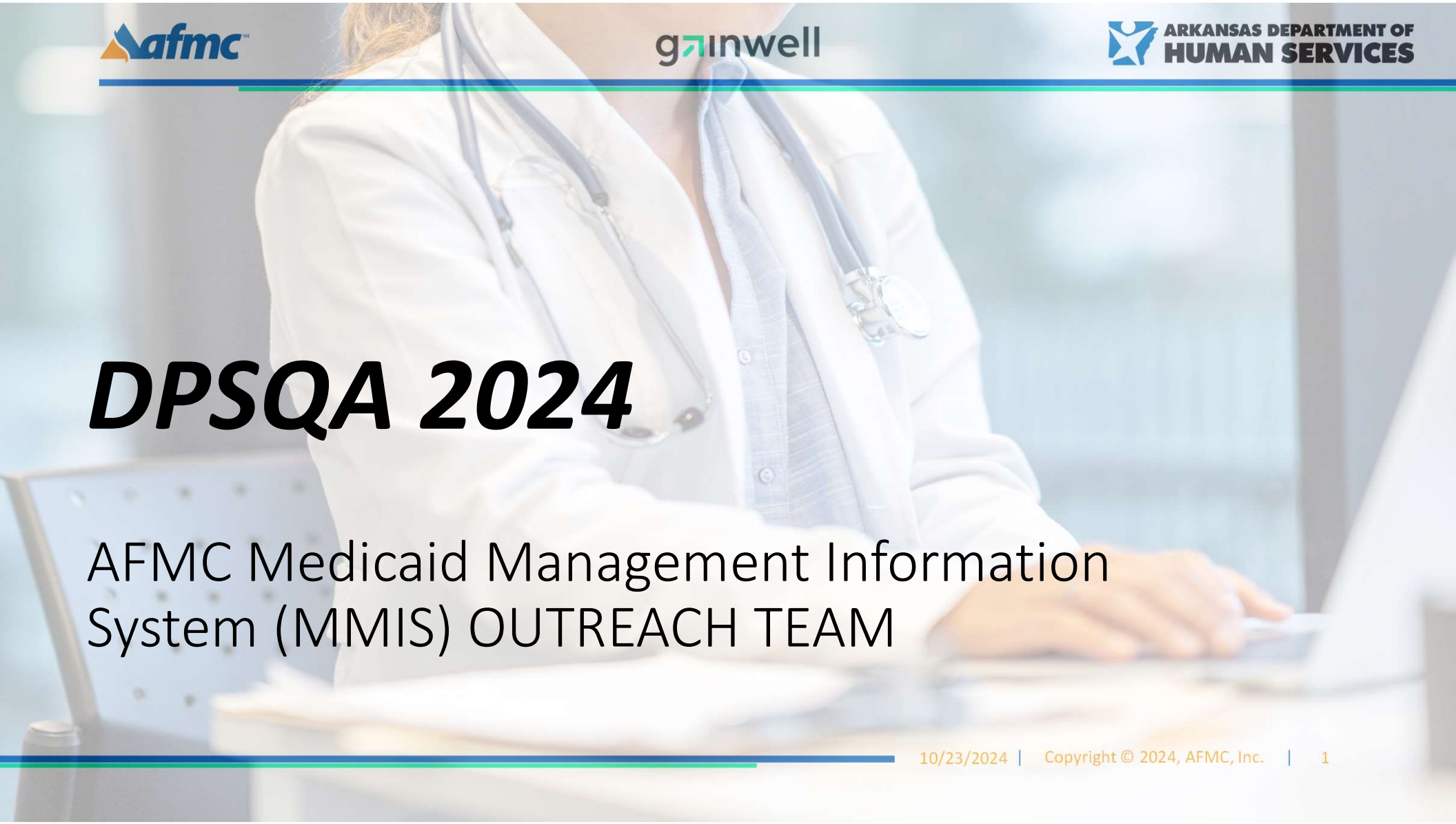


DPSQA 2024

AFMC Medicaid Management Information System (MMIS) OUTREACH TEAM

QR Code to Access Training Resources

Use your IOS, Android, or any device to access all our MMIS Tools and Resources for your convenience.

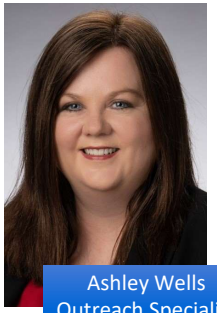
Becky Andrews
Manager, MMIS

Andrea Allen
Supervisor, MMIS

Tanasia Johnson-Kamal
Supervisor, MMIS

Karen Young
MMIS Training & Program Developer

Samantha DeSalvo
MMIS EPSDT & Program Specialist



Ashley Wells
Outreach Specialist Team Lead

Linda Counts
Outreach Specialist

Kristie Williams
Outreach Specialist

Mary Riley
Outreach Specialist

Rose Bruton
Outreach Specialist

Renee Smith
Outreach Specialist

Christy Owens
Outreach Specialist

Angie Riggan
Outreach Specialist

Echole Fuller
Sr. Administrative Specialist

Agenda

Revised DMS-600 Forms

PWK Segment Requirements for Vendors

Ordering, Referring, Rendering, and Prescribing (ORP)

Managed Care Eligibility Verification

Medicare Savings Programs

- SLMB
- QMB
- QI-1

MMIS Annual Billing Conference

Spring 2025

DMS-600 Form

DMS-600 Forms (CMS 1500 and UB-04)

CMS-1500 Medicare Header Amounts:

Refer to the Explanation of Medicare Benefit (EOMB) to find the total header amounts to enter in the table below.

Medicare Paid Amount:		Medicare Allowed Amount:	
Medicare Coinsurance Amount:		Medicare Deductible Amount:	
Medicare Non-Covered Charges:		Medicare Paid Date:	
Psychiatric Reduction Amount:		Medicare Copayment Amount:	
		Medicare Prorated Deductible:	

CMS-1500 Medicare Detail Amounts:

Refer to the Explanation of Medicare Benefit (EOMB) to find the detail amounts to enter below.

Detail Number	Medicare Paid Date	Medicare Allowed Amount	Medicare Paid Amount	Medicare Non-Covered Charges	Medicare Deductible Amount	Psychiatric Reduction Amount	Medicare Coinsurance Amount	Medicare Copayment Amount

Note: If there are more than 20 lines to report, copy this page.

CMS-1450 (UB04) Medicare Header Amounts:

Refer to the Explanation of Medicare Benefit (EOMB) to find the total header amounts to enter below.

Medicare Paid Amount:		Medicare Allowed Amount:	
Medicare Coinsurance Amount:		Medicare Deductible Amount:	
Medicare Non-Covered Charges:		Medicare Paid Date:	
Blood Deductible Amount:		Medicare Copayment Amount:	

CMS-1450 (UB04) Medicare Detail Amounts):

Refer to the Explanation of Medicare Benefit (EOMB) to find the detail amounts to enter in the table below.

Detail Number	Medicare Paid Date	Medicare Allowed Amount	Medicare Paid Amount	Medicare Non-Covered Charges	Medicare Deductible Amount	Blood Deductible Amount	Medicare Coinsurance Amount	Medicare Copayment Amount

Note: If there are more than 20 lines to report, copy this page.

Vendor PWK Segment Requirements

Starting April 2, 2024, for 837P and 837I Fee-For-Service Non-COBA Medicare Crossover claims, the PWK segment must be submitted at the header level.

PWK Segment Requirement RA Message

Companion Guides

PWK Segment Requirement Details

Starting April 2, 2024, for 837P and 837I Fee-For-Service Non-COBA Medicare Crossover claims, the PWK segment must be submitted at the header level.

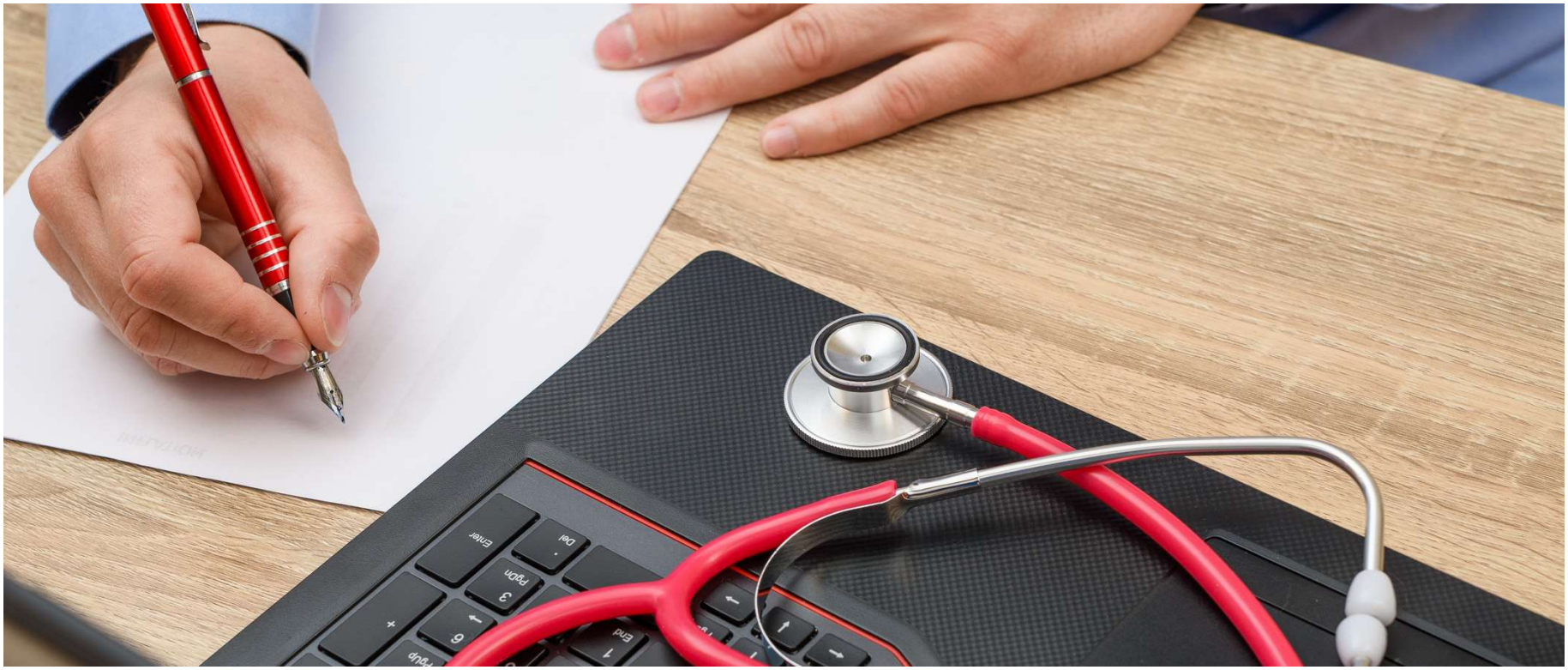
Failure to submit at the header will result in a claim denial.

The specific information required is:

- PWK01 (Attachment Report Type Code Value) =EB
- PWK02 (Attachment Transmission Code Value)=AA.

For additional information, refer to the 2300 Claim Information loop for the PWK segment in the updated Companion Guides.

Ordering, Referring, and Prescribing



Definition of Ordering, Referring, and Prescribing

Ordering — The Ordering Provider is the individual who requested the services or items being reported on this service line.

Referring — The Referring Provider is the primary care physician (PCP) of a client. Please note, the PCP can also be the person who orders a service for a client, but the ordering and referring do not have to be the same.

Prescribing — The Prescribing Provider is the individual who advised and authorized the use of a medicine or treatment for someone, especially in writing.

Managed Care Eligibility Verification

Two Ways to Verify Eligibility

HEALTHCARE PORTAL VIA THE WEB

VOICE RESPONSE SYSTEM (VRS)

Healthcare Portal Panels to View for QHP

Benefit Details

Members aged 19 or 20 with HCIP, ABP, FRAIL or IABP coverage have dental coverage. Members 21 and over with HCIP, ABP, FRAIL or IABP coverage DO NOT have dental coverage.

Coverage	Description	County	Effective Date	End Date
06-HCIP	Health Care Independence (ARHOME)	021 ASHLEY	09/05/2024	09/05/2024

Copayments	Amount	Elig Effective Date	Elig End Date
06-HCIP 30 (Health Benefit Plan Coverage)	$0.00	09/05/2024	09/05/2024

Limit Details

Managed Care Assignment Details

Plan	Effective Dates	Provider Name	Provider Phone
Non Emergency Transportation	01/01/2024-12/31/2024	VERIDA, INC.	1-501-954-8900
ARHOME Plan	01/01/2024-12/31/2024	QUALCHOICE LIFE AND HEALTH INSURA	1-877-617-0390
PCP NOT REQUIRED	09/05/2024-09/05/2024		

Managed Care Panel

The Managed Care Assignment Details Panel includes the following:

- The Primary Care Physician (PCP) of the beneficiary
- NET (Transportation) plan of the beneficiary
- PASSEs assigned to the beneficiary
- ARHome (if the beneficiary has HCIP)

Aid Category 06 |Qualified Healthcare Plan (QHP)

- **IABP (Interim Alternative Benefit Plan)**
  The recipient will have full-range Medicaid with no benefit limits for physician services, prescriptions, or lab and x-ray.
- **ABP (Alternative Benefit Plan)**
  Bypasses benefit limits for physician services, prescriptions, lab, and x-ray.
- **FRAIL (Full Medicaid for Medically Frail)**
  Abides by standard benefit limits for doctor visits, lab, and x-ray. Full-Range Medicaid
- **HCIP (Health Care Independence; Private Option)**
  Coverage has started with commercial healthcare provider (Ambetter, BCBS, QualChoice, etc), and all claims should be billed to that carrier

Sample of Qualified Heathcare Plan (QHP)

Managed Care Assignment Details

Plan	Effective Dates	Provider Name	Provider Phone
Non Emergency Transportation	01/01/2024-12/31/2024	VERIDA, INC.	1-501-954-8900
ARHOME Plan	01/01/2024-12/31/2024	QUALCHOICE LIFE AND HEALTH INSURA	1-877-617-0390
PCP NOT REQUIRED	09/05/2024-09/05/2024		

Medicare Savings Programs

Section 124.150-124.170 of the Provider Manuals

Medicare Savings Programs Descriptions

- ## Qualified Medicare Beneficiary (QMB)
  - For QMB beneficiaries, Medicaid pays Medicare premiums, coinsurance, and deductible.
  - **Medicaid will not pay secondary to Medicare or primary if Medicare denies the services**.

- ## Specified Low Income Medicare Beneficiary (SLMB)
  - For SLMB beneficiaries, Medicaid pays Medicare premiums, coinsurance, and deductible.
  - **Medicaid only pays for these members to have Medicare. Medicaid will not pay secondary to Medicare or primary if Medicare denies the services**.

- ## QI-1-Qualfying Individual One
  - For QI-1 is a Medicare Savings Program that helps people pay their Medicare Part B premiums.
  - **Medicaid only pays for these members to have Medicare. Medicaid will not pay secondary to Medicare or primary if Medicare denies the services**.

AFMC MMIS Annual Billing Conference 2025

- Benton Event Center
- Benton, Arkansas
- Date to be announced soon!

Medicaid Contacts

- Division of Medical Services (DMS)
  https://humanservices.arkansas.gov/offices
- County offices (DCO)
  https://humanservices.arkansas.gov/find-a-county-office/
- AFMC
  afmc.org
  - MMIS outreach specialists — 501-906-7566, afmc.org/mmis
  - ConnectCare — 1-800-275-1131, seeyourdoc.org
  - Provider relations outreach specialists— afmc.org/providerrelations
  - AFMC Clinical Services — 479-649-8501, clinicalservices@afmc.org
- Office of Medicaid Inspector General (OMIG) — 1-855-527-6644
- Prime Therapeutics pharmacy help desk — 1-800-424-7895, Option 2 for prescribers
- Gainwell Technologies — 1-800-457-4454
- PASSE-DHS PASSE provider call center — 1-888-889-6451
- Acentra (formerly Kepro) — ar.acentra.com
  - arkansaspr@acentra.com or 1-888-660-3831


Questions?