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| 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.**

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| 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.](https://humanservices.arkansas.gov/wp-content/uploads/CNM_ProcCodes.xlsx)

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](https://humanservices.arkansas.gov/wp-content/uploads/AFMC.doc) 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.](https://humanservices.arkansas.gov/wp-content/uploads/AFMC.doc)

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.

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| 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](https://humanservices.arkansas.gov/wp-content/uploads/AFMC.doc).

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.](https://humanservices.arkansas.gov/wp-content/uploads/PAC.doc)

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.

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| 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.

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| 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.

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| 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](https://humanservices.arkansas.gov/wp-content/uploads/Pharmacy.doc).

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.

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| 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.](https://humanservices.arkansas.gov/wp-content/uploads/CNM_ProcCodes.xlsx)

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](https://humanservices.arkansas.gov/wp-content/uploads/CNM_ProcCodes.xlsx).

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](https://humanservices.arkansas.gov/wp-content/uploads/PAC.doc).

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

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| 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](https://humanservices.arkansas.gov/wp-content/uploads/CNM_ProcCodes.xlsx).

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](https://humanservices.arkansas.gov/wp-content/uploads/CNM_ProcCodes.xlsx)  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.