

Arkansas Department of Human Services (AR DHS)
Billing and MMIS

October 23, 2025



Billing and MMIS Overview

- Overview of Billing
 - Provider Manual
 - HCPCS Procedure Codes
 - Fee Schedule
 - Prior Authorizations
 - Electronic Visit Verification
- Medicaid Management Information System MMIS
 - Enrollment
 - Revalidation
 - Updating Provider Information
 - Ability to Enter Rendering Provider using portal billing



Billing Overview Provider Manual

- Start with the Provider Manual: <https://humanservices.arkansas.gov/divisions-shared-services/medical-services/helpful-information-for-providers/manuals/>

Provider Manuals And Other Provider Notifications

Drop Down



Click a link below to access the manual, transmittal letters, notices of rule making, official notices, and RA messages for the given provider type. Check each provider type that applies to you and all providers for information that impacts every provider type.

Important Notice: The [DMS COVID-19 Provider Manual](#) contains information about suspension of programs during the COVID-19 Public Health Emergency (PHE) and other COVID-19-related information. See also the [DHS COVID-19 Page for Providers](#).

Provider Types

- [All Providers](#)
- [Adult Development Day Treatment \(ADDT\)](#)
- [Ambulatory Surgical Center \(ASC\)](#)
- [Applied Behavior Analysis \(ABA\) Therapy](#)
- [ARChoices in Home Care Home and Community-Based 2176 Waiver](#)
- [Area Health Education Center \(AHEC\)](#)
- [Arkansas Department of Health \(ADH\)](#)
- [Arkansas Independent Assessment \(ARIA\)](#)

Billing Overview

Provider Manual Sections

Personal Care

Drop Down



The following documents are available for this provider type. See also [All Providers](#).

Provider Manual

- Section I – General Medicaid Policy
 - [Section I](#)
 - [Section I Update Log](#)
 - [Other Policy-Related Notifications for All Provider Types](#)
- Section II – Program Policy
 - [Section II](#)
 - [Section II Update Log](#)
 - [Other Policy-Related Notifications for this Provider Type](#)
- Section III – Billing Information
 - [Section III](#)
 - [Section III Update Log](#)
- Section IV – Glossary
 - [Section IV](#)
 - [Section IV Update Log](#)
- Section V – Forms and Contacts
 - [Section V](#)
 - [Section V Update Log](#)



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Billing Overview

Provider Manual Section II

Personal Care

Section II

260.000

BILLING PROCEDURES

- 261.000 Introduction to Billing
- 261.100 Electronic Visit Verification (EVV)
- 262.000 CMS-1500 Billing Procedures
- 262.100 Personal Care Billing
 - 262.101 Personal Care for a Beneficiary Aged 21 or Older (Non-RCF)
 - 262.102 Personal Care for a Beneficiary Under 21 (Non-RCF)
 - 262.103 Personal Care in a Public School
 - 262.104 Personal Care in an RCF or ALF
 - 262.105 Employment-Related Personal Care Outside the Home
 - 262.106 Billing RCF and ALF Personal Care Services
 - 262.110 Coding Home and DDS Facility Places of Service
- 262.300 Calculating Individual Service Times for Services Delivered in a Congregate Setting
- 262.310 Unit Billing
 - 262.311 Calculating Units
 - 262.312 Rounding
- 262.400 Billing Instructions—Paper Only
- 262.410 Completing a CMS-1500 Claim Form for Personal Care

Billing Overview

Provider Manual Section III

SECTION III - BILLING DOCUMENTATION CONTENTS

300.000 GENERAL INFORMATION

- 301.000 Introduction
- 301.100 Electronic Claims Submission
- 301.105 Modifiers For Electronic Billing
- 301.110 Arkansas Provider Portal
- 301.130 Vendor Systems
- 301.200 Electronic Transactions
- 301.210 Eligibility Verification
- 301.220 Claim Status Inquiry
- 301.230 Remittance Advice Reports
- 301.240 Prior Authorization Request
- 301.300 Contacts
- 302.000 Timely Filing
- 302.100 Medicare/Medicaid Crossover Claims
- 302.200 Clean Claims and New Claims
- 302.300 Claims Paid or Denied Incorrectly
- 302.400 Claims With Retroactive Eligibility
- 302.410 Claims Involving Retroactive Eligibility
- 302.500 Submitting Adjustments and Resubmitting Claims
- 302.510 Adjustments
- 302.520 Claims Denied Incorrectly
- 302.600 ClaimXten® Enhancement
- 303.000 Claim Inquiries
- 303.100 Claim Inquiry Form
- 303.200 Completion of the Claim Inquiry Form
- 304.000 Supply Procedures
- 304.100 Ordering Forms from the Arkansas Medicaid Fiscal Agent
- 305.000 Telemedicine Billing Guidelines

310.000 REMITTANCE ADVICE REPORTS

- 311.000 Introduction of Remittance Advice Reports
- 311.100 Electronic Funds Transfer (EFT)
- 312.000 Purpose of Remittance Advice Reports
- 313.000 Remittance Advice Reports



Billing Overview

Procedure Codes

262.000 CMS-1500 Billing Procedures

262.100 Personal Care Billing 3-1-08

- A. Providers must use applicable HCPCS procedure codes and modifiers listed in the following section.
- B. All billing by any media requires the correct national standard place of service code.

262.101 Personal Care for a Beneficiary Aged 21 or Older (Non-RCF) 1-1-19

Procedure Code	Modifier	Service Description
T1019	U3	Personal Care for a non-RCF Beneficiary Aged 21 or Older, per 15 minutes (requires prior authorization)

262.102 Personal Care for a Beneficiary Under 21 (Non-RCF) 3-1-08

Section II-49

Billing Overview

Procedure Code Linking Table



ADULT DEVELOPMENTAL DAY TREATMENT (ADDT)

Procedure Code Table & Fee Schedule | Division of Developmental Disabilities Services (DDS)

Provider Contract ADDT | Table Version 12/15/2021 | Fee Schedule Run Date 9/15/2021

PROCEDURE CODE TABLE LEGAL DISCLAIMER | FEE SCHEDULE LEGAL DISCLAIMER



[For Provider Resources, Click Here >>>](#)

Procedure Code, Description & Modifiers						Fee Schedule Information	Procedure Code Information & Billing Requirements							
Procedure Code	State Descr Flag	Procedure Code Description	M1	M2	M3	Fee Schedule Rate	Max Units Per Day	Benefit Limits	PA, Age, Diag and POS Requirements	Age Limits	Diag Required	Place of Service Codes (POS)	Links & Information	Type of Therapy or Services
92507		SPEECH/HEARING THERAPY	UB			\$23.20		1 unit equals 15 minutes; maximum of 6 units per week	Refer to 220.000	18+ Years Old	Refer to 212.300	02, 49	Individual Speech-Language Therapy by Speech-Language Language Pathology Assistant	Speech-Language Therapy Procedure Codes
92507		SPEECH/HEARING THERAPY				\$29.02		1 unit equals 15 minutes; maximum of 6 units per week	Refer to 220.000	18+ Years Old	Refer to 212.300	02, 49	Individual Speech-Language Session by Speech-Language Therapist	Speech-Language Therapy Procedure Codes



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Billing Overview

Procedure Code Linking Table

 ADULT DEVELOPMENTAL DAY TREATMENT Procedure Code Table & Fee Schedule Division of Developmental Disabilities Provider Contract ADDT Table Version 12/15/2021 Fee Schedule Run Date: 12/15/2021 PROCEDURE CODE TABLE LEGAL DISCLAIMER FEE SCHEDULE LEGAL DISCLAIMER									
Procedure Code, Description & Modifiers						Fee Schedule Information			
Procedure Code	State Descr Flag	Procedure Code Description	M1	M2	M3	Fee Schedule Rate	Max Units Per Day	Benefit Limits	PA, A, R
92507		SPEECH/HEARING THERAPY	UB			\$23.20		1 unit equals 15 minutes; maximum of 6 units per week	Rel
92507		SPEECH/HEARING THERAPY				\$29.02		1 unit equals 15 minutes; maximum of 6 units per week	Re

Billing Overview

Procedure Code Linking Table

MENT (ADDT) al Disabilities Services (DDS) Run Date 9/15/2021 LE LEGAL DISCLAIMER 					
For Provider Resources, Click Here >>>					
Procedure Code Information & Billing Requirements					
PA, Age, Diag and POS Requirements	Age Limits	Diag Required	Place of Service Codes (POS)	Links & Information	Type of Therapy or Services
Refer to 220.000	18+ Years Old	Refer to 212.300	02, 49	Individual Speech-Language Therapy by Speech-Language Language Pathology Assistant	Speech-Language Therapy Procedure Codes
Refer to 220.000	18+ Years Old	Refer to 212.300	02, 49	Individual Speech-Language Session by Speech-Language Therapist	Speech-Language Therapy Procedure Codes



Billing Overview

HCPCS Codes- Example

262.210 Place of Service Codes

10-1-22

The national place of service (POS) code is used for both electronic and paper billing.

Place of Service	POS Codes
Inpatient Hospital	21
Participant's Home	12
Day Care Facility	99
Nursing Facility	32
Provider's Office	11
Other Locations	99



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Billing

Billing Overview

Fee Schedule

- Fee Schedule is located: <https://humanservices.arkansas.gov/wp-content/uploads/ARCHOICES-fees.pdf>

Procedure Code	Mod 1	Mod 2	Mod 3	Mod 4	Medicaid Maximum Allowed Amount
Q3014					\$2.54
S5100					\$2.47
S5100	U1				\$2.47
S5100	TD				\$3.14
S5100	TD	U1			\$3.14
S5125	U2				\$5.12
S5135					\$1.68
S5150					\$5.12
S5160					\$29.90
S5161	UA				\$32.62
S5165					\$7,500.00
S5170	U1				\$5.97
S5170	U2				\$5.97
S5170					\$5.97
T1005					\$0.56
T2015					\$6.40
T2015	U3				\$6.40

Billing Overview

Prior Authorization

240.000

PRIOR AUTHORIZATION

10-1-22

Attendant care, personal care and prevocational services provided under an authorized PCSP require prior authorization. Other services provided under the ARChoices Waiver program under an authorized PCSP do not require prior authorization. The PCSP signed by the DHS PCSP/CC Nurse serves as the authorization for ARChoices waiver services and Personal Care services.



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Billing

Act 853

95th General Assembly of 2025

As of August 5, 2025, Personal Care, Attendant Care, and Respite Care Providers were no longer required to obtain a certification from the Arkansas Department of Human Services (DHS), Division of Provider Services and Quality Assurance (DPSQA). Act 853 revises Arkansas Code § 20-10-2301(b), by only requiring providers to obtain a private care agency license from the Arkansas Department of Health (ADH).



Electronic Visit Verification

Billing



The screenshot displays the official website of the Arkansas Department of Human Services. The header includes navigation links such as "The Official Website of the State of Arkansas", "State Directory", "All State Agencies", "Elected Officials", "Arkansas Code", "State Employees", "Help Center", and "Accessibility & Settings". Below the header, a secondary navigation bar lists "DIVISIONS & SHARED SERVICES", "NEWS", "DATA & REPORTS", "CAREERS", "FIND A COUNTY OFFICE", "FILE AN APPEAL", and "CONTACT US". The main content area features a large banner with the title "Electronic Visit Verification (EVV) Information" and a background image of an elderly man and a young child. The Arkansas Department of Human Services logo is visible in the top left corner of the banner. Below the banner, a sidebar on the left lists "Divisions & Shared Services" and "Division of Medical Services". The main content area below the banner shows a breadcrumb trail: "Home > Divisions & Shared Services > Division of Medical Services > Electronic Visit Verification (EVV) Information".

<https://humanservices.arkansas.gov/divisions-shared-services/medical-services/ewv-info/>

Electronic Visit Verification

Home Health Billing

Electronic Visit Verification (EVV) Home Health–Rendering Provider Requirements

- The services listed below require the rendering provider to be submitted, and indicate the provider type/specialty that the rendering provider must be enrolled as:

Procedure/Modifier Description	Provider Type/Specialty
T1021/TD Home Health RN Visit, Per Visit	95/NT
T1021/TE Home Health LPN Visit, Per Visit	95/NT
T1021/(no Mod) Home Health Aide Visit, Per Visit	95/NT
S9131/UB Home Health Physical Therapy by a Qualified Physical Therapy Assistant	21/TP or 95/NT
S9131/(no Mod) Home Health Physical Therapy by a Qualified Physical Therapist	21/T1 or 95/NT



Electronic Visit Verification

Home Health Billing

EVV Home Health – Rendering Provider Requirements

In accordance with EVV program requirements, Home Health providers must include specific information with each claim or encounter for services subject to EVV. Specifically, the **Performing Provider ID** field must be completed using either the **NPI** or **PIN** of the individual rendering the service, depending on provider type.

Regardless of provider type, this field must always reflect the credentials (NPI or PIN) of the person who delivered the service.

AR Medicaid

Home Eligibility Claims Care Management Provider Functions Files Exchange Resources

PCP Information | Provider LTC Census | Search Update Requests | Submit an Update Request | Life 360 Hospital Information

Claims > Submit Claim Init

Provider Name: AAA PROJECT TEST AGENCY Role ID: Provider - In Network - 1770933798 (NPI)

Submit Institutional Claim: Step 1

The * (in red) indicates required fields. (Note: When the Add/Save button is present, all fields with * are only required when selecting Add/Save for that section.)

Claim Type: Home Health

Provider Information

If Surgical Procedure Code(s) are to be submitted with the claim, an Operating Provider ID is required.

Billing Provider ID: 1770933798 ID Type: NPI Name: AAA PROJECT TEST AGENCY

Taxonomy: HOME HEALTH

Select from Favorites: [Search] ID Type: [Dropdown] Name: [Text] Add to Favorites: [Button]

Performing Provider ID: [Search] ID Type: [Dropdown] Name: [Text] Add to Favorites: [Button]

Taxonomy: [Dropdown]

Select from Favorites: [Search] ID Type: [Dropdown] Name: [Text] Add to Favorites: [Button]

Institutional Provider ID: [Search] ID Type: [Dropdown] Name: [Text] Add to Favorites: [Button]

Taxonomy: [Dropdown]

Select from Favorites: [Search] ID Type: [Dropdown] Name: [Text] Add to Favorites: [Button]

Attending Provider ID: [Search] ID Type: [Dropdown] Name: [Text] Add to Favorites: [Button]

Service Details

Select the row number to edit the row. Click the Remove link to remove the entire row.

Instructions:

If values are required for submission, please fill in the required fields. Otherwise you may leave the field blank and proceed. These fields are required when the ADD button is selected.

Svc #	Revenue Code	HCPCS/Proc Code	From Date	To Date	Units	Charge Amount	Action
1						\$0.00	

1 *Revenue Code: [Text] HCPCS/Proc Code: [Text]

Modifiers: [Text]

*From Date: [Text] To Date: [Text] *Units: [Text] Unit Type: [Dropdown]

*Charge Amount: [Text]

*Performing Provider ID: [Search] ID Type: [Dropdown] Taxonomy: [Dropdown] State License #: [Text]

NDICs for Svc. # 1

Add Reset

Attachments

Click the Remove link to remove the entire row.

#	Transmission Method	File	Control #	Attachment Type	Action
Click to add attachment.					

Back to Step 1 Back to Step 2 Submit Finish Later Cancel



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Billing-EVV

Electronic Visit Verification

Home Health Billing

EVV Home Health – Rendering Provider Requirements

- **PIN** to be used by provider types **95/NT**
- **NPI** to be used by provider type **21/TP** and **21/T1**

Error
The Performing Provider must be the NPI when the provider is a Healthcare Provider.

Service Details

Select the row number to edit the row. Click the **Remove** link to remove the entire row.

Instructions:
If values are required for submission, please fill in the required fields. Otherwise you may leave the field blank and proceed. These fields are required when the ADD button is selected.

Svc #	Revenue Code	HCPCS/Proc Code	From Date	To Date	Units	Charge Amount	Action
1						\$0.00	

1 *Revenue Code 421-PHYS THERP/VISIT HCPCS/Proc Code S9131-PT IN THE HOME PER DIEM

Modifiers

*From Date 10/02/2025 To Date 10/02/2025 *Units 1.00 *Unit Type Unit

*Charge Amount 150.00

Performing Provider ID 21 ID Type Atypical/Medicaid ID Taxonomy PHYSICAL THERAPIST State License #

The Performing Provider must be the NPI when the provider is a Healthcare Provider.



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Billing-EVV

Arkansas Medicaid Management Information System MMIS

Application Information and New Electronic Submission Requirements

Initial provider enrollment applications (except Long Term Care Facilities) [must be submitted electronically through the provider portal.](#)

<https://humanservices.arkansas.gov/divisions-shared-services/medical-services/provider-enrollment/>



MMIS

MMIS

Revalidation

- Revalidation is required every five years for all provider types except Provider Type 95, which is exempt.
 - The Arkansas Medicaid Provider Portal automatically generates notification letters to advise providers the date their enrollment will expire.
 - Providers are strongly encouraged to submit revalidation **at least 60 days prior to this revalidation due date** to avoid disruption.
 - All required documentation must be submitted *before* the expiration date.



MMIS

Updating Information in MMIS

- Each provider must notify the Medicaid Provider Enrollment Unit in writing immediately regarding any changes to its application or contract, such as:
 - Change of address (**View or print form DMS-673 – Address Change Form.**)
 - Change in members of group, professional association or affiliations
 - Change in practice or specialty



MMIS

Updating Information in MMIS

- Continued:
 - Change in Federal Employer Identification Number (FEIN)
 - Retirement or death of provider
 - Complete change of ownership (**View or print form DMS-0688 – Provider Change of Ownership Information Form.**)
 - Change in Ownership Control (5% or more) or Conviction of Crime (**View or print form DMS-675 – Ownership and Conviction Disclosure.**)
 - Disclosure of Significant Business Transactions (**View or print form DMS-689 – Disclosure of Significant Business Transactions.**)

Billing and MMIS

Summary

- Billing
 - Sections II and III
 - Procedure Codes
 - Procedure Code Linking Table
 - Electronic Visit Verification
- MMIS
 - Enrollment
 - Revalidation
 - Updating Provider Information

