS) seeks to revise the rate and claims process for prenatal, delivery, and postpartum professional services under Medicaid pursuant to Acts 124 and 140 of 2025, known widely as "Healthy Moms, Healthy Babies".

(2) the problem the agency seeks to address with the proposed rule, including a statement of whether a rule is required by statute; The goal of the rate and claims revision is to improve Medicaid reimbursement to ensure adequate access to care and to improve collection of utilization data for prenatal and postpartum services.

(3) a description of the factual evidence that:

(a) justifies the agency's need for the proposed rule; and
(b) describes how the benefits of the rule meet the relevant statutory objectives and justify the rule's costs; Increasing the professional fees for obstetrical services provided by qualified Medicaid practitioners and removing global billing bundles will allow improved access to a wider range of prenatal, delivery, and postpartum services across the state to ensure adequate access is available. This rule, combined with others resulting from Acts 124 and 140 of 2025 will support the overarching purpose of promoting Healthy Moms and Healthy Babies in Arkansas.

(4) a list of less costly alternatives to the proposed rule and the reasons why the alternatives do not adequately address the problem to be solved by the proposed rule; N/A

(5) a list of alternatives to the proposed rule that were suggested as a result of public comment and the reasons why the alternatives do not adequately address the problem to be solved by the proposed rule; N/A

(6) a statement of whether existing rules have created or contributed to the problem the agency seeks to address with the proposed rule and, if existing rules have created or contributed to the problem, an explanation of why amendment or repeal of the rule creating or contributing to the problem is not a sufficient response; N/A and

(7) an agency plan for review of the rule no less than every ten (10) years to determine whether, based upon the evidence, there remains a need for the rule including, without limitation, whether:

(a) the rule is achieving the statutory objectives;
(b) the benefits of the rule continue to justify its costs; and
(c) the rule can be amended or repealed to reduce costs while continuing to achieve the statutory objectives. The Agency monitors State and Federal rules and policies for opportunities to reduce and control costs.