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TO: Arkansas Medicaid Health Care Providers – Prosthetics

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EFFECTIVE DATE: May 1, 2017

SUBJECT: Provider Manual Update Transmittal PROSTHETICS

BUREAU OF
LEGISLATIVE RESEARCH

REMOVE

Section	Effective Date
242.191	5-31-15
242.192	12-1-12
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INSERT

Section	Effective Date
242.191	5-1-17
242.192	5-1-17
242.194	5-1-17
242.195	5-1-17

Explanation of Updates

Section 242.191 has been updated to provide an overview on documentation required when submitting claims for wheelchairs and wheelchair seating systems for individuals ages two through adult. Included are instructions on completing the new form, Evaluation for Wheelchair and Wheelchair Seating (DMS-0843).

Section 242.192 has been updated to change some of the procedure code payment methods from "Purchase" to "Manually Priced."

Section 242.194, Replacement, Growth and Modification of Specialized Wheelchairs and Wheelchair Seating Systems, has been added.

Section 242.195, Repairs of Specialized Wheelchairs and Wheelchair Seating Systems, has been added.

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 Hewlett Packard Enterprise 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 the Program Development and Quality Assurance Unit at (501) 320-6429.

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

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Thank you for your participation in the Arkansas Medicaid Program.


Dawn Stehle
Director

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*TOC required***242.191 Wheelchairs and Wheelchair Seating Systems for Individuals Ages Two Through Adult**

5-1-17

Arkansas Medicaid covers wheelchairs and wheelchair seating systems for individuals ages two through adult.

For any item to be covered by Arkansas Medicaid, the beneficiary must be eligible for a defined Medicaid Aid Category. Coverage is subject to the requirement that the equipment must be medically necessary for the diagnosis or treatment of an illness or injury to improve the functioning of an affected body part, and must meet all other Medicaid statutory and regulatory requirements and established criteria.

The beneficiary's diagnosis must warrant the type of equipment being purchased. Items may not be covered in every instance.

Providers are cautioned that an approved prior authorization does not guarantee payment. Reimbursement is contingent upon eligibility of both the beneficiary and the provider at the time service is provided and submission of an accurate and complete request. The DME provider is responsible for verifying the eligibility of the beneficiary at the time service is provided.

Specialized wheelchairs and wheelchair seating systems must be ordered by a physician.

When a request is submitted for a power wheelchair, Power-Operated Vehicle (POV) or specialized manual wheelchair, the following Medicaid requirements must be met:

- A. A Prescription & Prior Authorization Request for Medical Equipment form (DMS-679) must be completed and submitted. This form must not be altered by the provider. **View or print form DMS-679 and instructions for completion.**
- B. The DMS-679 must be signed and dated by the beneficiary's PCP or the ordering physician. The signature must be original. Stamp signatures are not acceptable. Medicaid will accept electronic signatures provided the electronic signatures comply with Arkansas Code § 25-31-103 et seq.
- C. Correct Medicaid procedure codes and modifiers must be utilized. Requested items will be denied if correct procedures codes and modifiers are not used.
- D. All requests for prior authorization must be legible (felt pens must not be used).
- E. Medicaid requires the submission of the original request.
- F. Medical documentation from the beneficiary's PCP or ordering physician which included a detailed face-to-face medical examination must be submitted to establish medical necessity.
- G. An Evaluation for Wheelchair and Wheelchair Seating form (DMS-0843) must be submitted. This evaluation will be completed in three parts:
 1. Part A—to be completed by the DME provider.
 2. Part B—to be completed by the assistive technology practitioner or can be completed by a physical therapist or occupational therapist or seating specialist for Group 1 (one) and Group 2 (two) power wheelchairs with no power options.
 3. Part C—to be completed by the beneficiary's PCP or the ordering physician.
 4. An Evaluation for Wheelchair and Wheelchair Seating form (DMS-0843) must be completed for all specialized wheelchairs except for rental wheelchairs. **View or print form DMS-0843 and instructions for completion.**

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- H. A manufacturer's order form documenting the suggested retail price for the brand and model wheelchair and accessories and a manufacturer's quote must be submitted with the DMS-679.
- I. A DMS-693, Early and Periodic Screening, Diagnosis and Treatment (EPSDT) form, must be submitted for all pediatric wheelchairs and include detailed PCP medical documentation that clearly demonstrates medical necessity and clearly identifies the medical condition and the specific equipment that will meet the beneficiary's medical needs. Form DMS-693 and the supporting documentation must be submitted as an attachment to the request for prior authorization. It will then be reviewed for medical necessity. **View or print form DMS-693.**
- J. If requirements A through I are not completed correctly, the request could be denied.
- K. Arkansas Medicaid requires a Durable Medical Equipment (DME) provider to employ a RESNA (Rehabilitation Engineering and Assistive Technology Society of North America) certified ATP (Assistive Technology Practitioner) who specializes in wheelchair seating. The ATP will provide direct in-person recommendations for evaluation of the beneficiary's wheelchair selection, and is employed by the supplier. This applies for specialized manual wheelchair and power wheelchair in the category of Group 2 (single power option) and above.

The ATP's involvement in the wheelchair selection must be documented. Documentation of the ATP's involvement does not qualify as a face-to-face examination and may not be cosigned by a physician.

Procedure codes found in this section must be billed either electronically or on paper with modifier **EP** for beneficiaries under 21 years of age or modifier **NU** for beneficiaries age 21 and older. When a second modifier is listed, that modifier must be used in conjunction with either **EP** or **NU**.

Modifiers in this section are indicated by the headings M1 and M2. Prior authorization requirements are shown under the heading PA. If prior authorization is needed, that information is indicated with a "Y" in the column; if not, an "N" is shown.

Other coding information found in the chart:

- ¹ **The purchase of this component for beneficiaries age 21 and older is limited to one per five-year period.**
- ² **The purchase of this wheelchair component for beneficiaries under age 21 is limited to one per two-year period.**
- * **The purchase of wheelchairs for beneficiaries age 21 and older is limited to one per five-year period.**
- ** **Bill only for beneficiaries under age 21.**
- # **This procedure code is payable for beneficiaries ages 2 through 20. Prior authorization is required through Utilization Review.**
- **** **Items listed require prior authorization (PA) when used in combination with other items listed and the total combined value exceeds the \$1,000.00 Medicaid maximum allowable reimbursement limit.**
- ◆ **Prior authorization is not required when other insurance pays at least 50% of the Medicaid maximum allowable reimbursement amount.**

Note: W/C or w/c indicates wheelchair.

***(...)** This symbol, along with text in parentheses, indicates the Arkansas Medicaid description of the product. When using a procedure code with this symbol, the product must meet the indicated Arkansas Medicaid description.

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**Wheelchairs and Wheelchair Seating Systems for Individuals Ages Two Through Adult
(Section 242.191)**

Procedure Code	M1	M2	Description	PA	Payment Method
E0700	NU EP	U1 U1	Safety equipment, e.g., belt, harness or vest	N****	Purchase
E0700	NU EP	U2 U2	*(Travel restraint auto safe harness, E-Z on vest, no known comparable product) Safety equipment, e.g., belt, harness or vest	N****	Purchase
E0950	NU EP		*(Tray for W/C) W/C accessory, tray, each	Y	Purchase
E0950	NU EP	U2 U2	*(ABS tray, 4-SM 5-LG) W/C accessory, tray, each	Y	Purchase
E0950	NU EP	U3 U3	*(W/C Tray, Custom) W/C accessory, tray, each	Y	Purchase
E0950	NU EP	U4 U4	*(Tray, customized) W/C accessory, tray, each	N	Purchase
E0950	NU EP	U5 U5	*(Clear upper Ex support system) W/C accessory, tray, each	Y	Purchase
E0950	NU EP	U6 U6	*(Lap Tray Switch Array) Wheelchair accessory, tray, each	Y	Purchase
E0950	NU EP	U7 U7	Wheelchair accessory, tray, each	Y	Purchase
E0950	NU EP UE	U7 U7	*(Removable Hinged Overlay for Tray) W/C accessory, tray, each	Y****	Purchase
E0950	NU EP	U8 U8	*(Lap Tray for Switch Array) Wheelchair accessory, tray, each	Y	Purchase
E0951	NU EP		Heel loop/holder, with or without ankle strap, each	N****	Purchase
E0952	NU EP		Toe loop/holder, each	N****	Purchase
E0955	NU EP		Wheelchair accessory, headrest, cushioned, any type, including fixed mounting hardware, each	N	Purchase
E0956	NU EP		*(Trunk supports for any W/C, other than travel, with hardware) Wheelchair accessory, lateral trunk or hip support, any type, including fixed mounting hardware, each	N****	Purchase
E0956	NU EP	U1 U1	*(Lateral trunk supports, swing-away, each) Wheelchair accessory, lateral trunk or hip support, any type, including fixed mounting hardware, each	N****	Purchase

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**Wheelchairs and Wheelchair Seating Systems for Individuals Ages Two Through Adult
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Procedure Code	M1	M2	Description	PA	Payment Method
E0956	NU EP	U2 U2	*(Med. Chest Panel Support) Wheelchair accessory, lateral trunk or hip support, any type, including fixed mounting hardware, each	N****	Purchase
E0956	NU EP	U3 U3	*(Chest/Thoracic Supports) Wheelchair accessory, lateral trunk or hip support, any type, including fixed mounting hardware, each	N****	Purchase
E0957	NU EP		Wheelchair accessory, medial thigh support, (*-flip-up) any type, including fixed mounting hardware, each	N	Purchase
E0958	NU EP		Manual W/C accessory, one-arm drive attachment, each	N****	Purchase
E0959	NU EP		*(Amputee adapters for conventional chair, ea.) Manual W/C accessory, adapter for amputee, each	N****	Purchase
E0959	NU EP		*(Amputee axle plate for high performance manual W/C, ea.) Manual wheelchair accessory, adapter for amputee, each	N****	Purchase
E0959	NU EP	U1 U1	Manual W/C accessory, adapter for amputee, each	N	Purchase
E0960	NU EP		W/C accessory, shoulder harness/straps or chest strap including any type mounting hardware	N	Purchase
E0961	NU EP		Manual W/C accessory, wheel lock brake extension (handle), each	N****	Purchase
E0966	NU EP		Manual wheelchair accessory, headrest extension, each	N****	Purchase
E0967	NU EP		*(Hand rim, any type) Manual W/C accessory, hand rim w/projections, any type, replacement only, each	N****	Purchase
E0967	NU EP	U1 U1	*(Hand rim, any type) Manual W/C accessory, hand rim w/projections, any type, replacement only, each	N****	Purchase
E0967	NU EP	U2 U2	*(Hand rim, any type) Manual W/C accessory, hand rim w/projections, any type, replacement only, each	N****	Purchase
E0967	NU EP	U3 U3	*(Hand rim, any type) Manual W/C accessory, hand rim w/projections, any type, replacement only, each	N****	Purchase
E0967	NU EP	U4 U4	*(Hand rim, any type) Manual W/C accessory, hand rim w/projections, any type, replacement only, each	N****	Purchase

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**Wheelchairs and Wheelchair Seating Systems for Individuals Ages Two Through Adult
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Procedure Code	M1	M2	Description	PA	Payment Method
E0970	NU EP		No. 2 footplates, except for elevating leg rest	N****	Purchase
E0971	NU EP		Anti-tipping device W/C	N****	Purchase
E0973	NU EP		W/C accessory, adjustable height, detachable armrest, complete assembly, each	N****	Purchase
E0973	NU EP	U1 U1	**(Height Adj. Arms, replacement) W/C accessory, adjustable height, detachable armrest, complete assembly, each	N****	Purchase
E0974	NU EP		Manual wheelchair accessory, anti-rollback device (** grade aids), each	N****	Purchase
E0978	NU EP		Wheelchair accessory, positioning belt/safety belt/pelvic strap, each	N****	Purchase
E0978	NU EP	U1 U1	*(Belt, safety or chest, w/pad) Wheelchair accessory, positioning belt/safety belt/ pelvic strap, each	N**** N	Purchase
E0978	NU EP	U2 U2	Wheelchair accessory, positioning belt/safety belt/pelvic strap, each	N****	Purchase
E0980	NU EP		*(Chest panel, 21-SM 22-LG) Safety vest, wheelchair	N****	Purchase
E0980	NU EP	U1 U1	*(Shoulder retractors) Safety vest, W/C	N****	Purchase
E0981	NU EP		W/C accessory, seat upholstery, replacement only, each	N	Purchase
E0982	NU EP		W/C accessory, back upholstery, replacement only, each	N****	Purchase
E0982	NU EP	U1 U1	*(Standard back upholstery replacement) W/C accessory, back upholstery, replacement only, each	N****	Purchase
E0990	NU EP		*(Elevating foot, legrest) W/C accessory, elevating legrest, complete assembly, each	N****	Purchase
E0990	NU EP	U1 U1	*(Elevating legrest 90 Degree, 12" - 16" Width) W/C accessory, elevating legrest, complete assembly, each	N****	Purchase
E0992	NU EP		*(Manual wheelchair accessory, solid seat)	N****	Purchase
E0992	NU EP	U1 U1	*(Manual w/c accessory, solid seat insert (Large adjustable solid seat w/hardware)	N****	Purchase
E0992	NU EP	U2 U2	*(Foam and Plywood Flat Side Manual wheelchair accessory, solid seat)	N****	Purchase

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**Wheelchairs and Wheelchair Seating Systems for Individuals Ages Two Through Adult
(Section 242.191)**

Procedure Code	M1	M2	Description	PA	Payment Method
E0992	NU EP	U3 U3	*(Foam & Plywood Seat, MPI Like Manual wheelchair accessory, solid seat)	N****	Purchase
E0992	NU EP	U4 U4	*(Adjustable solid standard seat with hardware Manual wheelchair accessory, solid seat)	N****	Purchase
E0994	NU EP		Armrest, each	N****	Purchase
E1002	NU EP		W/C accessory power seating system, tilt only	Y♦	Purchase
E1004	NU EP		W/C accessory, power seating system, recline only, with mechanical shear reduction	Y♦	Purchase
E1006	NU EP		W/C accessory, power seating system, combination tilt and recline, w/o shear reduction	Y	Purchase
E1007	NU EP		Wheelchair accessory, power seating system, combination tilt and recline, with mechanical shear reduction	Y	Purchase
E1010	NU EP		W/C accessory, addition to power seating system, power leg elevation system, including legrest, each	Y	Purchase
E1020	NU EP		*(Adjustable Contour Lateral Thigh Support) Residual limb support system for W/C	N****	Purchase
E1028	NU EP		Wheelchair accessory, manual swing- away, retractable or removable mounting hardware for joystick, other control interface or positioning accessory	N	Purchase
E1029	NU EP		*(Ventilator Tray With Battery Tray) Wheelchair accessory, ventilator tray, fixed	Y	Purchase
E1030	NU EP		Wheelchair accessory, ventilator tray, gimbaled	Y	Purchase
E1050*	NU EP		Full reclining W/C, fixed full-length arms, swing-away, detachable elevating legrests	N****	Purchase
E1060*	NU EP		Full reclining W/C, detachable arms, desk or full-length, swing-away detachable, elevating legrests	Y♦	Purchase
E1070 [#]	EP		*(A maximum use of three months only) Fully-reclining wheelchair, detachable arms, (desk or full-length) swing-away, detachable footrest/elevated legrests	Y	Rental only

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**Wheelchairs and Wheelchair Seating Systems for Individuals Ages Two Through Adult
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Procedure Code	M1	M2	Description	PA	Payment Method
E1084*	NU EP		Hemi-W/C; detachable arms, desk or full-length, swing-away, detachable, elevating legrests	N****	Purchase
E1086*	NU EP		Hemi W/C; detachable arms, desk or full-length, swing-away, detachable footrests	N****	Purchase
E1086*	NU EP	U1 U1	Hemi W/C, detachable arms, desk or full-length, swing-away detachable footrests	Y	Purchase
E1088*	NU EP		High strength lightweight W/C; detachable arms, desk or full-length, swing-away, detachable, elevating legrests	Y♦	Purchase
E1090	NU EP		High-strength lightweight W/C; detachable arms, desk or full-length, swing-away, detachable footrests	N****	Purchase
E1092*	NU EP		Wide, heavy-duty W/C; detachable arms, desk or full-length, swing-away, detachable, elevating legrests	Y♦	Purchase
E1093*	NU EP		Wide, heavy-duty W/C; detachable arms, desk or full-length arms, swing-away, detachable footrests	Y♦	Purchase
E1110*	NU EP		Semi-reclining W/C; detachable arms, desk or full-length, elevating legrests	Y♦	Purchase
E1161	NU EP		Manual adult size W/C, includes tilt in space	Y♦	Purchase
E1170*	NU EP		Amputee W/C; fixed full-length arms, swing-away, detachable, elevating legrests	N****	Purchase
E1172*	NU EP		Amputee W/C; detachable arms, desk or full-length, without footrests or legrests	Y♦	Purchase
E1180*	NU EP		Amputee W/C; detachable arms, desk or full-length, swing-away, detachable footrests	Y♦	Purchase
E1200*	NU EP		Amputee W/C; fixed full-length arms, swing-away, detachable footrests	N****	Purchase
E1220*	NU EP		W/C, specially sized or constructed (indicate brand name, model number, if any, and justification)	Y	Manually Priced
E1225	NU EP		**(Folding Backrest, 8 Degree Bend, Low, 15" - 16") Manual W/C accessory, semi-reclining back, (recline greater than 15 degrees, but less than 80 degrees), each	N****	Purchase
E1228	NU EP		**(Folding Backrest, Tall, 19" - 20") Special back height for W/C	N****	Purchase

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**Wheelchairs and Wheelchair Seating Systems for Individuals Ages Two Through Adult
(Section 242.191)**

Procedure Code	M1	M2	Description	PA	Payment Method
E1228	NU EP		⌘(Folding Straight Backrest, Low, (15" - 16") Special back height for W/C	N****	Purchase
E1228	NU EP		⌘(Folding Straight Backrest, Tall, 19" - 20") Special back height for W/C	N****	Purchase
E1228	NU EP	U1 U1	⌘(High back contour seat) Special back height for W/C	N****	Purchase
E1228	NU EP	U2 U2	⌘(Positioning tall back) Special back height for W/C	N****	Purchase
E1230*	NU EP		Power operated vehicle (three- or four-wheel nonhighway), specify brand name and model number	Y♦	Purchase
E1230	EP NU	U1 U1	Power operated vehicle (three- or four-wheel nonhighway), specify brand name and model number	Y♦	Purchase
E1232*	EP		W/C, pediatric size, tilt-in-space, folding, adjustable, with seating system	Y♦	Purchase
E1233*	EP		W/C, pediatric size, tilt-in-space, rigid, adjustable, without seating system	Y♦	Purchase
E1234*	EP		W/C, pediatric size, tilt-in-space, folding, adjustable, without seating system	Y♦	Purchase
E1235*	NU EP		Wheelchair, pediatric size, rigid, adjustable, with seating system	Y♦	Purchase
E1235 ²	EP	U1	⌘(Rigid W/C Frame) W/C, pediatric size, rigid, adjustable with seating system	Y	Purchase
E1236	EP		Wheelchair, pediatric size, folding, adjustable, with seating system	Y	Purchase
E1237*	EP		W/C, pediatric size, rigid, adjustable, without seating system	Y♦	Purchase
E1238*	EP		W/C, pediatric size, folding, adjustable, without seating system	Y♦	Purchase
E1240*	NU EP		Lightweight W/C; detachable arms, desk or full-length, swing-away, detachable, elevating legrests	Y♦	Purchase
E1260*	NU EP		Lightweight W/C; detachable arms, desk or full-length, swing-away, detachable footrests	N****	Purchase
E1280*	NU EP		Heavy-duty W/C; detachable arms, desk or full-length, elevating legrests	Y♦	Purchase
E1290*	NU EP		Heavy-duty W/C; detachable arms, swing-away, detachable footrests	Y♦	Purchase

**Wheelchairs and Wheelchair Seating Systems for Individuals Ages Two Through Adult
(Section 242.191)**

Procedure Code	M1	M2	Description	PA	Payment Method
E2201	NU EP		**(Seat Width 20") Manual w/c accessory, nonstandard seat frame width > than or equal to 20 inches and < 24 inches	N****	Purchase
E2201	NU EP	U1 U1	**(Frame Width 14"-15") Manual w/c accessory, nonstandard seat frame width > than or equal to 20 inches and < 24 inches	N****	Purchase
E2201	NU EP	U2 U2	**(Frame Width 19"-20") Manual w/c accessory, nonstandard seat frame width > than or equal to 20 inches and < 24 inches	N****	Purchase
E2201	NU EP	U3 U3	Manual w/c accessory, nonstandard seat frame width > than or equal to 20 inches and < 24 inches	N****	Manually Priced
E2203	NU EP		**(Seat Depth 15") Manual w/c accessory, nonstandard seat frame depth, 20 to less than 22 inches	N****	Purchase
E2203	NU EP	U1 U1	**(Seat Depth 17" - 18") Manual w/c accessory, nonstandard seat frame depth, 20 to less than 22 inches	N****	Purchase
E2203	NU EP	U2 U2	**(Frame, Long; 16", 17"3, 18", 19"3, 20" Depth) Manual w/c accessory, nonstandard seat frame depth, 20 to less than 22 inches	N****	Purchase
E2203	NU EP	U3 U3	**(Seat Depth 19" - 20") Manual w/c accessory, nonstandard seat frame depth, 20 to less than 22 inches	N****	Purchase
E2203	NU EP	U4 U4	Manual w/c accessory, nonstandard seat frame depth, 20 to less than 22 inches	N	Manually Priced
E2206	NU EP		Manual wheelchair accessory, wheel lock assembly, complete, each	N	Purchase
E2207	NU EP		Wheelchair accessory, crutch and cane holder, each	N****	Purchase
E2208	NU EP		Wheelchair accessory, cylinder tank carrier, each	N	Purchase
E2209	NU EP		Wheelchair accessory, arm trough, each	N	Purchase
E2210	NU EP		Wheelchair accessory, bearings, any type, replacement only, each	N	Purchase
E2211	NU EP		Manual wheelchair accessory, pneumatic propulsion tire, any size, each	N	Purchase
E2212	NU EP		Manual wheelchair accessory, tube for pneumatic propulsion tire, any size, each	N	Purchase

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**Wheelchairs and Wheelchair Seating Systems for Individuals Ages Two Through Adult
(Section 242.191)**

Procedure Code	M1	M2	Description	PA	Payment Method
E2213	NU EP		Manual wheelchair accessory, insert for pneumatic propulsion tire (removable), any type, any size, each	N	Purchase
E2214	NU EP		Manual wheelchair accessory, pneumatic caster tire, any size, each	N	Purchase
E2215	NU EP		Manual wheelchair accessory, tube for pneumatic caster tire, any size, each	N	Purchase
E2220	NU EP		Manual wheelchair accessory, solid (rubber/plastic) propulsion tire, any size, each	N	Purchase
E2221	NU EP		Manual wheelchair accessory, solid (rubber/plastic) caster tire (removable), any size, each	N	Purchase
E2226	NU EP		Manual wheelchair accessory, caster fork, any size, replacement only, each	N	Purchase
E2231	NU EP		Manual wheelchair accessory, solid seat support base (replaces sling seat), includes any type mounting hardware	Y	Purchase
E2291	EP		Back, planar, for pediatric-size wheelchair, including fixed attaching hardware	N	Manually Priced
E2292	EP		Seat, planar, for pediatric-size wheelchair, including fixed attaching hardware	N	Manually Priced
E2293	EP		Back, contoured, for pediatric-size wheelchair, including fixed attaching hardware	N	Manually Priced
E2294	EP		Seat, contoured, for pediatric-size wheelchair, including fixed attaching hardware	N	Manually Priced
E2295	EP		Manual wheelchair accessory, for pediatric size wheelchair, dynamic seating frame, allows coordinated movement of multiple positioning features	Y	Manually Priced
E2310	NU EP		Power w/c accessory, electronic connection between wheelchair controller and one power seating system motor, including all related electronics, indicator feature, mechanical function selection switch, and fixed mounting hardware	Y	Purchase

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**Wheelchairs and Wheelchair Seating Systems for Individuals Ages Two Through Adult
(Section 242.191)**

Procedure Code	M1	M2	Description	PA	Payment Method
E2311	NU EP		Power w/c accessory, electronic connection between wheelchair controller and two or more power seating system motors, including all related electronics, indicator feature, mechanical function selection switch, and fixed mounting hardware	Y	Purchase
E2322	NU EP		Power w/c accessory, hand control interface, multiple mechanical switches, nonproportional, including all related electronics, mechanical stop switch, and fixed mounting hardware	Y	Purchase
E2323	NU EP		Power w/c accessory, specialty joystick handle for hand control interface, prefabricated	Y	Purchase
E2324	NU EP		Power w/c accessory, chin cup for chin control interface	Y	Purchase
E2325	NU EP		Power w/c accessory, sip & puff interface nonproportional, including all related electronics, mechanical stop switch, and manual swing-away mounting hardware	Y	Purchase
E2326	NU EP		Power wheelchair accessory, breath tube kit for sip and puff interface * (replacement only)	Y	Purchase
E2327	NU EP		Power w/c accessory, head control interface, mechanical, proportional, including all related electronics, mechanical direction change switch, and fixed mounting hardware	Y	Purchase
E2359	NU EP		Power w/c accessory, group 34 sealed lead acid battery, each	N	Purchase
E2360	NU EP		Power w/c accessory, 22 NF non-sealed lead acid battery, each	N	Purchase
E2361	NU EP		Power w/c accessory, 22 NF sealed lead acid battery, each, (e.g., gel cell, absorbed glassmat)	N	Purchase
E2363	NU EP		Power w/c accessory, group 24 sealed lead acid battery, each (e.g., gel cell, absorbed glassmat)	N	Purchase
E2363	NU EP	U1 U1	Power w/c accessory, group 24 sealed lead acid battery, each (e.g., gel cell, absorbed glassmat)	N	Purchase
E2365	NU EP		* (U-1 gel cell battery, each) Power wheelchair accessory, U-1 sealed lead acid battery, each, (e.g., gel cell, absorbed glassmat)	N	Purchase

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**Wheelchairs and Wheelchair Seating Systems for Individuals Ages Two Through Adult
(Section 242.191)**

Procedure Code	M1	M2	Description	PA	Payment Method
E2365	NU EP	U1 U1	Power w/c accessory, U-1 sealed lead acid battery, each, gel cell	N	Purchase
E2366	NU EP		**(24-Volt Battery Charger - Standard, Replacement) Power w/c accessory, battery charger, single mode, for use with only one battery type, sealed or non-sealed, each	N	Purchase
E2367	NU EP		**(24-Volt Battery Charger - Dual Mode, Replacement) Power w/c accessory, battery charger, dual mode, sealed or non-sealed, each	N	Purchase
E2368	NU EP		Power wheelchair component, motor, replacement only	N	Purchase
E2369	NU EP		Power wheelchair component, gear box, replacement only	N	Purchase
E2370	NU EP		Power wheelchair component, motor and gear box combination, replacement only	Y	Purchase
E2372	NU EP		Power wheelchair accessory, group 27 non-sealed lead acid battery, each	Y	Purchase
E2373	NU EP		Power wheelchair accessory, hand or chin control interface, mini-proportional, compact, or short throw remote joystick or touchpad, proportional, including all related electronics and fixing mounting hardware.	Y	Purchase
E2375	NU EP		Power wheelchair accessory, nonexpandable controller, including all related electronics and mounting hardware, replacement only	Y	Purchase
E2376	NU EP		Power wheelchair accessory, expandable controller, including all related electronics and mounting hardware, replacement only	Y	Purchase
E2377	NU EP		Power wheelchair accessory, expandable controller, including all related electronics and mounting hardware, upgrade provided at initial issue	Y	Purchase
E2378	NU EP		Power wheelchair component, actuator, replacement only	Y	Purchase
E2381	NU EP		Power wheelchair accessory, pneumatic drive wheel tire, any size, replacement only, each	Y	Purchase
E2382	NU EP		Power wheelchair accessory, tube for pneumatic drive wheel tire, any size, replacement only, each	Y	Purchase

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**Wheelchairs and Wheelchair Seating Systems for Individuals Ages Two Through Adult
(Section 242.191)**

Procedure Code	M1	M2	Description	PA	Payment Method
E2383	NU EP		Power wheelchair accessory, insert for pneumatic drive wheel tire (removable), any type, any size, replacement only, each	Y	Purchase
E2384	NU EP		Power wheelchair accessory, pneumatic caster tire, any size, replacement only, each	Y	Purchase
E2385	NU EP		Power wheelchair accessory, tube for pneumatic caster tire, any size, replacement only, each	Y	Purchase
E2386	NU EP		Power wheelchair accessory, foam filled drive wheel tire, any size, replacement only, each	Y	Purchase
E2387	NU EP		Power wheelchair accessory, foam caster tire, any size, replacement only, each	Y	Purchase
E2601	NU EP UE		General use wheelchair seat cushion, width less than 22 in., any depth	N****	Purchase
E2602	NU EP UE		General use wheelchair seat cushion, width 22 in. or greater, any depth	N	Purchase
E2611	NU EP UE		General use wheelchair back cushion, width less than 22 in., any height, including any type mounting hardware	N	Purchase
E2612	NU EP UE		General use wheelchair back cushion, width 22 in. or greater, any height, including any type mounting hardware	N	Purchase
E2619	NU EP		Replacement cover for wheelchair seat cushion or back cushion, each	N	Purchase
E2622	NU EP UE		Skin protection wheelchair seat cushion, adjustable, width less than 22 inches, any depth	N	Purchase
E2623	NU EP UE		Skin protection wheelchair seat cushion, adjustable, width 22 inches or greater, any depth	N	Purchase
E2624	NU EP UE		Skin protection and positioning wheelchair seat cushion, adjustable width less than 22 inches, any depth	N	Purchase
E2625	NU EP UE		Skin protection and positioning wheelchair seat cushion, adjustable width 22 inches or greater, any depth	N	Purchase
E2626	NU EP		Wheelchair accessory, shoulder elbow, mobile arm support attached to wheelchair, balanced, adjustable	Y	Purchase

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**Wheelchairs and Wheelchair Seating Systems for Individuals Ages Two Through Adult
(Section 242.191)**

Procedure Code	M1	M2	Description	PA	Payment Method
E2627	NU EP		Wheelchair accessory, shoulder elbow, mobile arm support attached to wheelchair, balanced, adjustable Rancho type	Y	Purchase
E2628	NU EP		Wheelchair accessory, shoulder elbow, mobile arm support attached to wheelchair, balanced, reclining	Y	Purchase
E2629	NU EP		Wheelchair accessory, shoulder elbow, mobile arm support attached to wheelchair, balanced, friction arm support (friction dampening to proximal and distal joints)	Y	Purchase
E2630	NU EP		Wheelchair accessory, shoulder elbow, mobile arm support, monosuspension arm and hand support, overhead elbow forearm hand sling support, yoke type suspension support	Y	Purchase
E2631	NU EP		Wheelchair accessory, addition to mobile arm support, elevating proximal arm	Y	Purchase
E2632	NU EP		Wheelchair accessory, addition to mobile arm support, offset or lateral rocker arm with elastic balance control	Y	Purchase
E2633	NU EP		Wheelchair accessory, addition to mobile arm support, supinator	Y	Purchase
K0004	NU EP		High-strength lightweight wheelchair	Y****	Purchase
K0005*	NU EP		**(High-performance manual W/C-adult) Ultralightweight W/C	Y♦	Purchase
K0005*	NU EP	U1 U1	**(High-performance manual W/C with growth adjustability-child) Ultralightweight W/C	Y♦	Purchase
K0010	NU EP		**(Motorized, standard frame, DA, swing-away footrests) Standard weight frame motorized/power W/C	Y♦	Purchase
K0010	NU EP	U1 U1	**(Motorized, standard frame, DA, swing-away ELR) Standard weight frame motorized/power W/C	Y♦	Purchase
K0011	NU EP		**(Motorized, power base or conventional frame w/c DA/swing-away footrests, programmable electronics and custom options) Standard-weight frame motorized/power, W/C with programmable control parameters for speed adjustment, tremor dampening, acceleration control and braking	Y♦	Purchase

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**Wheelchairs and Wheelchair Seating Systems for Individuals Ages Two Through Adult
(Section 242.191)**

Procedure Code	M1	M2	Description	PA	Payment Method
K0011	NU EP	U1 U1	*(Motorized, power base or conventional frame w/c DA/swing-away footrests, programmable electronics and custom options) Standard-weight frame motorized/power, W/C with programmable control parameters for speed adjustment, tremor dampening, acceleration control and braking	Y♦	Purchase
K0012	NU EP		*(Motorized folding frame, DA, swing-away footrests) Lightweight portable motorized/power W/C	Y♦	Purchase
K0012	NU EP	U1 U1	*(Motorized folding frame, DA, swing-away ELR) Lightweight portable motorized/power W/C	Y♦	Purchase
K0014 ^{1,2}	NU EP		Other motorized/power W/C base	Y♦	Purchase
K0014 ^{1,2}	NU EP	U1 U1	*(Center Drive power base) Other motorized/ power W/C base	Y♦	Purchase
K0014 ^{1,2}	NU EP	U3 U3	*(Motorized, Power Base or conventional frame W/C DA/swing-away foot rests, programmable electronics and custom options) Other motorized/power W/C base	Y♦	Purchase
K0014 ^{1,2}	NU EP	U4 U4	*(Motorized, Power Base or conventional frame W/C DA/swing-away elevated foot rests, programmable electronics and custom options) Other motorized/power W/C base	Y♦	Purchase
K0017	NU EP		*(Receiver for height adjustable arms) Detachable, adjustable height armrest, base, each	N****	Purchase
K0017	NU EP	U1 U1	*(Dual post and adjustable height DA) Detachable, adjustable height armrest, base, each	N****	Purchase
K0019	NU EP		Arm pad, each	N	Purchase
K0020	NU EP		Fixed, adjustable height armrest, pair	N****	Purchase
K0038**	EP	U1	*(Knee strap) Leg strap, each	N	Purchase
K0038	NU EP		*(Single leg strap, each) Leg strap, each	N****	Purchase
K0038	NU EP	U2 U2	*(Foot straps, pair) Leg strap, each	N****	Purchase

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**Wheelchairs and Wheelchair Seating Systems for Individuals Ages Two Through Adult
(Section 242.191)**

Procedure Code	M1	M2	Description	PA	Payment Method
K0039	NU EP		Leg strap, H style, each *	N****	Purchase
K0040	NU EP		Adjustable angle footplate, each	N****	Purchase
K0043	NU EP		*(SWFR, replacement) Footrest, lower extension tube, each	N	Purchase
K0044	NU EP		*(SWFR Hanger bracket, replacement) Footrest, upper hanger bracket, each	N****	Purchase
K0045	NU EP		*(Padded custom foot box) Footrest, complete assembly	N****	Purchase
K0047	NU EP		Elevating legrest, upper hanger bracket, each	N****	Purchase
K0056	NU EP		Seat height less than 17 inches or equal to or greater than 21 inches for a high-strength, lightweight, or ultralightweight W/C	N****	Manually Priced
K0056	NU EP	U1 U1	*(Seat height 19.5"5) Seat height less than 17 inches or equal to or greater than 21 inches for a high strength, lightweight or ultralightweight W/C	N****	Purchase
K0065	NU EP		Spoke protectors, each	N****	Purchase
K0070	NU EP		*(Wheel assembly, complete with pneumatic tires, 20"/22"/24"/26"/ea. replacement) Rear wheel assembly, complete with pneumatic tire, spokes or molded, each	N****	Purchase
K0071	NU EP	U1 U1	*(Wheel assembly with pneumatic tires, 22", pair, rear wheels) Front caster assembly, complete, with pneumatic tire, each	N****	Purchase
K0071	NU EP		*(Polyurethane casters, 5", pair, front casters) Front caster assembly, complete, with pneumatic tire, each	N****	Purchase
K0072	NU EP		*(Polyurethane casters, 5", pair, front casters) Front caster assembly, complete, with semipneumatic tire, each	N****	Purchase
K0073	NU EP		Caster pin lock, each	N****	Purchase
K0077	NU EP		Front caster assembly, complete, with solid tire, each	N	Purchase

**Wheelchairs and Wheelchair Seating Systems for Individuals Ages Two Through Adult
(Section 242.191)**

Procedure Code	M1	M2	Description	PA	Payment Method
K0108	NU EP		** (W/C miscellaneous equipment; applicable pages from the manufacturer's catalog must be attached to the claim form.) Other accessories	N****	Manually Priced
K0739	NU EP	U1 U1	*(Labor only, Repair or non-routine service for durable medical equipment requiring the skill of a technician, labor component, per 15 minutes. A maximum of twenty units per date of service is allowable, 20 units = 5 hours of labor)	Y	Purchase
S1002	EP		*(Wheelchair, custom molded seating system only) Customized item, list in addition to code for basic item	N****	Manually Priced
S1002	NU EP	U1 U1	*(Foam-in-place seat, Pindot quick foam contour system) Customized item, list in addition to code for basic item	N****	Purchase

The following procedure codes may be billed only on paper.

**Wheelchairs and Wheelchair Seating Systems for Individuals Ages Two Through Adult
(Section 242.191)**

No National Code	M1	M2	Local Code	Description	PA	Payment Method
Bill on paper	NU EP		Z1613	One-piece footboard (each)	N****	Purchase
Bill on paper	NU EP		Z1793	Custom foot platform	N****	Purchase
Bill on paper	EP		Z1824**	PC Car Seat/Snug Seat	Y	Purchase
Bill on paper	NU EP		Z2137	Adjustable Rem. Abductor w/hardware (ea)	N****	Purchase
Bill on paper	NU EP		Z2138	Adjustable Flip Down Abductor w/hardware (ea)	N****	Purchase
Bill on paper	NU EP		Z2139	Lateral Hip/Thigh support w/hardware (ea)	N****	Purchase
Bill on paper	NU EP		Z2140	Adductor - no hardware	N****	Purchase
Bill on paper	NU EP		Z2141	Abductor - no hardware	N****	Purchase

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The following procedure codes may be billed only on paper.

**Wheelchairs and Wheelchair Seating Systems for Individuals Ages Two Through Adult
(Section 242.191)**

No National Code	M1	M2	Local Code	Description	PA	Payment Method
Bill on paper	NU EP		Z2142	Hip guides - no hardware	N	Purchase
Bill on paper	NU EP		Z2143	Fluid supplement	N	Purchase
Bill on paper	NU EP		Z2145	Laterals - no hardware	N****	Purchase
Bill on paper	NU		Z2158	Air Exchange Seat Cover for Cushions (Replacement)	N	Purchase
Bill on paper	NU EP		Z2159	Fluid Flo-lite pad (Replacement)	N	Purchase
Bill on paper	NU EP		Z2175	Power W/C Sleeve Top or Bottom Stem Bearing (Replacement)	N****	Purchase
Bill on paper	NU EP		Z2178	SWFR Pivot Saddle (Replacement)	N	Purchase
Bill on paper	NU EP		Z2180	SWFR Latch Block (Replacement)	N	Purchase
Bill on paper	NU EP		Z2181	SWFR Composite Foot Plate (Replacement)	N****	Purchase
Bill on paper	NU EP		Z2183	Shoe Holders S/M/L/XL	N****	Purchase
Bill on paper	NU EP		Z2184	X-Tube Assembly Folding W/C (Replacement)	N****	Purchase
Bill on paper	NU EP		Z2185	Rigid Wheelchair Growth Kit	N	Purchase
Bill on paper	NU EP		Z2186	Rigid Side Guard	N****	Purchase
Bill on paper	NU EP		Z2187	Fabric Side Guard	N****	Purchase
Bill on paper	NU EP		Z2188	Sub Occipital Three Piece Head Set W/REM Hardware	N****	Purchase
Bill on paper	NU EP		Z2189	Forehead Strap System	N****	Purchase
Bill on paper	NU EP		Z2190	Regular Links	N****	Purchase
Bill on paper	NU EP		Z2196	Swing-away Adj. Stroller Handles	N****	Purchase
Bill on paper	NU EP		Z2203	Elbow Block w/Bracket	N****	Purchase

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The following procedure codes may be billed only on paper.

**Wheelchairs and Wheelchair Seating Systems for Individuals Ages Two Through Adult
(Section 242.191)**

No National Code	M1	M2	Local Code	Description	PA	Payment Method
Bill on paper	NU EP		Z2582	Quick Release Axle	N****	Purchase
Bill on paper	NU EP		Z2585	Growing Seat Pan	N****	Purchase
Bill on paper	NU EP		Z2586	Growing Back Upholstery	N****	Purchase
Bill on paper	NU EP		Z2588	Deep Contour Back 20" Width	N****	Purchase
Bill on paper	NU EP		Z2589	Adjustable Contour Lateral Pelvic Support	N****	Purchase
Bill on paper	NU EP		Z2592	Remote Joystick Module	N****	Purchase
Bill on paper	NU EP		Z2599	Transit Option	N****	Purchase
Bill on paper	NU EP		Z2604	Adjustable Back Upholstery	N****	Purchase
Bill on paper	NU EP		Z2616	Swing-away Mount (Joystick)	N****	Purchase

Required Documentation

Face-to-Face Examination

In order for Medicaid to provide reimbursement for a Power/motorized Wheelchair (PWC), Power Operated Vehicle (POV) (scooter) or specialized manual wheelchair, the following requirements must be met.

- A. A face-to-face physician examination must be performed.
- B. The physician must perform a medical examination for the specific purpose of assessing the beneficiary's mobility limitation and needs. The results of this exam must be recorded in the patient's medical record.
- C. The prescription must be written only **after** the face-to-face physician examination and assessment of mobility limitations have occurred and the medical history and physical examination is completed.
- D. The prescription and the medical records documenting the in-person visit and examination report must be sent to the equipment supplier within forty-five (45) days of completion of the examination.
- E. The physician may refer the beneficiary to a licensed/certified professional, a Physical Therapist (PT) or Occupational Therapist (OT) to perform a wheelchair assessment.

If the beneficiary is referred to a physical/occupational therapist before the physician completes the face-to-face examination, the physician must review the physical/occupational therapist's written report and perform the final examination. The forty-five (45)-day period begins on the

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date of the physician's final face-to-face examination and must be submitted with the prior authorization request.

The face-to-face examination must include:

A. History of the present condition(s) and past medical history that is relevant to mobility needs:

1. Symptoms that limit ambulation.
2. Diagnoses that are responsible for these symptoms.
3. Medications or other treatment for these symptoms.
4. Progression of ambulation difficulty over time.
5. Other diagnoses that may relate to ambulatory problems.
6. How far the patient can walk without stopping.
7. What ambulatory assistance (cane, walker, wheelchair, caregiver) is currently being used.
8. What has changed to now require use of a power mobility device.
9. Ability to stand up from a seated position without assistance.

B. Physical examination that is relevant to mobility needs:

1. Beneficiary's weight and height.
2. Cardiopulmonary examination.
3. Musculoskeletal examination, arm and leg strength and range of motion.
4. Neurological examination, gait, balance and coordination.

The examination should be tailored to the individual patient's condition. The history should clearly establish the patient's functional abilities and limitations related to mobility and ambulation.

In addition to all other requirements, a power mobility device is covered by Medicaid **only** if the beneficiary has a mobility limitation that significantly impairs his/her ability to perform activities of daily living within the home.

Provider-created forms and letters are not a substitute for other required forms and will not be considered.

Additional Wheelchair Documentation

- A. The purchase of a wheelchair for individuals twenty-one (21) years of age and over is limited to one wheelchair per five (5)-year period if medically necessary. A wheelchair is a dependable mobility base with positioning components. It has complex positioning capabilities and is designed to grow in width, depth and height to accommodate physical changes of its users, it is of use to people with certain medical conditions and serves a specific medical purpose related to the condition of the patient.
- B. The purchase of a wheelchair for an individual twenty (20) years of age and under is limited to one per two (2)-year period, if medically necessary.
- C. Payment is made for one wheelchair only as stipulated in A. and B. Backup and loaner wheelchairs are not covered by Arkansas Medicaid.
- D. Requests for a wheelchair that is beneficial primarily in allowing the beneficiary to perform leisure or recreational activities only will be denied. It is not medical in nature. Wheelchairs are authorized for medical use only.

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- E. Strollers and stroller-like chairs of any kind are not covered by Arkansas Medicaid. A stroller is a four-wheeled, often collapsible, chair-like carriage. They are helpful to caregivers and are typically used for transportation. Although stroller and stroller-like chairs may be used to transport individuals with medical conditions, such items do not serve a medical purpose. Strollers and stroller-like chairs have no positioning components for medical use, cannot be modified for growth and accommodate changes in medical or physical condition, and cannot be self-propelled by the individual.
- F. Prior authorization is required even when insurance pays primary to Medicaid. Explanation of benefits (EOB) of the other insurance must be submitted with the request.
- G. All wheelchair requests require a manufacturer's brand and the model name of the base.
- H. In the event a wheelchair is stolen, damaged in the home, or by vehicle or fire, a police/fire report, copy of the home owners/auto insurance coverage and detailed documentation of events leading to the loss/damage are required.
- I. Mobility bases for car seats are not covered by Medicaid.
- J. Options, accessories, and replacement parts that are medically necessary for wheelchairs that do not have specific HCPCS codes should be coded K0108 (other accessories). The manufacturer's suggested retail price (MSRP) must be listed for each item coded K0108, and the MSRP quote to the DME provider must be included. The MSRP quote **must not be altered** by the DME provider. If the MSRP is altered in any way, the request will be denied.
- K. In the event a beneficiary wishes to change services from one DME provider to another DME provider, an affidavit signed and dated by the beneficiary must be submitted with the request from the new DME provider.
- L. The existence of a procedure code does not necessarily indicate coverage by Arkansas Medicaid.
- M. The allowed amount of a POV includes all options and accessories that are provided at the time of initial issue. This includes but is not limited to batteries, battery chargers, seating systems, etc. All options and accessories provided at the initial issue of a Power-Operated Vehicle (POV) are included and should not be billed separately.
- N. If coverage criteria is not met for a specific item requested, and Arkansas Medicaid determines that another item is more appropriate and meets medical necessity, that item will be authorized.
- O. The wheelchair will significantly improve the beneficiary's ability to participate in Mobility Related Activities of Daily Living (MRADL) and the individual will use the wheelchair on a regular basis in the home.
- P. The individual's home will provide adequate access between rooms, maneuvering space and surface for use of the requested wheelchair.

Non-Covered Items for Specialized Wheelchairs and Wheelchair Systems

- A. Items that are deluxe in nature. Deluxe items are items of convenience that are not medically necessary. Deluxe items are often used for social purposes or convenience. Deluxe items include deluxe accessories which increase the cost of purchase or operation. Deluxe items and deluxe accessories are not covered by Arkansas Medicaid.
- B. Items for use in hospitals, nursing home or other institutions.
- C. Items for the beneficiary's comfort or the caregiver's convenience.
- D. Two pieces of equipment that serve the same purpose.

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- E. Backup and loaner wheelchairs.
- F. Wheelchairs that primarily allow the beneficiary to perform leisure or recreational activities.
- G. Mobility bases for car seats.
- H. Items that are not primarily used in the treatment of a disease, injury or illness.
- I. Any items or item upgrades that add cost without improving the beneficiary's ability to perform Mobility Related Activities of Daily Living.

Warranty, Maintenance and Replacement of Specialized Wheelchairs and Wheelchair Systems

All standard durable medical equipment must have a manufacturer's warranty. If a DME provider supplies equipment that is not covered under a warranty, the provider is responsible for repairs, adjustments, replacements and maintenance. The warranty begins on the date of delivery (date of service) to the beneficiary. The DME provider must keep a copy of the warranty for audit review by Medicaid. Medicaid may request a copy of the warranty.

DME suppliers must furnish at least a minimum of six (6) months warranty for any adjustments to new wheelchairs at no charge.

Labor will not be covered for the initial chair and for parts and services that are under warranty.

242.192 Specialized Rehabilitative Equipment for Beneficiaries of All Ages

5-1-17

Procedure codes found in this section must be billed either electronically or on paper with modifier **EP** for beneficiaries under 21 years of age or modifier **NU** for beneficiaries age 21 and over. When a second modifier is listed, that modifier must be used in conjunction with either **EP** or **NU**.

Modifiers in this section are indicated by the headings M1 and M2. Prior authorization requirements are shown under the heading PA. If prior authorization is needed, that information is indicated with a "Y" in the column; if not, an "N" is shown.

**** Indicates that providers may bill only for beneficiaries under age 21.**

◆ Prior authorization is not required when other insurance pays at least 50% of the Medicaid maximum allowable reimbursement amount.

***(...) This symbol, along with text in parentheses, indicates the Arkansas Medicaid description of the product. When using a procedure code with this symbol, the product must meet the indicated Arkansas Medicaid description.**

Specialized Rehabilitative Equipment, All Ages (Section 242.192)

Procedure Code	M1	M2	Description	PA	Payment Method
A8000	NU EP		Helmet, protective, soft, prefabricated, includes all components and accessories	N	Purchase
A8001	NU EP		Helmet, protective, hard, prefabricated, includes all components and accessories	N	Purchase
A8002	NU EP		Helmet, protective, soft, custom fabricated, includes all components and accessories	N	Purchase
A8003	NU EP		Helmet, protective, hard, custom fabricated, includes all components and accessories	N	Purchase

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Specialized Rehabilitative Equipment, All Ages (Section 242.192)

Procedure Code	M1	M2	Description	PA	Payment Method
E0149	NU EP		**(4 Wheel Reverse Walker) Walker, heavy-duty, wheeled, rigid or folding, any type	N	Purchase
E0163	EP NU	U1 U1	**(Potty Chair - Small) Commode chair, stationary, with fixed arms	Y	Purchase
E0168	EP		**(Rehab Shower/Commode Chair) Commode chair, extra wide and/or heavy-duty, stationary or mobile, with or without arms, any type, each	Y♦	Purchase
E0168	EP	UB	**(Adaptive Commode Chair) Commode chair, extra wide and/or heavy-duty, stationary or mobile, with or without arms, any type, each	N	Purchase
E0168	NU		**(Adaptive Commode Chair) Commode chair, extra wide and/or heavy-duty, stationary or mobile, with or without arms, any type, each	N	Purchase
E0168	NU	U1	**(Rehab Shower/Commode Chair) Commode chair, extra wide and/or heavy-duty, stationary or mobile, with or without arms, any type, each	Y♦	Purchase
E0241	NU EP		**(Bolt-on Sm. Grab Bar) Bathroom wall rail, each	N	Purchase
E0241	NU EP	U1 U1	**(Bolt-on Lg. Grab Bar) Bathroom wall rail, each	N	Purchase
E0241	NU EP	U2 U2	**(Bolt-on Med. Grab Bar) Bathroom wall rail, each	N	Purchase
E0245	NU EP		**(Adj. Bath Chair w/Back) Tub stool or bench	N	Purchase
E0245	NU EP	U2 U2	**(Padded Tub Transfer Bench) Tub stool or bench	N	Purchase
E0245	NU EP	U3 U3	**(30" Bath Chair) Tub stool or bench	N	Purchase
E0245	NU EP	U4 U4	**(38" Bath Chair) Tub stool or bench	N	Purchase
E0245	NU EP	U5 U5	**(47" Bath Chair) Tub stool or bench	N	Purchase
E0245	NU EP	U6 U6	**(56" Bath Chair) Tub stool or bench	N	Purchase
E0245	NU EP	UB UB	**(Non-padded tub transfer bench) Tub stool or bench	N	Purchase
E0246	NU EP		**(Clamp-on Tub Grab Bar) Transfer tub rail attachment	N	Purchase

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Specialized Rehabilitative Equipment, All Ages (Section 242.192)

Procedure Code	M1	M2	Description	PA	Payment Method
E0637	NU EP		Combination sit-to-stand frame/table system, any size, including pediatric, with seat lift feature, with or without wheels	Y	Purchase
E0638	NU EP		Standing frame system, any size, with or without wheels	Y	Purchase
E0638	EP EP	U1 U2	Standing frame system, any size, with or without wheels	Y	Purchase
E0700	NU EP		**(Chin Guard for Safety Helmet, Sm.) Safety equipment, e.g., belt, harness or vest	N	Purchase
E0705	NU EP		Transfer device, any type, each	Y	Purchase
E0911	NU EP		Trapeze bar, heavy-duty, for patient weight capacity greater than 250 pounds, attached to bed, with grab bar	N	Capped Rental
E0950	NU EP	U1 U1	**(Tray for gait trainer) Wheelchair accessory, tray, each	N	Purchase
E1031**	EP		**(Transition Toddler Chair - Sm.) Rollabout chair, any and all types with casters five inches or greater	N	Purchase
E1031**	EP		**(Transition Toddler Chair - Lg.) Rollabout chair, any and all types with casters five inches or greater	Y	Purchase
E1031**	EP	U1	**(Corner Chair w/Tray & Casters - Sm.) Rollabout chair, any and all types with casters five inches or greater	N	Purchase
E1031**	EP	U2	Rollabout chair, any and all types with casters five inches or greater	N	Purchase
E1031**	EP	U3	**(Corner Chair w/Tray & Casters - Lg.) Rollabout chair, any and all types with casters five inches or greater	N	Purchase
E1031**	EP	U4	**(Bolster Chair w/Tray, Chest Support & Casters - Sm.) Rollabout chair, any and all types with casters five inches or greater	N	Purchase
E1031**	EP	U5	**(Low Back Activity Chair) Rollabout chair, any and all types with casters five inches or greater	N	Purchase
E1035**	EP		**(Carrie Seat - Preschool) Multi-positional patient transfer system, with integrated seat, operated by care giver	Y	Purchase
E1035**	EP	U1	**(Carrie Seat - Elementary) Multi-positional patient transfer system, with integrated seat, operated by care giver	Y	Purchase

Specialized Rehabilitative Equipment, All Ages (Section 242.192)

Procedure Code	M1	M2	Description	PA	Payment Method
E1035**	EP	U2	** (Carrie Seat - Jr.) Multi-positional patient transfer system, with integrated seat, operated by care giver	Y	Purchase
E1035	NU EP	U3 U3	** (Carrie Seat - Sm. Adult) Multi-positional patient transfer system, with integrated seat, operated by care giver	Y♦	Purchase
E8000	EP		** (14") Gait trainer, pediatric size, posterior support, includes all accessories and components	Y	Manually Priced
E8000	EP	U1	** (19") Gait trainer, pediatric size, posterior support, includes all accessories and components	Y	Manually Priced
E8000	EP	U2	** (Intermediate) Gait trainer, pediatric size, posterior support, includes all accessories and components	Y	Manually Priced
E8001	EP		** (14") Gait trainer, pediatric size, upright support, includes all accessories and components	Y	Manually Priced
E8001	EP	U1	** (19") Gait trainer, pediatric size, upright support, includes all accessories and components	Y	Manually Priced
E8001	EP	U2	** (Intermediate) Gait trainer, pediatric size, upright support, includes all accessories and components	Y	Manually Priced
E8002	EP		** (14") Gait trainer, pediatric size, anterior support, includes all accessories and components	Y	Manually Priced
E8002	EP	U1	** (19") Gait trainer, pediatric size, anterior support, includes all accessories and components	Y	Manually Priced
E8002	EP	U2	** (Intermediate) Gait trainer, pediatric size, anterior support, includes all accessories and components	Y	Manually Priced

The following list of codes may only be billed on paper.

Specialized Rehabilitative Equipment, All Ages (Section 242.192)

No National Code	M1	Local Code	Description	PA	Payment Method
Bill on paper	NU EP	Z1996	Sm. 51" Supine Stander	Y♦	Purchase
Bill on paper	NU EP	Z1997	Lg. 71" Supine Stander	Y♦	Purchase
Bill on paper	EP	Z1998**	27" Prone Stander	Y	Purchase

PROPOSED

The following list of codes may only be billed on paper.
Specialized Rehabilitative Equipment, All Ages (Section 242.192)

No National Code	M1	Local Code	Description	PA	Payment Method
Bill on paper	EP	Z1999**	35" Prone Stander	Y	Purchase
Bill on paper	EP	Z2000**	42" Prone Stander	Y♦	Purchase
Bill on paper	NU EP	Z2001	50" Prone Stander	Y♦	Purchase
Bill on paper	NU EP	Z2002	Adj. Abduction Wedge w/hip stabilizer	N	Purchase
Bill on paper	NU EP	Z2003	Tray for Stander-Prone	N	Purchase
Bill on paper	NU EP	Z2004	Tray for Stander-Supine	N	Purchase
Bill on paper	NU EP	Z2005	Foot Sandals for Standers	N	Purchase
Bill on paper	EP	Z2006**	Up Rite Stander - Sm.	Y	Purchase
Bill on paper	EP	Z2007**	Up Rite Stander - Med.	Y	Purchase
Bill on paper	NU EP	Z2008	Up Rite Stander - Lg.	Y	Purchase
Bill on paper	NU EP	Z2009	Caster Base for Up Rite Stander - Sm.	N	Purchase
Bill on paper	NU EP	Z2010	Caster Base for Up Rite Stander - Med.	N	Purchase
Bill on paper	NU EP	Z2011	Caster Base for Up Rite Stander - Lg.	N	Purchase
Bill on paper	EP	Z2012**	Tumble Form Tri Stander w/Tray - Sm.	Y♦	Purchase
Bill on paper	EP	Z2013**	Tumble Form Tri Stander w/Tray - Lg.	Y♦	Purchase
Bill on paper	EP	Z2015**	48" Side Lier	N	Purchase
Bill on paper	EP	Z2016**	72" Side Lier	N	Purchase
Bill on paper	EP	Z2017**	Tumble Form Feeder Seat - Sm.	N	Purchase
Bill on paper	NU EP	Z2018**	Tumble Form Feeder Seat - Med.	N	Purchase
Bill on paper	EP	Z2019**	Tumble Form Feeder Seat - Lg.	N	Purchase

PROPOSED

The following list of codes may only be billed on paper.
Specialized Rehabilitative Equipment, All Ages (Section 242.192)

No National Code	M1	Local Code	Description	PA	Payment Method
Bill on paper	EP	Z2021**	Mobile Floor Sitter Med/Lg.	N	Purchase
Bill on paper	EP	Z2038**	Therapy Ball - Sm.	N	Purchase
Bill on paper	EP	Z2039**	Therapy Ball - Med.	N	Purchase
Bill on paper	EP	Z2040**	Therapy Ball - Lg.	N	Purchase
Bill on paper	EP	Z2043**	Seat & Back Pad for Toddler Chairs	Y	Purchase
Bill on paper	EP	Z2044**	Tray for Toddler Chair	Y	Purchase
Bill on paper	EP	Z2045**	14" T&S High Back w/Support Activity Chair	Y	Purchase
Bill on paper	EP	Z2046**	16" T&S High Back w/Support Activity Chair	Y	Purchase
Bill on paper	NU EP	Z2047	Orthopedic Car Seat	Y	Purchase
Bill on paper	NU EP	Z2072	Lg. Wrap Around Bath Support	N	Purchase
Bill on paper	NU EP	Z2073	Sm. Wrap Around Back Support	N	Purchase
Bill on paper	NU EP	Z2074	Lg. Toilet Support w/Hi Back	N	Purchase
Bill on paper	NU EP	Z2075	Sm. Toilet Support w/Hi Back	N	Purchase
Bill on paper	NU EP	Z2077	Flexible Shower Hose	N	Purchase
Bill on paper	NU EP	Z2089	Toilet Seat Reducer Ring (Padded)	N	Purchase
Bill on paper	NU EP	Z2093	Adult Gait Trainer	Y♦	Purchase
Bill on paper	EP	Z2094**	Tyke Strider Walker w/2 Wheels	N	Purchase
Bill on paper	EP	Z2095**	Tweener Strider Walker w/2 Wheels	N	Purchase
Bill on paper	EP	Z2096**	Middle Strider Walker w/2 Wheels	N	Purchase
Bill on paper	NU EP	Z2097	Adult Strider Walker w/2 Wheels	N	Purchase

PROPOSED

The following list of codes may only be billed on paper.

Specialized Rehabilitative Equipment, All Ages (Section 242.192)

No National Code	M1	Local Code	Description	PA	Payment Method
Bill on paper	NU EP	Z2099	4 Wheel Reverse Walker	N	Purchase
Bill on paper	NU EP	Z2100	4 Wheel Reverse Walker	N	Purchase
Bill on paper	NU EP	Z2101	4 Wheel Reverse Walker	N	Purchase
Bill on paper	NU EP	Z2102	4 Wheel Reverse Walker	N	Purchase
Bill on paper	NU EP	Z2104	4 Wheel Front Swivel Reverse Walker	N	Purchase
Bill on paper	NU EP	Z2105	4 Wheel Front Swivel Reverse Walker	N	Purchase
Bill on paper	NU EP	Z2106	4 Wheel Front Swivel Reverse Walker	N	Purchase
Bill on paper	NU EP	Z2107	4 Wheel Front Swivel Reverse Walker	N	Purchase
Bill on paper	NU EP	Z2239	Bath Chair Headrest	N	Purchase
Bill on paper	NU EP	Z2605	Diverter Valve for Handheld Shower	N	Purchase

242.194 Replacement, Growth and Modification of Specialized Wheelchairs and Wheelchair Seating Systems

5-1-17

Arkansas Medicaid will cover replacement equipment as needed due to growth, normal wear and tear, theft, irreparable damage or loss not covered by insurance.

The following requirements must be met:

- A. Detailed documentation from the beneficiary's PCP or ordering physician describing the significant changes in the beneficiary's condition that require growth/modification or replacement must be submitted.
- B. The request must be submitted on form DMS-679 (Prescription & Prior Authorization Request for Medical Equipment). **View or print form DMS-679 and instructions for completion.**
- C. An Evaluation for Wheelchair and Wheelchair Seating form (DMS-0843) must be submitted. The evaluation must be signed and dated by the beneficiary's PCP or ordering physician. The signature must be an original signature. A stamped signature will not be accepted by Arkansas Medicaid. An electronic signature will be accepted. **View or print form DMS-0843.**
- D. A manufacturer's suggested retail price list and a manufacturer's quote must be submitted. A quote created by the DME provider will not be accepted.

PROPOSED

- E. Requests for replacement where malicious damage, neglect or misuse of the equipment may have occurred may be investigated by Arkansas Medicaid. Requests may be denied if such circumstances are confirmed.
- F. If a wheelchair is stolen or damaged by vehicle, fire or in the home, the beneficiary must provide the following with the request:
 - 1. A police or fire report.
 - 2. Copy of the homeowner's or auto insurance coverage.
 - 3. Detailed documentation of events leading to the loss and damage.

If Arkansas Medicaid denies a repair or replacement in a case of malicious damage or misuse, payment of repairs is the responsibility of the beneficiary or caregiver.

242.195 Repairs of Specialized Wheelchairs and Wheelchair Systems

5-1-17

- A. Arkansas Medicaid will cover repairs for wheelchairs and wheelchair seating.
- B. Repair services must receive prior authorization from AFMC.
- C. Detailed documentation from the technician that supports the equipment or services being requested must be submitted. Documentation must include the following:
 - 1. Date and place of purchase of the current chair.
 - 2. Brand and model name of the base.
 - 3. Brand and model name of parts and accessories needed for repairs.
- D. Correct procedure codes per the current Medicaid policy must be used.
- E. Requests for repairs must be submitted on form DMS-679 (Prescription & Prior Authorization Request for Medical Equipment) and must be signed and dated by the beneficiary's PCP or ordering physician. **View or print form DMS-679 and instructions for completion.**
- F. Repairs for previously authorized wheelchairs that the beneficiary has outgrown will not be covered if a new chair has been authorized.
- G. In the event a request is submitted for repairs for a wheelchair authorized by another state agency, documentation or a delivery ticket showing that the wheelchair was authorized by another state agency must be submitted with the request.
- H. Arkansas Medicaid will not cover repairs/damage due to the following:
 - 1. Neglect.
 - 2. Misuse.
 - 3. Abuse.
 - 4. Improper installation or repair by the DME provider.
 - 5. Use of parts or changes by the DME provider or the beneficiary not authorized by Arkansas Medicaid.
- I. When a request is submitted for a new wheelchair with a statement that the previous wheelchair cannot be repaired, documentation from the manufacturer of the previous chair stating the reason why the previous wheelchair cannot be repaired must be included.
- J. If the previous wheelchair cannot be repaired, several color photographs taken at different angles must be included with the new request.

PROPOSED

Miscellaneous

- A. A wheelchair can be ordered only by a physician.
- B. A physician's evaluation is valid for a period of six (6) months. After six (6) months, the beneficiary must be re-evaluated by the physician to determine medical necessity for continued need because conditions and measurements do change.
- C. A DME request is considered to be outdated by Medicaid when it is first presented to Medicaid more than ninety (90) days from the date it was written, signed and dated by the physician.

PROPOSED



Division of Medical Services
Program Development & Quality Assurance

P.O. Box 1437, Slot S295 · Little Rock, AR 72203-1437
501-320-6428 · Fax: 501-404-4619
TDD/TTY: 501-682-6789



TO: Arkansas Medicaid Health Care Providers – All Providers

EFFECTIVE DATE: May 1, 2017

SUBJECT: Provider Manual Update Transmittal SecV-7-16

PROPOSED

REMOVE

Section	Effective Date
500.000	—
DMS-679	12/14
DMS-679A	12/14
—	—

INSERT

Section	Effective Date
500.000	—
DMS-679	5-1-17
—	—
DMS-0843	5-1-17

Explanation of Updates

Section 500.000 has been updated to remove the Prescription & Prior Authorization Request for Medical Equipment form (DMS-679A), revise the Medical Equipment Request for Prior Authorization and Prescription form (DMS-679) and add the Evaluation for Wheelchair and Wheelchair Seating form (DMS-0843).

Form DMS-679 is being updated to reflect the most current version of the form.

Form DMS-0843 is being added to all provider manuals.

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

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 Hewlett Packard Enterprise 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 the Program Development and Quality Assurance Unit at (501) 320-6429.

Arkansas Medicaid provider manuals (including update transmittals), official notices, notices of rule making 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.

Dawn Stehle
Director

PROPOSED

SECTION V – FORMS**500.000****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
<u>Professional – CMS-1500</u>	Business Form Supplier
<u>Institutional – CMS-1450*</u>	Business Form Supplier
<u>Visual Care – DMS-26-V</u>	1-800-457-4454
<u>Inpatient Crossover – HP-MC-001</u>	1-800-457-4454
<u>Long Term Care Crossover – HP-MC-002</u>	1-800-457-4454
<u>Outpatient Crossover – HP-MC-003</u>	1-800-457-4454
<u>Professional Crossover – HP-MC-004</u>	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
<u>Alternatives Attendant Care Provider Claim Form – AAS-9559</u>	Client Employer
<u>Dental – ADA-J430</u>	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	<u>DMS-2606</u>
Address Change Form	<u>DMS-673</u>
Adjustment Request Form – Medicaid XIX	<u>HP-AR-004</u>
Adjustment Request Form – Medicaid XIX – Pharmacy Program	<u>DMS-802</u>

Form Name	Form Link
Adverse Effects Form	<u>DMS-2704</u>
Amplification/Assistive Technology Recommendation Form	<u>DMS-686</u>
Application for WebRA Hardship Waiver	<u>DMS-7736</u>
Approval/Denial Codes for Inpatient Psychiatric Services	<u>DMS-2687</u>
Arkansas Early Intervention Infant & Toddler Program Intake/Referral/Application for Services	<u>DDS/FS#0001.a</u>
Arkansas Medicaid Patient-Centered Medical Home Program Practice Participation Agreement	<u>DMS-844</u>
Arkansas Medicaid Patient-Centered Medical Home Program Practice Update/Change Request Form	<u>DMS-801</u>
Arkansas Medicaid Patient-Centered Medical Home Program Pooling Request Form	<u>DMS-845</u>
Arkansas Medicaid Patient-Centered Medical Home Program Practice Withdrawal Form	<u>DMS-846</u>
ARKids First Behavioral Health Services Provider Qualification Form	<u>DMS-612</u>
Authorization for Automatic Deposit	<u>autodeposit</u>
Authorization for Payment for Services Provided	<u>MAP-8</u>
Certification of Need – Medicaid Inpatient Psychiatric Services for Under Age 21	<u>DMS-2633</u>
Certification of Schools to Provide Comprehensive EPSDT Services	<u>CSPC-EPSDT</u>
Certification Statement for Abortion	<u>DMS-2698</u>
Change of Ownership Information	<u>DMS-0688</u>
Child Health Management Services Enrollment Orders	<u>DMS-201</u>
Child Health Management Services Discharge Notification Form	<u>DMS-202</u>
CHMS Benefit Extension for Diagnosis/Evaluation Procedures	<u>DMS-699A</u>
CHMS Request for Prior Authorization	<u>DMS-102</u>
Claim Correction Request	<u>DMS-2647</u>
Consent for Release of Information	<u>DMS-619</u>
Contact Lens Prior Authorization Request Form	<u>DMS-0101</u>
Contract to Participate in the Arkansas Medical Assistance Program	<u>DMS-653</u>
DDTCS Transportation Log	<u>DMS-638</u>
DDTCS Transportation Survey	<u>DMS-632</u>
Dental Treatment Additional Information	<u>DMS-32-A</u>
Disclosure of Significant Business Transactions	<u>DMS-689</u>
Disproportionate Share Questionnaire	<u>DMS-628</u>

PROPOSED

Form Name	Form Link
Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Prescription/Referral For Medically Necessary Services/Items Not Specifically Included in the Medicaid State Plan	<u>DMS-693</u>
Early Childhood Special Education Referral Form	<u>ECSE-R</u>
EPSDT Provider Agreement	<u>DMS-831</u>
Evaluation for Wheelchair and Wheelchair Seating	<u>DMS-0843</u>
Explanation of Check Refund	<u>HP-CR-002</u>
Gait Analysis Full Body	<u>DMS-647</u>
Home Health Certification and Plan of Care	<u>CMS-485</u>
Hospital/Physician/Certified Nurse-Midwife Referral for Newborn Infant Medicaid Coverage	<u>DCO-645</u>
Inpatient Psychiatric Medicaid Agency Review Team Transmittal Sheet	<u>DMS-2685</u>
Individual Renewal Form for School-Based Audiologists	<u>DMS-7782</u>
Lower-Limb Prosthetic Evaluation	<u>DMS-650</u>
Lower-Limb Prosthetic Prescription	<u>DMS-651</u>
Media Selection/E-Mail Address Change Form	<u>HP-MS-005</u>
Medicaid Claim Inquiry Form	<u>HP-CI-003</u>
Medicaid Form Request	<u>HP-MFR-001</u>
Medical Equipment Request for Prior Authorization & Prescription	<u>DMS-679</u>
Medical Transportation and Personal Assistant Verification	<u>DMS-616</u>
Mental Health Services Provider Qualification Form for LCSW, LMFT and LPC	<u>DMS-633</u>
Notice Of Noncompliance	<u>DMS-635</u>
NPI Reporting Form	<u>DMS-683</u>
Occupational, Physical and Speech Therapy for Medicaid Eligible Beneficiaries Under Age 21 Prescription/Referral	<u>DMS-640</u>
Ownership and Conviction Disclosure	<u>DMS-675</u>
Personal Care Assessment and Service Plan	<u>DMS-618 English</u> <u>DMS-618 Spanish</u>
Practitioner Identification Number Request Form	<u>DMS-7708</u>
Prescription & Prior Authorization Request For Nutrition Therapy & Supplies	<u>DMS-2615</u>
Primary Care Physician Managed Care Program Referral Form	<u>DMS-2610</u>
Primary Care Physician Participation Agreement	<u>DMS-2608</u>
Primary Care Physician Selection and Change Form	<u>DMS-2609</u>
Procedure Code/NDC Detail Attachment Form	<u>DMS-664</u>
Provider Application	<u>DMS-652</u>

PROPOSED

Form Name	Form Link
Provider Communication Form	<u>AAS-9502</u>
Provider Data Sharing Agreement – Medicare Parts C & D	<u>DMS-652-A</u>
Provider Enrollment Application and Contract Package	<u>Application Packet</u>
Quarterly Monitoring Form	<u>AAS-9506</u>
Referral for Audiology Services – School-Based Setting	<u>DMS-7783</u>
Referral for Certification of Need Medicaid Inpatient Psychiatric Services for Under Age 21	<u>DMS-2634</u>
Referral for Medical Assistance	<u>DMS-630</u>
Request for Appeal	<u>DMS-840</u>
Request for Extension of Benefits	<u>DMS-699</u>
Request for Extension of Benefits for Clinical, Outpatient, Laboratory and X-Ray Services	<u>DMS-671</u>
Request for Extension of Benefits for Medical Supplies for Medicaid Beneficiaries Under Age 21	<u>DMS-602</u>
Request for Molecular Pathology Laboratory Services	<u>DMS-841</u>
Request For Orthodontic Treatment	<u>DMS-32-0</u>
Request for Private Duty Nursing Services Prior Authorization and Prescription – Initial Request or Recertification	<u>DMS-2692</u>
Request for Targeted Case Management Prior Authorization for Beneficiaries Under Age 21	<u>DMS-601</u>
Research Request Form	<u>HP-0288</u>
Service Log – Personal Care Delivery and Aides Notes	<u>DMS-873</u>
Sterilization Consent Form	<u>DMS-615 English</u> <u>DMS-615 Spanish</u>
Sterilization Consent Form – Information for Men	<u>PUB-020</u>
Sterilization Consent Form – Information for Women	<u>PUB-019</u>
Targeted Case Management Contact Monitoring Form	<u>DMS-690</u>
Upper-Limb Prosthetic Evaluation	<u>DMS-648</u>
Upper-Limb Prosthetic Prescription	<u>DMS-649</u>
Vendor Performance Report	<u>Vendorperformreport</u>
Verification of Medical Services	<u>DMS-2618</u>

PROPOSED

In order by form number:

<u>AAS-9502</u>	<u>DMS-2618</u>	<u>DMS-618</u>	<u>DMS-673</u>	<u>ECSE-R</u>
<u>AAS-9506</u>	<u>DMS-2633</u>	<u>Spanish</u>	<u>DMS-679</u>	<u>HP-0288</u>
<u>AAS-9559</u>	<u>DMS-2634</u>	<u>DMS-619</u>	<u>DMS-683</u>	<u>HP-AR-004</u>
<u>Address</u>	<u>DMS-2647</u>	<u>DMS-628</u>	<u>DMS-686</u>	<u>HP-CI-003</u>
<u>Change</u>	<u>DMS-2685</u>	<u>DMS-630</u>	<u>DMS-689</u>	<u>HP-CR-002</u>
<u>Autodeposit</u>	<u>DMS-2687</u>	<u>DMS-632</u>	<u>DMS-693</u>	<u>HP-MFR-001</u>
<u>CMS-485</u>	<u>DMS-2692</u>	<u>DMS-633</u>	<u>DMS-699</u>	<u>HP-MS-005</u>
<u>CSPC-EPSDT</u>	<u>DMS-2698</u>	<u>DMS-635</u>	<u>DMS-699A</u>	<u>MAP-8</u>
<u>DCO-645</u>	<u>DMS-2704</u>	<u>DMS-638</u>	<u>DMS-7708</u>	<u>Performance</u>
<u>DDS/FS#0001.a</u>	<u>DMS-32-A</u>	<u>DMS-640</u>	<u>DMS-7736</u>	<u>Report</u>
<u>DMS-0101</u>	<u>DMS-32-0</u>	<u>DMS-647</u>	<u>DMS-7782</u>	<u>Provider</u>
<u>DMS-0688</u>	<u>DMS-601</u>	<u>DMS-648</u>	<u>DMS-7783</u>	<u>Enrollment</u>
<u>DMS-0843</u>	<u>DMS-602</u>	<u>DMS-649</u>	<u>DMS-801</u>	<u>Application</u>
<u>DMS-102</u>	<u>DMS-612</u>	<u>DMS-650</u>	<u>DMS-802</u>	<u>and Contract</u>
<u>DMS-201</u>	<u>DMS-615</u>	<u>DMS-651</u>	<u>DMS-831</u>	<u>Package</u>
<u>DMS-202</u>	<u>English</u>	<u>DMS-652</u>	<u>DMS-840</u>	<u>PUB-019</u>
<u>DMS-2606</u>	<u>DMS-615</u>	<u>DMS-652-A</u>	<u>DMS-841</u>	<u>PUB-020</u>
<u>DMS-2608</u>	<u>Spanish</u>	<u>DMS-653</u>	<u>DMS-844</u>	
<u>DMS-2609</u>	<u>DMS-616</u>	<u>DMS-664</u>	<u>DMS-845</u>	
<u>DMS-2610</u>	<u>DMS-618</u>	<u>DMS-671</u>	<u>DMS-846</u>	
<u>DMS-2615</u>	<u>English</u>	<u>DMS-675</u>	<u>DMS-873</u>	

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 Finance Administration, Sales and Tax Use Unit](#)

[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](#)

PROPOSED

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, Hewlett Packard Enterprise 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

Arkansas DHS, Division of Medical Services, Medical Director for Clinical Affairs

Arkansas DHS, Division of Medical Services, Pharmacy Unit

Arkansas DHS, Division of Medical Services, Program Communications Unit

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 Foundation for Medical Care, Retrospective Review for Therapy and Prior Authorization for Personal Care for Under Age 21

Arkansas Foundation for Medical Care, Provider Relations Representative

Arkansas Hospital Association

Arkansas Office of Medicaid Inspector General (OMIG)

ARKids First-B

ARKids First-B ID Card Example

Central Child Health Services Office (EPSDT)

ConnectCare Helpline

County Codes

Dental Contractor

Hewlett Packard Enterprise Claims Department

PROPOSED

Hewlett Packard Enterprise EDI Support Center (formerly AEVCS Help Desk)

Hewlett Packard Enterprise Inquiry Unit

Hewlett Packard Enterprise Manual Order

Hewlett Packard Enterprise Provider Assistance Center (PAC)

Hewlett Packard Enterprise Supplied Forms

Example of Beneficiary Notification of Denied ARKids First-B Claim

Example of Beneficiary Notification of Denied Medicaid Claim

First Connections Infant & Toddler Program, Developmental Disabilities Services

First Connections Infant & Toddler Program, Developmental Disabilities Services, Appeals

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

Health Care Declarations

Immunizations Registry Help Desk

Magellan Pharmacy Call Center

Medicaid ID Card Example

Medicaid Managed Care Services (MMCS)

Medicaid Reimbursement Unit Communications Hotline

Medicaid Tooth Numbering System

National Supplier Clearinghouse

Partners Provider Certification

Primary Care Physician (PCP) Enrollment Voice Response System

Provider Qualifications, Division of Behavioral Health Services

Select Optical

Standard Register

Table of Desirable Weights

U.S. Government Printing Office

ValueOptions

Vendor Performance Report

PROPOSED

PROPOSED

**ARKANSAS DEPARTMENT OF HUMAN SERVICES
DIVISION OF MEDICAL SERVICES
PRESCRIPTION & PRIOR AUTHORIZATION REQUEST FOR MEDICAL EQUIPMENT**

SECTION A - TO BE COMPLETED BY THE PROVIDER

<input type="checkbox"/> INITIAL <input type="checkbox"/> RECERT <input type="checkbox"/> MODIFICATION <input type="checkbox"/> EXT OF BENEFITS				START DATE:			
BENEFICIARY NAME: (LAST, FIRST, MI)				BENEFICIARY MEDICAID ID #:			
BENEFICIARY MAILING ADDRESS:				DATE OF BIRTH:		SEX: <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	
PROVIDER NAME:				PROVIDER MAILING ADDRESS:			
PROVIDER IDENTIFICATION #/TAXONOMY CODE:				PROVIDER PHONE & CONTACT PERSON:			
PRESCRIBING PHYSICIAN NAME:				PHYSICIAN PROVIDER IDENTIFICATION #/TAXONOMY CODE:			

PROCEDURE CODE	MOD 1	MOD 2	TOS	DESCRIPTION OF ITEMS	UNITS	MSRP	POWER WHEELCHAIR GROUP (IF APPLICABLE)

I attest that the above information is true to the best of my knowledge.

DME PROVIDER SIGNATURE

DATE

SECTION B - TO BE COMPLETED BY THE PHYSICIAN

EST. LENGTH OF NEED: ____ WKS ____ MONTHS ____ LIFETIME		EPSDT REFERRAL: <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A		CURRENT HEIGHT: ____ INCHES		CURRENT WEIGHT: ____ LBS	
DIAGNOSIS & ICD CODE:		DIAGNOSIS & ICD CODE:		DIAGNOSIS & ICD CODE:		DIAGNOSIS & ICD CODE:	
IS THIS EQUIPMENT BEING SUPPLIED FOR USE IN THE BENEFICIARY'S HOME? <input type="checkbox"/> YES <input type="checkbox"/> NO							

It is my professional opinion that the equipment requested above is medically necessary:

PHYSICIAN NAME (PRINT)

PHYSICIAN MEDICAID ID NUMBER

PHYSICIAN SIGNATURE (NO STAMP)

DATE

PROPOSED

IF (PCP) PRIMARY CARE PHYSICIAN IS NOT THE PRESCRIBING PHYSICIAN, THEN PLEASE PROVIDE THE FOLLOWING INFORMATION:

PRIMARY CARE PHYSICIAN (PCP) NAME (PRINT)

PCP MEDICAID ID NUMBER

Instructions for Completion of Prior Authorization Request for Medical Equipment Form

SECTION A - TO BE COMPLETED BY THE PROVIDER

- REVIEW TYPE:** Indicate the type of prior authorization request: initial, recertification, modification to a current authorization, or extension of benefits.
- DATE(S) OF SERVICE REQUESTED:** Enter the requested date(s) of service.
- PATIENT INFORMATION:** Enter the beneficiary's full name (Last, First, MI), ten-digit (10-digit) Medicaid ID number, mailing address, date of birth (MM/DD/YYYY), and sex (male or female).
- PROVIDER INFORMATION:** Enter the provider name, address, provider identification number and taxonomy code, telephone number, and contact person.
- PHYSICIAN INFORMATION:** Enter the prescribing physician's name, provider identification number, and taxonomy code.
- PROCEDURE CODES:** List all procedure codes (including any modifier or type of service if applicable) for items ordered that require authorization. (Procedure codes that do not require authorization should not be listed.) Enter the number of units requested and a narrative description for each item ordered.
- PERSON SUBMITTING REQUEST:** The person submitting the request must sign and date, verifying the attestation in this section.

SECTION B - TO BE COMPLETED BY THE PHYSICIAN

- EST. LENGTH OF NEED:** Enter the estimated length of need (the length of time the physician expects the patient to require use of the ordered item) by filling in the appropriate number of weeks or months or indicate permanent if the physician expects that the patient will require the item for the duration of his/her life.
- EPSDT REFERRAL:** If applicable, indicate if the request is made as the result of an EPSDT referral.
- HEIGHT & WEIGHT:** Enter the beneficiary's current height measured in inches and weight measured in pounds.
- DIAGNOSIS & ICD CODES:** In the first space, list the diagnosis & ICD code that represents the primary reason for ordering this item. List any additional diagnosis & ICD codes that would further describe the medical need for the item (up to 4 codes).
- QUESTION SECTION:** Answer the question by checking the appropriate "YES" or "NO" box.
- PRESCRIBING PHYSICIAN:** The prescribing physician must sign/date in the space indicated. Signature and date stamps are not acceptable.
- MEDICAL NECESSITY:** Documentation supporting medical necessity of the requested items must be submitted.

PROPOSED

**ARKANSAS DEPARTMENT OF HUMAN SERVICES
DIVISION OF MEDICAL SERVICES**

EVALUATION FOR WHEELCHAIR AND WHEELCHAIR SEATING

PART A (MUST BE COMPLETED BY DME PROVIDER ONLY)

1. CLIENT INFORMATION:

Date:	Medicaid ID #:	Date of Birth:		
Client Name:		Sex: Male: <input type="checkbox"/> Female: <input type="checkbox"/>	Current Height:	Current Weight:
Address:	City:	State:	Zip:	

2. ACCESSIBILITY AND TRANSPORTATION:

Ramp to House: Yes: <input type="checkbox"/> No: <input type="checkbox"/>	School Bus: Yes: <input type="checkbox"/> No: <input type="checkbox"/>
Doorway Accessible: Yes: <input type="checkbox"/> No: <input type="checkbox"/>	Tie Down: Yes: <input type="checkbox"/> No: <input type="checkbox"/>
Bathroom Accessible: Yes: <input type="checkbox"/> No: <input type="checkbox"/>	Van Lift: Yes: <input type="checkbox"/> No: <input type="checkbox"/>
Equipment Fits in Trunk: Yes: <input type="checkbox"/> No: <input type="checkbox"/>	

If no ramp to house; describe access to house: _____

Type of vehicle: _____

Type of house:

Single-Family: ☐ Apartment: ☐ Multiplex: ☐ Mobile Home: ☐ Other: ☐

If Multi-Story, Will Client Be Required to Get Upstairs: Yes: ☐ No: ☐ N/A: ☐

If Yes, Explain: _____

Is Client Enrolled in a School: Yes: ☐ No: ☐

If Yes, Name of School: _____

School Address: _____

Hours Per Day Client Spends in Wheelchair: _____

PROPOSED

**ARKANSAS DEPARTMENT OF HUMAN SERVICES
DIVISION OF MEDICAL SERVICES
EVALUATION FOR WHEELCHAIR AND WHEELCHAIR SEATING**

PART A (MUST BE COMPLETED BY DME PROVIDER ONLY)

3. CURRENT WHEELCHAIR AND SEATING SYSTEMS:

Has a Wheelchair: Yes: ☐ No: ☐ Serial Number: _____

Model/Brand Name: _____ Manufacturer: _____

Power: ☐ Scooter: ☐ Manual: ☐ Standard: ☐ Folding: ☐ Rigid: ☐

Date of Purchase: _____ Previous DME Provider: _____

4. PRESENT SEATING SYSTEMS:

Type of Seat: _____ Type of Back: _____

Seat Width: _____ Seat Depth: _____

Can the Current Wheelchair Be Grown/Modified/Repaired to Meet the Client's Need: Yes: ☐ No: ☐

If No, Explain: _____

PROPOSED

**ARKANSAS DEPARTMENT OF HUMAN SERVICES
DIVISION OF MEDICAL SERVICES**

EVALUATION FOR WHEELCHAIR AND WHEELCHAIR SEATING

PART B (MUST BE COMPLETED BY ATP ONLY)

PT/OT/SEATING SPECIALIST must **ONLY** complete **PART B** when requesting a Scooter, Group One or Group Two Power Wheelchairs with No Power Options

1. NEW WHEELCHAIR SPECIFICATIONS:

Power: ☐ If Power Wheelchair, Group #: _____ Scooter: ☐ Manual: ☐

Brand/Model Name: _____ Manufacturer: _____

Seat Width: _____ Seat Depth: _____

Seat To Floor Height: _____ Front: _____ Rear: _____

2. DRIVE CONTROLS:

Joystick: Yes: ☐ No: ☐ Standard Mount: _____ Swing-Away: _____

Type of Joystick: Standard: _____ T-Bar: _____ Ball: _____

Chin Control: _____ Sip N' Puff: _____ Head Array: _____

Other: _____

Justification: _____

3. SEATING:

SEAT	BACK	LATERAL SUPPORT
Contour Seat:	Contour:	Curved Pad:
Custom Molded:	Custom Molded:	Fixed: Left/Right
Planar Seat:	Folding:	Flat Pad:
Size:	Planar:	Swing-Away:
Sling Seat:	Sling Back:	Other:
Solid Seat:	Captain's Seat:	Justification:
Captain's Seat:	Other:	
Other:	Justification:	
Justification:		

PROPOSED

**ARKANSAS DEPARTMENT OF HUMAN SERVICES
DIVISION OF MEDICAL SERVICES
EVALUATION FOR WHEELCHAIR AND WHEELCHAIR SEATING**

PART B (MUST BE COMPLETED BY ATP ONLY)

4. BASIC MEASURING AND FITTING:

Independence in a wheelchair and seating device can be either enhanced or inhibited as a result of accurate or inaccurate measurements. Make sure there are complete anatomic and equipment measurements.

ACTUAL USER MEASUREMENTS

A: _____

B (R): _____

B (L): _____

C (R): _____

C (L): _____

D1: _____

D2: _____

E (R): _____

E (L): _____

F: _____

G: _____

H: _____

I (R): _____

I (L): _____

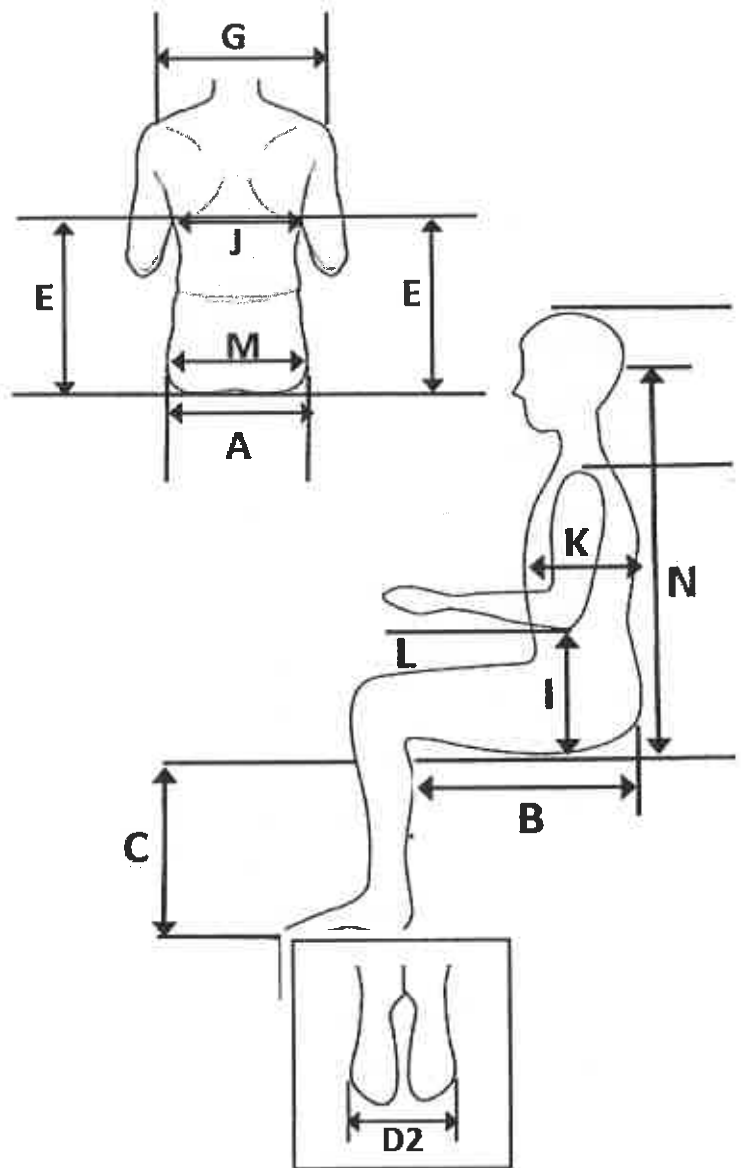
J: _____

K: _____

L: _____

M: _____

N: _____



Overall Width of Body (When Scoliosis Present)
Overall Depth of Body (When Kyphosis Present)

PROPOSED

**ARKANSAS DEPARTMENT OF HUMAN SERVICES
DIVISION OF MEDICAL SERVICES**

EVALUATION FOR WHEELCHAIR AND WHEELCHAIR SEATING

PART B (MUST BE COMPLETED BY ATP ONLY)

5. ACCESSORIES:

ARMRESTS	FRONT RIGGING	REAR WHEELS
Adj. Height:	Angle Adjustable/High Mount:	Composite/Mag:
Arm Troughs:	Ankle Straps:	Flat Free Inserts:
Desk Length:	Articulating Leg-Rests: <i>(Circle Number)</i>	One Arm Drive:
Detachable:	60 70 75 80 85 90 Degrees	Right: Left:
Flip Back:	Detachable:	Hand-Rims <i>(Any Type)</i> :
Full Length:	Heel Loops:	Pneumatic Tires:
Padded Swing-Away:	Leg Straps:	Projection Hand-Rims:
Swing-Away:	One Piece/Platform:	Vertical/Oblique:
Other:	Shoe Holders Size:	Size:
	Swing-Away:	Spokes:
Justification:	Toe Straps:	Other:
	XLG Footplates:	
	Other:	Justification:
	Justification:	

Was Client Evaluated in a Power Wheelchair: Yes: ☐ No: ☐

If No, State Reasons Why:

If Yes, Does The Client Have The Fine Motor, Fine Sensory and Cognitive Abilities To Operate The Power Wheelchair Safely With Respect To Others?

Yes: ☐ No: ☐

If No, Explain:

Additional Information:

PROMISED

**ARKANSAS DEPARTMENT OF HUMAN SERVICES
DIVISION OF MEDICAL SERVICES
EVALUATION FOR WHEELCHAIR AND WHEELCHAIR SEATING**

PART B (MUST BE COMPLETED BY ATP ONLY)

6. ACCESSORIES: (Continued)

CASTORS:	ACCESSORIES:	SEATBELTS:
Flat-Free Inserts:	Anti-Tip Tubes:	Airplane Styles:
Pneumatic Tires:	Batteries:	Auto Styles:
Solid Tires:	Tray:	Padded:
Justification:	Type:	Velcro:
	Wheel-Lock Extensions:	Other:
	Other:	
		Justification:
	Justification:	

7. POSITIONING COMPONENTS:

Abductors: Flip Down: ☐ Removable: ☐ Fixed: ☐ Custom: ☐ Size: Detachable: ☐

Thigh Support: Left: ☐ Right: ☐ Bilateral: ☐ Fixed: ☐ Detachable: ☐

Hip Guide: Left: ☐ Right: ☐ Bilateral: ☐ Fixed: ☐ Detachable: ☐

Head/Neck Support: Type:

Vest: Chest Harness: Straps: Padded: Non-Padded:

Size: Small: Medium: Large: Extra-Large:

Anterior Trunk Support: Type: Size:

Size:

Tilt Or Recline Requirements and Justification:

PROPOSED

ARKANSAS DEPARTMENT OF HUMAN SERVICES
DIVISION OF MEDICAL SERVICES
EVALUATION FOR WHEELCHAIR AND WHEELCHAIR SEATING

PART B (MUST BE COMPLETED BY ATP ONLY)

8. PHYSICAL THERAPY:

Physical Therapy: Yes: ☐ No: ☐

If Yes, Where and How Often:

Reason For Referral:

Client Lives: Alone: ☐ With Spouse: ☐ Parents: ☐ Foster Parents: ☐

Residential Facility: ☐ Other: ☐

If Residential Facility, Name of Facility:

Does Client Have Any of The Following: *(Check All That Apply)*

Walker: Cane: ☐ Crutches: ☐ Braces: ☐ Orthotics: ☐ Prosthesis ☐ Other: ☐

Describe How Any of The Above Are Used:

9. ENVIRONMENTAL EVALUATION:

Is Client Totally Chair Confined: Yes: ☐ No: ☐

Transfer Capabilities:

Is Client Ambulatory: Yes: ☐ No: ☐

If Yes, How Far Can Client Walk:

Please Specify Limitation:

PROPOSED

**ARKANSAS DEPARTMENT OF HUMAN SERVICES
DIVISION OF MEDICAL SERVICES
EVALUATION FOR WHEELCHAIR AND WHEELCHAIR SEATING**

PART B (MUST BE COMPLETED BY ATP ONLY)

10. ENVIRONMENTAL EVALUATION: (Continued)

a. Is Client Able To Adequately Self-Propel in a Standard/Manual Wheelchair:	Yes: <input type="checkbox"/>	No: <input type="checkbox"/>
b. Lightweight Wheelchair:	Yes: <input type="checkbox"/>	No: <input type="checkbox"/>
c. Ultra-Lightweight Wheelchair:	Yes: <input type="checkbox"/>	No: <input type="checkbox"/>
d. Any Difficulty Wheeling Over Carpet Or Grass:	Yes: <input type="checkbox"/>	No: <input type="checkbox"/>
If Yes, Explain:		
e. Type of Terrain Encountered Daily:		

11. MEDICAL NECESSITY CONSIDERATION: (Check all that apply)

a. Independent:	<input type="checkbox"/>	Pressure Relief:	<input type="checkbox"/>
b. Progressive Condition:	<input type="checkbox"/>	Endurance:	<input type="checkbox"/>
c. Comfort:	<input type="checkbox"/>	Growth:	<input type="checkbox"/>
d. Supported Position:	<input type="checkbox"/>	Other:	<input type="checkbox"/>

12. PRECAUTIONS:

Skin Breakdown: Yes: ☐ No: ☐ High Risk: ☐ Moderate Risk: ☐ Low Risk: ☐

If Yes, Describe:

Sensation: Absent: ☐ Impaired: ☐ Both: ☐

Location of Sensation:

PROPOSED

**ARKANSAS DEPARTMENT OF HUMAN SERVICES
DIVISION OF MEDICAL SERVICES
EVALUATION FOR WHEELCHAIR AND WHEELCHAIR SEATING**

PART B (MUST BE COMPLETED BY ATP ONLY)

13. ORTHOPEDIC DEFORMITIES:

(Check all that apply)

Scoliosis:	<input type="checkbox"/>
Kyphosis:	<input type="checkbox"/>
Trunk Rotation:	<input type="checkbox"/>
Pelvic Rotation:	<input type="checkbox"/>
Amputee (<i>Specify</i>):	<input type="checkbox"/>
Contractures:	<input type="checkbox"/>
Wind Swept:	<input type="checkbox"/>
Hip Dislocation:	<input type="checkbox"/>
Spasms:	<input type="checkbox"/>
Other:	<input type="checkbox"/>
Description and Severity of Each:	

TONE: *(Check all that apply)*

Hypertonic:	Yes: <input type="checkbox"/>	No: <input type="checkbox"/>
Hypotonic:	Yes: <input type="checkbox"/>	No: <input type="checkbox"/>
Mixed:	Yes: <input type="checkbox"/>	No: <input type="checkbox"/>
Normal:	Yes: <input type="checkbox"/>	No: <input type="checkbox"/>

WEAKNESS OF: *(Check All That Apply)*

All Extremities:	<input type="checkbox"/>
Right Lower Extremity:	<input type="checkbox"/>
Left Lower Extremity:	<input type="checkbox"/>
Right Upper Extremity:	<input type="checkbox"/>
Left Upper Extremity:	<input type="checkbox"/>

14. SPASTICITY OF: *(Check all that apply)*

All Extremities:	<input type="checkbox"/>	Detail of Spasticity:
Right Lower Extremity:	<input type="checkbox"/>	Detail of Spasticity:
Left Lower Extremity:	<input type="checkbox"/>	Detail of Spasticity:
Right Upper Extremity:	<input type="checkbox"/>	Detail of Spasticity:
Left Upper Extremity:	<input type="checkbox"/>	Detail of Spasticity:
Additional Details:		

15. HEAD CONTROL: *(Check all that apply)*

None:	<input type="checkbox"/>
Poor:	<input type="checkbox"/>
Fair:	<input type="checkbox"/>
Good:	<input type="checkbox"/>
Provide Detail of Each:	

TRUNK CONTROL: *(Check all that apply)*

None:	<input type="checkbox"/>
Poor:	<input type="checkbox"/>
Fair:	<input type="checkbox"/>
Good:	<input type="checkbox"/>
Provide Detail of Each:	

PART B (MUST BE COMPLETED BY ATP ONLY)

PROPOSED

**ARKANSAS DEPARTMENT OF HUMAN SERVICES
DIVISION OF MEDICAL SERVICES**

EVALUATION FOR WHEELCHAIR AND WHEELCHAIR SEATING

16. CONTRACTURES: *(Check all that apply)*

OTHER: *(Check all that apply)*

<u>Ankles:</u>	<u>Yes:</u>	<u>No:</u>	<u>Edemas:</u>	<u>Yes:</u>	<u>No:</u>
<u>Hips:</u>	<u>Yes:</u>	<u>No:</u>	<u>Incontinent:</u>	<u>Yes:</u>	<u>No:</u>
<u>Knees:</u>	<u>Yes:</u>	<u>No:</u>	<u>Poor Skin Integrity:</u>	<u>Yes:</u>	<u>No:</u>
<u>Feet:</u>	<u>Yes:</u>	<u>No:</u>	<u>History of Decubitus:</u>	<u>Yes:</u>	<u>No:</u>
<u>Shoulders:</u>	<u>Yes:</u>	<u>No:</u>	<u>Unable To Position:</u>	<u>Yes:</u>	<u>No:</u>
<u>Elbows:</u>	<u>Yes:</u>	<u>No:</u>	<u>Seizures:</u>	<u>Yes:</u>	<u>No:</u>
<u>Hands:</u>	<u>Yes:</u>	<u>No:</u>	<u>Vision:</u>	<u>Normal:</u>	<u>Impaired:</u>
<u>Wrists:</u>	<u>Yes:</u>	<u>No:</u>	<u>Hearing:</u>	<u>Normal:</u>	<u>Impaired:</u>

17. ADDITIONAL INFORMATION:

Will Client Self-Propel Manual Wheelchair Or Will Family Member Or Caregiver Push Client:

Name of ATP *(Please Print)*

Name of PT/OT/Seating Specialist

RESNA Certified: Yes ☐ No ☐

RESNA Certification Number: _____

Signature of PT/OT/Seating Specialist

Signature of ATP

Date

PROPOSED

ARKANSAS DEPARTMENT OF HUMAN SERVICES
DIVISION OF MEDICAL SERVICES
EVALUATION FOR WHEELCHAIR AND WHEELCHAIR SEATING

PART C (MUST BE COMPLETED BY PRESCRIBING PHYSICIAN ONLY)

1. **DIAGNOSIS:** **CURRENT**

MEDICATIONS:

1. _____

2. _____

3. _____

4. _____

5. _____

2. INJURY:

Date of Injury: _____

**Level of
Injury:** _____

Future Surgery Planned: Yes ☐ No ☐

If Yes, Explain: _____

3. MEDICAL EQUIPMENT:

Apnea Monitor: ☐

Oxygen: ☐

Communication Device: ☐

Ventilator: ☐

Other: ☐

4. ADDITIONAL INFORMATION:

Seizures: **Are They Controlled?**

If Yes, How Long?

Prescribing Physician Name (Please Print)

Physician's Provider Number

**Prescribing Physician Signature
(No Stamp Please)**

Date of Evaluation

PROPOSED

PROPOSED