QUESTIONNAIRE FOR FILING PROPOSED RULES AND REGULATIONS WITH THE ARKANSAS LEGISLATIVE COUNCIL AND JOINT INTERIM COMMITTEE

DEPARTMENT/AGENCY Department of Human Services
DIVISION Division of Medical Services
DIVISION DIRECTOR Andrew Allison, PhD
CONTACT PERSON Brett Hays
ADDRESS P.O Box 1437, Slot S295, Little Rock, AR 72203
PHONE NO. 682-8859 **FAX NO.** 682-2480 **E-MAIL** brett.hays@arkansas.gov
NAME OF PRESENTER AT COMMITTEE MEETING Marilyn Strickland
PRESENTER E-MAIL marilyn.strickland@arkansas.gov

INSTRUCTIONS

A. Please make copies of this form for future use.
B. Please answer each question completely using layman terms. You may use additional sheets, if necessary.
C. If you have a method of indexing your rules, please give the proposed citation after "Short Title of this Rule" below.
D. Submit two (2) copies of this questionnaire and financial impact statement attached to the front of two (2) copies of the proposed rule and required documents. Mail or deliver to:

Donna K. Davis
Administrative Rules Review Section
Arkansas Legislative Council
Bureau of Legislative Research
Room 315, State Capitol
Little Rock, AR 72201

****

1. What is the short title of this rule?

   Prosthetics 1-12 & Section V 1-12

2. What is the subject of the proposed rule?

   Section V and Section 212.600 of the Prosthetics manual is updated to indicate that Form DMS-648 has been renamed to Upper-Limb Prosthetic Evaluation and Form DMS-650 has been renamed to Lower-Limb Prosthetic Evaluation. They have also been updated to indicate that Form DMS-646 (Evaluation Form Lower Limb) has been discontinued and providers should use Form DMS-650 instead.

3. Is this rule required to comply with a federal statute, rule, or regulation? Yes ___ No _X_.
   If yes, please provide the federal rule, regulation, and/or statute citation.

4. Was this rule filed under the emergency provisions of the Administrative Procedure Act? Yes___ No _X_.

   If yes, what is the effective date of the emergency rule?

   When does the emergency rule expire?

   Will this emergency rule be promulgated under the permanent provisions of the Administrative Procedure Act? Yes____ No _____

5. Is this a new rule? Yes___ No __X__ If yes, please provide a brief summary explaining the regulation.

   Does this repeal an existing rule? Yes____ No__X__ If yes, a copy of the repealed rule is to be included with your completed questionnaire. If it is being replaced with a new rule, please provide a summary of the rule giving an explanation of what the rule does.

   Is this an amendment to an existing rule? Yes__X__ No ____If yes, please attach a mark-up showing the changes in the existing rule and a summary of the substantive changes. **Note: The summary should explain what the amendment does, and the mark-up copy should be clearly labeled "mark-up."**

6. Cite the state law that grants the authority for this proposed rule? If codified, please give Arkansas Code citation.

   Arkansas Statute 20-76-201

7. What is the purpose of this proposed rule? Why is it necessary?

   The purpose of the proposed rule is to combine two pre-existing Prosthetic lower limb evaluation forms into one form and to improve the forms in the interest of clarity for prosthetics providers. The proposed rule is necessary to improve the request and approval process for prosthetics providers seeking reimbursement for prosthetic limbs.

8. Please provide the address where this rule is publicly accessible in electronic form via the Internet as required by Arkansas Code § 25-19-108(b).

   https://www.medicaid.state.ar.us/InternetSolution/general/comment/comment.aspx

9. Will a public hearing be held on this proposed rule? Yes_____ No __X__.
   If yes, please complete the following:
   Date:______________________________
   Time:______________________________
   Place:_____________________________

10. When does the public comment period expire for permanent promulgation? (Must provide a date.)

    April 10, 2012

11. What is the proposed effective date of this proposed rule? (Must provide a date.)

    July 1, 2012

12. Do you expect this rule to be controversial? Yes_____ No __X__ If yes, please explain.

13. Please give the names of persons, groups, or organizations that you expect to comment on these rules? Please provide their position (for or against) if known.

    Medical associations, interested providers, and advocacy organizations. Their positions for or against is not known at this time.

FINANCIAL IMPACT STATEMENT

PLEASE ANSWER ALL QUESTIONS COMPLETELY

DEPARTMENT **Department of Human Services**
DIVISION **Division of Medical Services**
PERSON COMPLETING THIS STATEMENT **Tom Show**
TELEPHONE NO. **683-2483** **FAX NO.** **682-2480** **EMAIL:** **tom.show@arkansas.gov**

To comply with Act 1104 of 1995, please complete the following Financial Impact Statement and file two copies with the questionnaire and proposed rules.

SHORT TITLE OF THIS RULE – Prosthetics 1-12 and Section V 1-12

1. Does this proposed, amended, or repealed rule have a financial impact?
   Yes _____ No X .

2. Does this proposed, amended, or repealed rule affect small businesses?
   Yes _____ No X .

   If yes, please attach a copy of the economic impact statement required to be filed with the Arkansas Economic Development Commission under Arkansas Code § 25-15-301 et seq.

3. If you believe that the development of a financial impact statement is so speculative as to be cost prohibited, please explain.

4. If the purpose of this rule is to implement a federal rule or regulation, please give the incremental cost for implementing the rule. Please indicate if the cost provided is the cost of the program.

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	

5. What is the total estimated cost by fiscal year to any party subject to the proposed, amended, or repealed rule? Identify the party subject to the proposed rule and explain how they are affected.

Current Fiscal Year	**Next Fiscal Year**

6. What is the total estimated cost by fiscal year to the agency to implement this rule? Is this the cost of the program or grant? Please explain.

Current Fiscal Year	**Next Fiscal Year**
None	None

Summary for
Prosthetics 1-12 & Section V 1-12

Section 212.600 of the Prosthetics manual has been amended to rename Forms DMS-648 (Upper-Limb Prosthetics Evaluation) and DMS-650 (Lower Limb Prosthetics Evaluation). This section is also updated to indicate that Form DMS-646 (Evaluation Form Lower Limb) has been discontinued. Providers should use Form DMS-650 in place of Form DMS-646. Section 500.000 has also been updated to replace the renamed forms and to remove the obsolete form.

Division of Medical Services

Program Development & Quality Assurance

P.O. Box 1437, Slot S-295 · Little Rock, AR 72203-1437
501-682-8368 · Fax: 501-682-2480

TO: **Arkansas Medicaid Health Care Providers – Prosthetics**

DATE: **July 1, 2012**

SUBJECT: **Provider Manual Update Transmittal PROSTHET-1-12**

REMOVE		**INSERT**	
Section	**Date**	**Section**	**Date**
212.600	4-1-09	212.600	7-1-12

Explanation of Updates

Section 212.600 is updated to indicate that Form DMS-648 has been renamed to Upper-Limb Prosthetic Evaluation and Form DMS-650 has been renamed to Lower-Limb Prosthetic Evaluation. This section is also updated to indicate that Form DMS-646 (Evaluation Form Lower Limb) has been discontinued. Providers should use Form DMS-650 in place of Form DMS-646.

The paper version of this update transmittal includes revised pages that may be filed in your provider manual. See Section I for instructions on updating the paper version of the manual. For electronic versions, these changes have already been incorporated.

If you have questions regarding this transmittal, please contact the HP Enterprise Services Provider Assistance Center at 1-800-457-4454 (Toll-Free) within Arkansas or locally and Out-of-State at (501) 376-2211.

If you need this material in an alternative format, such as large print, please contact our Americans with Disabilities Act Coordinator at 501-682-0593 (Local); 1-800-482-5850, extension 2-0593 (Toll-Free) or to obtain access to these numbers through voice relay, 1-800-877-8973 (TTY Hearing Impaired).

Arkansas Medicaid provider manuals (including update transmittals), official notices and remittance advice (RA) messages are available for downloading from the Arkansas Medicaid website: www.medicaid.state.ar.us.

Thank you for your participation in the Arkansas Medicaid Program.

PROPOSED

Andrew Allison, PhD
Director

TOC not required

PROPOSED

212.600 Orthotic Appliances and Prosthetic Devices, All Ages 7-1-12

A. The Arkansas Medicaid Program covers orthotic appliances and prosthetic devices for beneficiaries under age 21 in the Child Health Services (EPSDT) Program. Providers of orthotic appliances and prosthetic devices may be reimbursed by the Arkansas Medicaid Program when the items are prescribed by a physician and documented as medically necessary for beneficiaries under age 21 participating in the Child Health Services (EPSDT) Program.

1. No prior authorization is required to obtain these services for beneficiaries under age 21.

2. No benefit limits apply to orthotic appliances and prosthetic devices for beneficiaries under age 21.

B. Arkansas Medicaid covers orthotic appliances for beneficiaries age 21 and over. The following provisions must be met before services may be provided.

1. Prior authorization is required for orthotic appliances valued at or above the Medicaid maximum allowable reimbursement rate of $500.00 per item for use by beneficiaries age 21 and over. Prior authorization may be requested by submitting form DMS-679A titled *Prescription & Prior Authorization Request for Medical Equipment Excluding Wheelchairs & Wheelchair Components* to AFMC. **View or print form DMS-679A and instructions for completion.** **View or print AFMC contact information.**

2. For beneficiaries age 21 and over, a benefit limit of $3,000 per state fiscal year (SFY; July 1 through June 30) has been established for reimbursement for orthotic appliances. No extension of benefits will be granted.

   The following restrictions apply to the coverage of orthotic appliances for beneficiaries age 21 and over:

   a. Orthotic appliances may not be replaced for 12 months from the date of purchase. If a beneficiary's condition warrants a modification or replacement and the $3,000.00 SFY benefit limit has not been met, the provider may submit documentation to AFMC, to substantiate medical necessity. **If approved, AFMC will issue a prior authorization number.** Section 221.000 of this provider manual may be referenced for information regarding prior authorization procedures.

   b. Custom-molded orthotic appliances are not covered for a diagnosis of carpal tunnel syndrome prior to surgery.

C. Arkansas Medicaid covers prosthetic devices for beneficiaries age 21 and over; however, the following provisions must be met before services may be provided.

1. Prior authorization will be required for prosthetic device items valued at or in excess of the $1,000.00 per item Medicaid maximum allowable reimbursement rate for use by beneficiaries age 21 and over. Prior authorization may be requested by submitting form DMS-679A titled *Prescription & Prior Authorization Request for Medical Equipment Excluding Wheelchairs & Wheelchair Components* to AFMC. **View or print form DMS-679A and instructions for completion.**

2. For beneficiaries age 21 and over, a benefit limit of $20,000 per SFY has been established for reimbursement for prosthetic devices. No extension of benefits will be granted.

3. The following restrictions apply to coverage of prosthetic devices for beneficiaries age 21 and over:

a. Prosthetic devices may be replaced only after five years have elapsed from their date of purchase. If the beneficiary's condition warrants a modification or replacement, and the $20,000 SFY benefit limit has not been met, the provider may submit documentation to AFMC to substantiate medical necessity. **If approved, AFMC will issue a prior authorization number.** Section 220.000 of this provider manual may be referenced for information regarding prior authorization procedures.

b. Myoelectric prosthetic devices may be purchased only when needed to replace myoelectric devices received by beneficiaries who were under age 21 when they received the original device.

D. The forms, listed below, are available for evaluating the need of beneficiaries age 21 and over for orthotic appliances and prosthetic devices, and prescribing the needed appliances and equipment. The Medicaid Program does not require providers to use the forms, but the information the forms are designed to collect is required by Medicaid to process requests for prior authorization of orthotic appliances and prosthetic devices for beneficiaries aged 21 and over.

The appropriate forms (or the required information in a different format) must accompany the form DMS-679A. **View or print DMS-679A *titled Prescription & Prior Authorization Request for Medical Equipment Excluding Wheelchairs & Wheelchair Components* and instructions for completion.**

The forms and their titles are as follows:

1. DMS-647 Gait Analysis: Full Body. **View or print form DMS-647.**
2. DMS-648 Upper-Limb Prosthetic Evaluation. **View or print form DMS-648**.
3. DMS-649 Upper-Limb Prosthetic Prescription. **View or print form DMS-649**.
4. DMS-650 Lower-Limb Prosthetic Evaluation. **View or print form DMS-650**.
5. DMS-651 Lower-Limb Prosthetic Prescription. **View or print form DMS-651**.

PROPOSED

Division of Medical Services

Program Development & Quality Assurance

P.O. Box 1437, Slot S-295 · Little Rock, AR 72203-1437
501-682-8368 · Fax: 501-682-2480

PROPOSED

TO:	Arkansas Medicaid Health Care Providers – All Providers
DATE:	July 1, 2012
SUBJECT:	Provider Manual Update Transmittal SecV-1-12

REMOVE		INSERT	
Section	**Date**	**Section**	**Date**
500.000	—	500.000	—
DMS-646	3/00	—	—
DMS-648	3/00	DMS-648	7/12
DMS-650	3/00	DMS-650	7/12

Explanation of Updates

This transmittal and the enclosed forms are for informational purposes only. **Please do not complete the enclosed forms.**

Section 500.000 is updated to indicate that Form DMS-646 (Evaluation Form Lower Limb) has been discontinued. It is also updated to indicate that Form DMS-648 has been renamed to Upper-Limb Prosthetic Evaluation and Form DMS-650 has been renamed to Lower-Limb Prosthetic Evaluation.

Form DMS-646 (Evaluation Form Lower Limb) has been discontinued. Providers should use Form DMS-650 (Lower-Limb Prosthetic Evaluation) instead.

Form DMS-648 has been renamed to Upper-Limb Prosthetic Evaluation and includes updated fields.

Form DMS-650 has been renamed to Lower-Limb Prosthetic Evaluation and includes updated fields.

The paper version of this update transmittal includes revised pages that may be filed in your provider manual. See Section I for instructions on updating the paper version of the manual. For electronic versions, these changes have already been incorporated.

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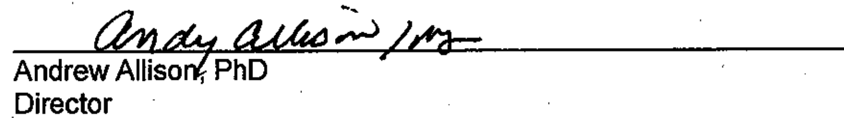
Thank you for your participation in the Arkansas Medicaid Program.



Andrew Allison, PhD
Director

PROPOSED

SECTION V – FORMS
500.000

PROPOSED

Claim Forms

Red-ink Claim Forms

The following is a list of the red-ink claim forms required by Arkansas Medicaid. The forms below cannot be printed from this manual for use. Information about where to get the forms and links to samples of the forms is available below. To view a sample form, click the form name.

Claim Type	Where To Get Them
Professional – CMS-1500	Business Form Supplier
Institutional – CMS-1450*	Business Form Supplier
Visual Care – DMS-26-V	1-800-457-4454
Inpatient Crossover – HP-MC-001	1-800-457-4454
Long Term Care Crossover – HP-MC-002	1-800-457-4454
Outpatient Crossover – HP-MC-003	1-800-457-4454
Professional Crossover – HP-MC-004	1-800-457-4454

* For dates of service after 11/30/07 – ALL HOSPICE PROVIDERS USE ONLY FORM CMS-1450 (formerly UB-04) for billing.

Claim Forms

The following is a list of the non-red-ink claim forms required by Arkansas Medicaid. Information about where to get a supply of the forms and links to samples of the forms is available below. To view a sample form, click the form name.

Claim Type	Where To Get Them
Alternatives Attendant Care Provider Claim Form - AAS-9559	Client Employer
Dental – ADA-J400	Business Form Supplier

Arkansas Medicaid Forms

The forms below can be printed from this manual for use.

In order by form name:

Form Name	Form Link
Acknowledgement of Hysterectomy Information	DMS-2606
Address Change Form	DMS-673
Adjustment Request Form – Medicaid XIX	HP-AR-004

Form Name	Form Link
AFMC Prescription & Prior Authorization Request for Medical Equipment Excluding Wheelchairs & Wheelchair Components	DMS-679A
Amplification/Assistive Technology Recommendation Form	DMS-686
Application for WebRA Hardship Waiver	DMS-7736
Approval/Denial Codes for Inpatient Psychiatric Services	DMS-2687
Arkansas Early Intervention Infant & Toddler Program Intake/Referral/Application for Services	DDS/FS#0001.a
ARKids First Mental Health Services Provider Qualification Form	DMS-612
Assisted Living Waiver Plan of Care	AAS-9565
Authorization for Automatic Deposit	autodeposit
Authorization for Payment for Services Provided	MAP-8
Certification of Need – Medicaid Inpatient Psychiatric Services for Under Age 21	DMS-2633
Certification of Schools to Provide Comprehensive EPSDT Services	CSPC-EPSDT
Certification Statement for Abortion	DMS-2698
Change of Ownership Information	DMS-0688
Child Health Management Services Enrollment Orders	DMS-201
Child Health Management Services Discharge Notification Form	DMS-202
CHMS Benefit Extension for Diagnosis/Evaluation Procedures	DMS-699A
CHMS Request for Prior Authorization	DMS-102
Claim Correction Request	DMS-2647
Consent for Release of Information	DMS-619
Contact Lens Prior Authorization Request Form	DMS-0101
Contract to Participate in the Arkansas Medical Assistance Program	DMS-653
DDTCS Transportation Log	DMS-638
DDTCS Transportation Survey	DMS-632
Dental Treatment Additional Information	DMS-32-A
Disclosure of Significant Business Transactions	DMS-689
Disproportionate Share Questionnaire	DMS-628
Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Prescription/Referral For Medically Necessary Services/Items Not Specifically Included in the Medicaid State Plan	DMS-693
Early Childhood Special Education Referral Form	ECSE-R
EPSDT Provider Agreement	DMS-831
Explanation of Check Refund	HP-CR-002
Gait Analysis Full Body	DMS-647

PROPOSED

Form Name	Form Link
Home Health Certification and Plan of Care	CMS-485
Hospital/Physician/Certified Nurse Midwife Referral for Newborn Infant Medicaid Coverage	DCO-645
Inpatient Psychiatric Medicaid Agency Review Team Transmittal Sheet	DMS-2685
Individual Renewal Form for School-Based Audiologists	DMS-7782
Lower-Limb Prosthetic Evaluation	DMS-650
Lower-Limb Prosthetic Prescription	DMS-651
Media Selection/E-Mail Address Change Form	HP-MS-005
Medicaid Claim Inquiry Form	HP-CI-003
Medicaid Form Request	HP-MFR-001
Medical Assistance Dental Disposition	DMS-2635
Medical Equipment Request for Prior Authorization & Prescription	DMS-679
Medical Transportation and Personal Assistant Verification	DMS-616
Mental Health Services Provider Qualification Form for LCSW, LMFT and LPC	DMS-633
Notice Of Noncompliance	DMS-635
NPI Reporting Form	DMS-683
Occupational, Physical and Speech Therapy for Medicaid Eligible Beneficiaries Under Age 21 Prescription/Referral	DMS-640
Ownership and Conviction Disclosure	DMS-675
Personal Care Assessment and Service Plan	DMS-618 English DMS-618 Spanish
Practitioner Identification Number Request Form	DMS-7708
Prescription & Prior Authorization Request For Nutrition Therapy & Supplies	DMS-2615
Primary Care Physician Managed Care Program Referral Form	DMS-2610
Primary Care Physician Participation Agreement	DMS-2608
Primary Care Physician Selection and Change Form	DMS-2609
Prior Authorization (PA) Request for Extension of Benefits-Prescription Drugs	DMS-0685-14
Procedure Code/NDC Detail Attachment Form	DMS-664
Provider Application	DMS-652
Provider Communication Form	AAS-9502
Provider Data Sharing Agreement – Medicare Parts C & D	DMS-652-A
Provider Enrollment Application and Contract Package	AppMaterial
Referral for Audiology Services – School-Based Setting	DMS-7783

Form Name	Form Link
Referral for Certification of Need Medicaid Inpatient Psychiatric Services for Under Age 21	DMS-2634
Referral for Medical Assistance	DMS-630
Request for Appeal	DMS-840
Request for Extension of Benefits	DMS-699
Request for Extension of Benefits for Clinical, Outpatient, Laboratory and X-Ray Services	DMS-671
Request for Extension of Benefits for Medical Supplies for Medicaid Beneficiaries Under Age 21	DMS-602
Request For Orthodontic Treatment	DMS-32-0
Request for Private Duty Nursing Services Prior Authorization and Prescription – Initial Request or Recertification	DMS-2692
Request for Targeted Case Management Prior Authorization for Beneficiaries Under Age 21	DMS-601
Research Request Form	HP-0288
Service Log – Personal Care Delivery and Aides Notes	DMS-873
Sterilization Consent Form	DMS-615 English DMS-615 Spanish
Sterilization Consent Form – Information for Men	PUB-020
Sterilization Consent Form – Information for Women	PUB-019
Upper-Limb Prosthetic Evaluation	DMS-648
Upper-Limb Prosthetic Prescription	DMS-649
Vendor Performance Report	Vendorperformreport
Verification of Medical Services	DMS-2618

PROPOSED

In order by form number:

AAS-9502
AAS-9559
AAS-9565
Address Change
Autodeposit
CMS-485
CSPC-EPSDT
DCO-645
DDS/FS#0001.a
DMS-0101
DMS-0685-14
DMS-0688
DMS-102
DMS-201
DMS-202
DMS-2606
DMS-2608
DMS-2609
DMS-2610
DMS-2615
DMS-2618
DMS-2633
DMS-2634
DMS-2635
DMS-2647
DMS-2685
DMS-2687
DMS-2692
DMS-2698
DMS-32-A
DMS-32-0
DMS-601
DMS-602
DMS-612
DMS-615 English
DMS-615 Spanish
DMS-616
DMS-618 English
DMS-618 Spanish
DMS-619
DMS-628
DMS-630
DMS-632
DMS-633
DMS-635
DMS-638
DMS-640
DMS-647
DMS-648
DMS-649
DMS-650
DMS-651
DMS-652
DMS-652-A
DMS-653
DMS-664
DMS-671
DMS-675
DMS-673
DMS-679
DMS-679A
DMS-683
DMS-686
DMS-689
DMS-693
DMS-699
DMS-699A
DMS-7708
DMS-7736
DMS-7782
DMS-7783
DMS-831
DMS-840
DMS-873
ECSE-R
HP-0288
HP-AR-004
HP-CI-003
HP-CR-002
HP-MFR-001
HP-MS-005
MAP-8
Performance Report
Provider Enrollment Application and Contract Package
PUB-019
PUB-020

PROPOSED

Arkansas Medicaid Contacts and Links

Click the link to view the information.

American Hospital Association

Americans with Disabilities Act Coordinator

Arkansas Department of Education, Health and Nursing Services Specialist

Arkansas Department of Education, Special Education

Arkansas Department of Human Services, Division of Aging and Adult Services

Arkansas Department of Human Services, Appeals and Hearings Section

Arkansas Department of Human Services, Division of Behavioral Health Services

Arkansas Department of Human Services, Division of Child Care and Early Childhood Education, Child Care Licensing Unit

Arkansas Department of Human Services, Division of Children and Family Services, Contracts Management Unit

Arkansas Department of Human Services, Children's Services

Arkansas Department of Human Services, Division of County Operations, Customer Assistance Section

Arkansas Department of Human Services, Division of Medical Services

Arkansas DHS, Division of Medical Services Director

Arkansas DHS, Division of Medical Services, Benefit Extension Requests, UR Section

Arkansas DHS, Division of Medical Services, Dental Care Unit

Arkansas DHS, Division of Medical Services, HP Enterprise Services Provider Enrollment Unit

Arkansas DHS, Division of Medical Services, Financial Activities Unit

Arkansas DHS, Division of Medical Services, Hearing Aid Consultant

Arkansas DHS, Division of Medical Services, Medical Assistance Unit

PROPOSED

Arkansas DHS, Division of Medical Services, Medical Director

Arkansas DHS, Division of Medical Services, Pharmacy Unit

Arkansas DHS, Division of Medical Services, Program Communications Unit

Arkansas DHS, Division of Medical Services, Program Integrity Unit (PI)

Arkansas DHS, Division of Medical Services, Provider Reimbursement Unit

Arkansas DHS, Division of Medical Services, Third-Party Liability Unit

Arkansas DHS, Division of Medical Services, UR/Home Health Extensions

Arkansas DHS, Division of Medical Services, Utilization Review Section

Arkansas DHS, Division of Medical Services, Visual Care Coordinator

Arkansas Department of Health

Arkansas Department of Health, Health Facility Services

Arkansas Department of Human Services, Accounts Receivable

Arkansas Foundation For Medical Care

Arkansas Hospital Association

ARKids First-B

ARKids First-B ID Card Example

Central Child Health Services Office (EPSDT)

ConnectCare Helpline

County Codes

CPT Ordering

Dental Contractor

HP Enterprise Services Claims Department

HP Enterprise Services EDI Support Center (formerly AEVCS Help Desk)

HP Enterprise Services Inquiry Unit

HP Enterprise Services Manual Order

HP Enterprise Services Pharmacy Help Desk

<u>HP Enterprise Services Provider Assistance Center (PAC)</u>

<u>HP Enterprise Services Supplied Forms</u>

<u>Example of Beneficiary Notification of Denied ARKids First-B Claim</u>

<u>Example of Beneficiary Notification of Denied Medicaid Claim</u>

<u>First Connections Infant & Toddler Program, Developmental Disabilities Services</u>

<u>Flow Chart of Intake and Prior Authorization Process For Intervention/Treatment</u>

<u>Health Care Declarations</u>

<u>ICD-9-CM, CPT, and HCPCS Reference Book Ordering</u>

<u>Immunizations Registry Help Desk</u>

<u>Medicaid ID Card Example</u>

<u>Medicaid Managed Care Services (MMCS)</u>

<u>Medicaid Reimbursement Unit Communications Hotline</u>

<u>Medicaid Tooth Numbering System</u>

<u>National Supplier Clearinghouse</u>

<u>Primary Care Physician (PCP) Enrollment Voice Response System</u>

<u>Provider Qualifications, Division of Behavioral Health Services</u>

<u>QSource of Arkansas</u>

<u>Select Optical</u>

<u>Standard Register</u>

<u>Table of Desirable Weights</u>

<u>ValueOptions</u>

<u>U.S. Government Printing Office</u>

<u>Vendor Performance Report</u>

PROPOSED

ARKANSAS MEDICAID

UPPER-LIMB PROSTHETIC EVALUATION FORM

INSTRUCTIONS: Carefully complete this entire form to the best of your professional knowledge leaving no portions blank. Mark inappropriate areas N/A (not applicable).

Name________________________________ Age_____ Sex_____ Date______________

Date of Amputation_______________ _____Right _____Left _____Bilateral

Level of Amputation:

_____ Partial Hand _____ Elbow Disarticulation

_____ Wrist Disarticulation _____ Transhumeral

_____ Transradial _____ Shoulder Disarticulation

PROPOSED

Dates of revision amputation surgery____________________

Has patient worn a prosthesis before _____Yes _____No

Age of current prosthesis___________________

Evaluation of fit and function of current prosthesis:

____

____

____

Name ____

Medical necessity for new prosthesis:

____

____

____

Recommendations for new prosthesis:

Socket type ____

Suspension of prosthesis ____

Type of wrist joint ____

Type of elbow joint ____

Type of terminal device ____

PROPOSED

L-Codes and description of new prosthesis:

____

____

____

____

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____

Name and Credentials of Prosthetist ____

Name ____

Attestation of Referring Physician:

I have reviewed all portions of this Upper-Limb Evaluation Form prepared for my patient, ________________________, and I agree with the treatment plan and accept this as a prescription for a medically necessary prosthesis.

______________________________MD ______________________Address

______________________________MD (Print Name) ______________________________

Date__________________________ ______________________Phone#

PROPOSED

ARKANSAS MEDICAID

LOWER-LIMB PROSTHETIC EVALUATION FORM

INSTRUCTIONS: Carefully complete this entire form to the best of your professional knowledge leaving no portions blank. Mark inappropriate areas N/A (not applicable).

Name ______________________________ Age_____ Sex_____ Date_____________

Date of Amputation________________ _____Right _____Left _____Bilateral

Level of Amputation:

_____ Partial Foot _____ Knee Disarticulation

_____ Symes _____ Transfemoral

_____ Transtibial _____ Hip Disarticulation

PROPOSED

Dates of revision amputation surgery_____________________

Has patient worn a prosthesis before _____Yes _____No

Age of current prosthesis____________________

Evaluation of fit and function of current prosthesis:

____

____

____

Name ______________________________

Medical necessity for prosthetic services requested: (Replacement socket, new prosthesis, etc.)

____
____
____

Recommendations for new prosthesis:

Socket type ______________________________

Suspension of prosthesis ______________________________

Type of knee joint ______________________________

Type of ankle / foot ______________________________

PROPOSED

L-Codes and description of new prosthesis:

____
____
____
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____
____

Name ____

Current Medicare Functional Level of Patient's Activity (K-Levels)

_____ K-0 Patient does not have the ability to ambulate or transfer safely with or without assistance and a prosthesis does not enhance their quality of life or mobility.

_____ K-1 Patient has the ability or potential to use a prosthesis for transfers or ambulation on level surfaces at a fixed cadence. Typical of a limited or unlimited household ambulatory.

_____ K-2 Patient has the ability or potential for ambulation with the ability to traverse low level environmental barriers such as curbs, stairs or uneven surfaces. Typical of the limited community ambulatory.

_____ K-3 Patient has the ability or potential for ambulation with variable cadence. Typical of the community ambulatory who has the ability to traverse most environmental barriers and may have vocational, therapeutic or exercise activity that demands prosthetic utilization beyond simple locomotion.

_____ K-4 Patient has the ability or potential for prosthetic ambulation that exceeds basic ambulation skills exhibiting high impact, stress or energy levels. Typical of the prosthetic demands of a child, active adult or athlete.

Name and Credentials of Prosthetist ______________________________

PROPOSED

Attestation of Referring Physician:

I have reviewed all portions of this Lower-Limb Evaluation Form prepared for my patient, ________________________, and I agree with the treatment plan and accept this as a prescription for a medically necessary prosthesis.

________________________MD ____________________Address

________________________MD (Print Name) ____________________

Date____________________ ____________________Phone#

TOC not required

212.600 Orthotic Appliances and Prosthetic Devices, All Ages 47-1-0912

A. The Arkansas Medicaid Program covers orthotic appliances and prosthetic devices for beneficiaries under age 21 in the Child Health Services (EPSDT) Program. Providers of orthotic appliances and prosthetic devices may be reimbursed by the Arkansas Medicaid Program when the items are prescribed by a physician and documented as medically necessary for beneficiaries under age 21 participating in the Child Health Services (EPSDT) Program.

1. No prior authorization is required to obtain these services for beneficiaries under age 21.
2. No benefit limits apply to orthotic appliances and prosthetic devices for beneficiaries under age 21.

B. Arkansas Medicaid covers orthotic appliances for beneficiaries age 21 and over. The following provisions must be met before services may be provided.

1. Prior authorization is required for orthotic appliances valued at or above the Medicaid maximum allowable reimbursement rate of $500.00 per item for use by beneficiaries age 21 and over. Prior authorization may be requested by submitting form DMS-679A titled *Prescription & Prior Authorization Request for Medical Equipment Excluding Wheelchairs & Wheelchair Components* to AFMC. **View or print form DMS-679A and instructions for completion. View or print AFMC contact information.**
2. For beneficiaries age 21 and over, a benefit limit of $3,000 per state fiscal year (SFY; July 1 through June 30) has been established for reimbursement for orthotic appliances. No extension of benefits will be granted.

   The following restrictions apply to the coverage of orthotic appliances for beneficiaries age 21 and over:

   a. Orthotic appliances may not be replaced for 12 months from the date of purchase. If a beneficiary's condition warrants a modification or replacement and the $3,000.00 SFY benefit limit has not been met, the provider may submit documentation to AFMC, to substantiate medical necessity. **If approved, AFMC will issue a prior authorization number.** Section 221.000 of this provider manual may be referenced for information regarding prior authorization procedures.

   b. Custom-molded orthotic appliances are not covered for a diagnosis of carpal tunnel syndrome prior to surgery.

C. Arkansas Medicaid covers prosthetic devices for beneficiaries age 21 and over; however, the following provisions must be met before services may be provided.

1. Prior authorization will be required for prosthetic device items valued at or in excess of the $1,000.00 per item Medicaid maximum allowable reimbursement rate for use by beneficiaries age 21 and over. Prior authorization may be requested by submitting form DMS-679A titled *Prescription & Prior Authorization Request for Medical Equipment Excluding Wheelchairs & Wheelchair Components* to AFMC. **View or print form DMS-679A and instructions for completion.**
2. For beneficiaries age 21 and over, a benefit limit of $20,000 per SFY has been established for reimbursement for prosthetic devices. No extension of benefits will be granted.
3. The following restrictions apply to coverage of prosthetic devices for beneficiaries age 21 and over:

a. Prosthetic devices may be replaced only after five years have elapsed from their date of purchase. If the beneficiary's condition warrants a modification or replacement, and the $20,000 SFY benefit limit has not been met, the provider may submit documentation to AFMC to substantiate medical necessity. **If approved, AFMC will issue a prior authorization number.** Section 220.000 of this provider manual may be referenced for information regarding prior authorization procedures.

b. Myoelectric prosthetic devices may be purchased only when needed to replace myoelectric devices received by beneficiaries who were under age 21 when they received the original device.

D. ~~Several~~ The forms, listed below, are available for evaluating the need of beneficiaries age 21 and over for orthotic appliances and prosthetic devices, and prescribing the needed appliances and equipment. The Medicaid Program does not require providers to use the forms, but the information the forms are designed to collect is required by Medicaid to process requests for prior authorization of orthotic appliances and prosthetic devices for beneficiaries aged 21 and over.

The appropriate forms (or the required information in a different format) must accompany the form DMS-679A. **View or print DMS-679A *titled Prescription & Prior Authorization Request for Medical Equipment Excluding Wheelchairs & Wheelchair Components* and instructions for completion.**

The forms and their titles are as follows:

~~1. DMS-646 Evaluation Form Lower Limb. **View or print form DMS-646.**~~

~~2~~1. DMS-647 Gait Analysis: Full Body. **View or print form DMS-647.**

~~3~~2. DMS-648 ~~Prosthetic-Orthotic~~ Upper-Limb ~~Amputee~~ Prosthetic Evaluation. **View or print form DMS-648**.

~~4~~3. DMS-649 Upper-Limb Prosthetic Prescription. **View or print form DMS-649**.

~~5~~4. DMS-650 ~~Prosthetic-Orthotic~~ Lower-Limb Prosthetic ~~Amputee~~ Evaluation. **View or print form DMS-650**.

~~6~~5. DMS-651 Lower-Limb Prosthetic Prescription. **View or print form DMS-651**.

~~PROSTHETIC-ORTHOTIC~~

~~Upper Limb Amputee Evaluation~~

~~Name ______ Age ______ Sex: M ______ F ______ Date: ______~~

~~Level of Amputation~~

~~Reference: L = Left; R = Right; B = Bilateral~~

~~Transradial ( ) Transhumeral ( ) SD ( ) ED ( ) WD ( )~~

~~I. Date of Amputation ______~~

~~Reason for Amputation ______~~

~~Dates of Revision ______~~

~~II. Medical Complications ______~~

______

~~Special Treatment or Medications ______~~

~~Phantom Sensation: Yes ______ No ______~~

~~Phantom Pain (describe) ______~~

______

~~III. Vocation (before amputation, while wearing prosthesis, future plans, Special interest)~~

______

______

~~IV. Worn Prosthesis Before: Yes ______ No ______~~

~~If worn before, date first fitted ______~~

~~How many prostheses? ______~~

~~Average Life of Prostheses ______~~

~~V. Range of Motion of Residual Limb~~

~~Hip: Flexion ______ Elbow: ______~~
~~Extension ______ Forearm Rotation: ______~~
~~Abduction ______ Scapular Complex: ______~~
~~Adduction ______~~

~~Is stretching indicated? ______ If so, frequency, type and duration ______~~

______

VI. Strength of Residual Limb:

Glenohumeral Joint ______ Elbow ______
Flexion ______ Forearm Rotation ______
Extension ______ Scapular Complex ______
Abduction ______ Protraction/Retraction ______
Adduction ______ Elevation/Depression ______

Is exercise indicated? ______ If so, type, frequency, duration ______

______

VII. Body build: Heavy ______ Medium ______ Light ______ Weight ______

VIII. Characteristics of Residual Limb (terms used are for guidance only; please describe in detail):

Shape (conical, bulbous, edematous, cylindrical) ______

______

Muscle Tone (flabby, atrophic, firm) ______

______

Pressure Tolerance (areas of tenderness, local or diffuse) ______

______

Sensation (anesthetic areas) ______

______

Skin (dermatitis, folliculitis, scars, open areas) ______

______

Circulation (pulses, warm, cool, moist, dry, cyanotic) ______

______

If below elbow, does residual limb disappear into antecubital fossa upon complete elbow flexion?

______

If shoulder disarticulation type, measure chest expansion ______

______

IX. Dominance prior to amputation: Right ______ Left ______

X. Treatment Prescribed: Yes ______ No ______

Frequency of treatment: Daily ______ Other ______

XI. Description of present prosthesis (in as much detail as possible)

A. Terminal Device

Hand ____________________

____

Hook ____________________

B. Wrist Unit ____________________

C. Socket ____________________

D. Elbow Hinge ____________________

E. Elbow Unit ____________________

F. Control System ____________________

G. Harnessing ____________________

H. Special Modifications ____________________

XII. Patient Remarks: ____________________

____

____

Clinic Team Remarks: ____________________

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____

____

Physician

____

Therapist

ARKANSAS MEDICAID

UPPER-LIMB PROSTHETIC EVALUATION FORM

INSTRUCTIONS: Carefully complete this entire form to the best of your professional knowledge leaving no portions blank. Mark inappropriate areas N/A (not applicable).

Name of Amputee ____________ Age ____ Sex ____ Date ____________

Date of Amputation ____________ Right ____ Left ____ Bilateral

Level of Amputation:

_____ Partial Hand _____ Elbow Disarticulation

_____ Wrist Disarticulation _____ Transhumeral

_____ Transradial _____ Shoulder Disarticulation

Dates of revision amputation surgery ____________

Has patient worn a prosthesis before ____ Yes ____ No

Age of current prosthesis ____________

Evaluation of fit and function of current prosthesis:

____

____

____

Medical necessity for new prosthesis:

Recommendations for new prosthesis:

Socket type

Suspension of prosthesis

Type of wrist joint

Type of elbow joint

Type of terminal device

L-Codes and description of new prosthesis:

Name and Credentials of Prosthetist

Attestation of Referring Physician:

I have reviewed all portions of this Upper-Limb Evaluation Form prepared for my patient, ______________________, and I agree with the treatment plan and accept this as prescription for this medically necessary prosthesis.

______________________ MD ______________________ Address

______________________ MD (Print Name) ______________________

Date ______________________ Phone#

PROSTHETIC-ORTHOTIC

Lower-Limb Amputee Evaluation

Name ______________________ Age ________ Sex: M _____ F _____ Date: __________

Level of Amputation

Reference Limb: L = Left; R = Right; B = Bilateral

HD ( ) Transfemoral ( ) Transtibial ( ) Symes ( ) Partial Foot ( )

I. Date of Amputation ______________________

Reason for Amputation ______________________

Dates of Revision ______________________

II. Medical Complications ______________________

____

Special Treatment or Medications ______________________

Phantom Sensation: Yes ________ No ________

Phantom Pain (describe) ______________________

____

III. Vocation (before amputation, while wearing prosthesis, future plans) ______________________

____

____

IV. Worn Prosthesis Before: Yes ________ No ________

If worn before, date first fitted ______________________

How many prostheses? ______________________

Average Life of Prostheses ______________________

V. Range of Motion of Residual Limb

Hip: Flexion ______________
Extension ______________
Abduction ______________
Adduction ______________

Knee: ______________________

Knee Ligament: (circle abnormal ligaments) AC PC MC LC

~~VI. Strength of Residual Limb:~~

~~Hip: Flexion~~ ____________ ~~Knee: Flexion~~ ____________
~~Extension~~ ____________ ~~Extension~~ ____________
~~Abduction~~ ____________
~~Adduction~~ ____________

~~Is exercise indicated?~~ ________ ~~If so, type, frequency, duration~~ ____________

____

~~VII. Length of Residual Limb~~ ______________________________

~~VIII. Body build: Heavy~~ ______ ~~Medium~~ ______ ~~Light~~ ______ ~~Weight~~ ______

~~IX. Characteristics of Residual Limb (terms used are for guidance only; please describe in detail):~~

~~Shape (conical, bulbous, edematous, cylindrical)~~ ____________________

____

~~Muscle Tone (flabby, atrophic, firm)~~ ____________________

____

~~Pressure Tolerance (areas of tenderness, local or diffuse)~~ ____________________

____

~~Sensation (anesthetic areas)~~ ____________________

____

~~Skin (dermatitis, folliculitis, scars, open areas)~~ ____________________

____

~~Circulation (pulses, warm, cool, moist, dry, cyanotic)~~ ____________________

____

~~Adductor Roll (if present, describe extent)~~ ____________________

____

VI. Strength of Residual Limb:

Hip: Flexion ____________ Knee: Flexion ____________
Extension ____________ Extension ____________
Abduction ____________
Adduction ____________

Is exercise indicated? ____________ If so, type, frequency, duration ____________

____

VII. Length of Residual Limb ____________

VIII. Body build: Heavy ______ Medium ______ Light ______ Weight ______

IX. Characteristics of Residual Limb (terms used are for guidance only; please describe in detail):

Shape (conical, bulbous, edematous, cylindrical) ____________

____

Muscle Tone (flabby, atrophic, firm) ____________

____

Pressure Tolerance (areas of tenderness, local or diffuse) ____________

____

Sensation (anesthetic areas) ____________

____

Skin (dermatitis, folliculitis, scars, open areas) ____________

____

Circulation (pulses, warm, cool, moist, dry, cyanotic) ____________

____

Adductor Roll (if present, describe extent) ____________

____

X. Condition of remaining leg:

Blood supply (arterial) ______
Skin ______
Pain ______
Edema ______
Venous insufficiency ______
Joints ______
Strength ______
Range of motion ______
Sensation ______

XI. Locomotion:

Method: Crutches ______ Prosthesis ______ Other ______
Adequate ______ Inadequate ______
Balance: Poor ______ Fair ______ Good ______
Coordination: Poor ______ Fair ______ Good ______

XII. Description of Present Prosthesis (in as much detail as needed):

Socket (type and fit) ______

______

Residual Limb Sock (ply) ______

Suspension ______

Knee Joint ______

Foot-Ankle ______

XIII. Patient Remarks: ______

______

______

Clinic Team Remarks: ______

______

______

______ ______
Physician

______ ______
Therapist

ARKANSAS MEDICAID

LOWER-LIMB PROSTHETIC EVALUATION FORM

INSTRUCTIONS: Carefully complete this entire form to the best of your professional knowledge leaving no portions blank. Mark inappropriate areas N/A (not applicable).

Name ________________________ Age ____ Sex ____ Date __________

Date of Amputation ________________________ Right ____ Left ____ Bilateral

Level of Amputation:

______ Partial Foot ______ Knee Disarticulation

______ Symes ______ Transfemoral

______ Transtibial ______ Hip Disarticulation

Dates of revision amputation surgery ______________

Has patient worn a prosthesis before ______ Yes ______ No

Age of current prosthesis ______________

Evaluation of fit and function of current prosthesis:

____

____

____

Name ____

Medical necessity for prosthetic services requested: (Replacement socket, new prosthesis, etc.)

____

____

____

Recommendations for new prosthesis:

Socket type ____

Suspension of prosthesis ____

Type of knee joint ____

Type of ankle / foot ____

L-Codes and description of new prosthesis:

____

____

____

____

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____

____

Name ____

Current Medicare Functional Level of Patient's Activity (K-Levels)

_______ K-0 Patient does not have the ability to ambulate or transfer safely with or without assistance and a prosthesis does not enhance their quality of life or mobility.

_______ K-1 Patient has the ability or potential to use a prosthesis for transfers or ambulation on level surfaces at a fixed cadence. Typical of a limited or unlimited household ambulatory.

_______ K-2 Patient has the ability or potential for ambulation with the ability to traverse low level environmental barriers such as curbs, stairs or uneven surfaces. Typical of the limited community ambulatory.

_______ K-3 Patient has the ability or potential for ambulation with variable cadence. Typical of the community ambulatory who has the ability to traverse most environmental barriers and may have vocational, therapeutic or exercise activity that demands prosthetic utilization beyond simple locomotion.

_______ K-4 Patient has the ability or potential for prosthetic ambulation that exceeds basic ambulation skills exhibiting high impact, stress or energy levels. Typical of the prosthetic demands of a child, active adult or athlete.

Name and Credentials of Prosthetist ____

Attestation of Referring Physician:

I have reviewed all portions of this Lower-Limb Evaluation Form prepared for my patient, ______________________, and I agree with the treatment plan and accept this as a prescription for a medically necessary prosthesis.

______________________ MD ______________________ Address

______________________ MD (Print Name) ______________________

Date ______________________ Phone# ______________________