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TO: **Arkansas Medicaid Health Care Providers - Child Health Management Services (CHMS)**

DATE: **August 1, 2005**

SUBJECT: **Provider Manual Update Transmittal No. 57**

REMOVE		**INSERT**	
Section	**Date**	**Section**	**Date**
201.000 – 201.110	10-13-03	201.000 – 201.110	8-1-05
201.200 – 202.000	10-13-03	201.200 – 202.000	8-1-05
220.100 – 220.200	10-13-03	220.100	8-1-05
261.000 – 262.130	10-13-03	261.000 – 262.130	8-1-05

Explanation of Updates

Sections 201.000 through 201.110 and 201.200 through 202.000 have been revised to change the name of the Department of Human Services to the Department of Health and Human Services. Minor wording changes have been made for clarity.

Section 220.100 has been revised to delete obsolete information and provide correct information regarding benefit limits of diagnosis and evaluation services. Section 220.200 has been deleted from the manual.

Sections 261.000 through 262.130 have been revised to include corrections in procedure codes and modifiers effective for dates of service on and after November 1, 2005.

Paper versions of this update transmittal have updated pages attached to file in your provider manual. See Section I for instructions on updating the paper version of the manual. For electronic versions, these changes will be automatically incorporated.

If you need this material in an alternative format, such as large print, please contact our Americans with Disabilities Act Coordinator at (501) 682-6789 or 1-877-708-8191. Both telephone numbers are voice and TDD.

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

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

Thank you for your participation in the Arkansas Medicaid Program.

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Roy Jeffus, Director

SECTION II - CHILD HEALTH MANAGEMENT SERVICES

CONTENTS

201.000 Arkansas Medicaid Participation Requirements for Child Health Management Services (CHMS) Providers 8-1-05

Providers of Child Health Management Services (CHMS) must meet the following criteria in order to be eligible to participate in the Arkansas Medicaid Program:

A. CHMS must be provided by an organization that is certified by Arkansas Foundation for Medical Care, Inc. (AFMC) to be in full compliance with one of the two conditions described below:

1. An academic medical center program specializing in Developmental Pediatrics that is administratively staffed and operated by an academic medical center and under the direction of a boarded or board-eligible developmental pediatrician. An academic medical center consists of a medical school and its primary teaching hospitals and clinical programs. In order to be eligible for CHMS reimbursement, the academic medical center must:

   a. Be located in the state of Arkansas;

   b. Provide multi-disciplinary diagnostic, evaluation and treatment services to children throughout Arkansas;

   c. Serve as a large multi-referral program as well as a referral source for other non-academic CHMS providers with the state and

   d. Be staffed to provide training of pediatric residents and other professionals in the multi-disciplinary diagnostics, evaluation and treatment of children with special health care needs.

   For an academic medical center CHMS program, services may be provided at different sites operated by the academic medical center as long as the CHMS program falls under one administrative structure within the academic medical center.

   OR

2. A program housed under one roof and one administrative structure.

B. An organization seeking to provide CHMS must complete a certification and licensure process for each CHMS service delivery site. A certification or a license is not transferable from one holder to another or from one location to another.

   A request for certification/licensure must be directed in writing to each of the following organizations:

1. The Arkansas Department of Health Human Services, Division of Health, Office of Quality Assurance. **View or print the Division of Health contact information.** (certification)

2. The Arkansas Foundation for Medical Care, Inc. (AFMC). **View or print AFMC contact information**.(certification)

3. The Arkansas Department of Health and Human Services, Division of Child Care and Early Childhood Education, Child Care Licensing Unit. **View or print the Arkansas Department of Human Services, Division of Child Care and Early Childhood Education, Child Care Licensing Unit contact information.** (licensure)

C. Providers of CHMS services must complete and submit to Medicaid Provider Enrollment a provider application (form DMS-652), a Medicaid contract (form DMS-653) and a Request for Taxpayer Identification Number and Certification (Form W-9). **View or print a provider application (form DMS-652), a Medicaid contract (form DMS-653) and a Request for Taxpayer Identification Number and Certification (Form W-9).**

D. The provider application and Medicaid contract must have accompanying copies of:

1. Current certification from the Division of Health, Office of Quality Assurance;
2. Current certification from AFMC and
3. Verification of current Child Care Center licensure from the Division of Child Care and Early Childhood Education.

Subsequent certifications and license renewals must be submitted to the Medicaid Provider Enrollment Unit within thirty days of issue.

E. The Arkansas Medicaid Program must approve the provider application and the Medicaid contract.

201.100 CHMS Certification Requirement Reviews: Arkansas Department of Health and Human Services, Office of Quality Assurance and Arkansas Foundation for Medical Care, Inc. 10-13-03

The Department of Health and Human Services or its designees (Arkansas Division of Health, Office of Quality Assurance and Arkansas Foundation for Medical Care, Inc.) shall conduct an annual CHMS Certification Review to substantiate continued compliance with these regulations and standards.

A formal report listing any cited deficiencies shall be forwarded by the reviewer to the CHMS clinic within fifteen (15) working days of the certification review.

201.110 CHMS Corrective Action Plan (CAP) 10-13-03

The CHMS clinic shall have thirty (30) calendar days from the receipt date of the report to develop and submit a written corrective action plan to remedy the deficiencies noted in the certification review report. The clinic may formally request an extension of up to thirty (30) days by submitting sufficient written justification to the Department of Health and Human Services or its designee, as appropriate, within the first thirty (30) day time frame.

Within five (5) working days of receipt of the plan the reviewing entity shall inform the CHMS clinic in writing of any recommended modification to the corrective action plan. The notification shall include a time frame for the CHMS clinic to respond to a request for CAP modification.

Failure to file a corrective action plan and/or subsequent revisions to the plan within the required time frames shall result in the CHMS clinic being placed in a non-certified status. Written notice of non-certification will be forwarded to the CHMS clinic and the Arkansas Medicaid Provider Enrollment Unit. **Enrollment in the Arkansas Medicaid Child Health Management Program is contingent upon the CHMS clinic's certification status.** Clinics holding a non-certification status are not eligible to receive reimbursement from the Arkansas Medicaid Program. A clinic's non-certification status will remain in effect until the clinic is found to be in compliance with the certification requirements.

The Director of the Division of Medical Services will be apprised of the site visit results. The Director must approve or disapprove recommendations for renewal or non-renewal of certification.

All certification review reports, corrective action plans and progress reports will be filed with and maintained by the Department of Health and Human Services or its designees

201.200 CHMS Licensing Requirement Reviews and Appeal Process: Division of Child Care and Early Childhood Education, Child Care Licensing Unit 10-13-03

The "Child Care Facility Licensing Act" Ark. Code Annotated §20-78-201-220, as amended, authorizes the Department of Health and Human Services, Division of Child Care and Early Childhood Education to establish rules and regulations governing the granting, denial, suspension and revocation of the licenses for child care facilities and their operation in Arkansas. Section 102, **Licensing Procedures**, of the *Minimum Licensing Requirements for Child Care Center*s manual, outlines the process for licensure and for maintaining licensed status. The process for licensing reviews, deficiency reports, corrective action plans and hearings and appeals administered by the Division of Child Care and Early Childhood Education shall be followed.

Enrollment in the Arkansas Medicaid CHMS Program is contingent upon the CHMS clinic's licensure status.

The Director of the Division of Medical Services will be apprised of the site visit results. All certification review reports, corrective action plans and progress reports will be filed with and maintained by the Department of Health and Human Services, Division of Child Care and Early Childhood Education.

202.000 Arkansas Medicaid Participation Requirements for Providers of Comprehensive Health Assessments for Foster Children 8-1-05

Providers of comprehensive health assessments for foster children must meet the following criteria in order to be eligible to participate in the Arkansas Medicaid Program:

A. An organization seeking to provide comprehensive health assessments for foster children must be certified by the Division of Children and Family Services (DCFS). The request for certification should be directed in writing to the Department of Health and Human Services, Division of Children and Family Services, Contracts Management Unit. **View or print the Contracts Management Unit contact information.**

B. A provider of comprehensive health assessments for foster children must complete and submit to the Medicaid Provider Enrollment Unit a provider application (form DMS-652), a Medicaid contract (form DMS-653) and a Request for Taxpayer Identification Number and Certification (Form W-9). A copy of the certification as a provider of comprehensive health assessments for foster children must accompany the application and contract. **View or print a provider application (DMS-652), a Medicaid contract (DMS-653) and a Request for Taxpayer Identification Number and Certification (Form W-9).**

C. The Arkansas Medicaid Program must approve the provider application and the Medicaid contract.

220.100 Benefit Limits for CHMS Diagnosis and Evaluation Procedures 8-1-05

Diagnosis and evaluation procedures are limited to two (2) diagnosis and evaluation encounters per state fiscal year (July 1 through June 30). Some diagnosis and evaluation procedures are also limited by a maximum number of units per state fiscal year. If additional diagnosis and evaluation services are required, the CHMS provider must request an extension of the benefit limit from the Arkansas Foundation for Medical Care, Inc. (AFMC).

261.000 Introduction to Billing 8-1-05

CHMS providers use the CMS-1500 form to bill the Arkansas Medicaid Program on paper for services provided to eligible Medicaid recipients. Each claim may contain charges for only one recipient.

Section III of this manual contains information about Provider Electronic Solutions (PES) and other available options for electronic claims submission.

262.000 CMS-1500 Billing Procedures 8-1-05

262.100 Child Health Management Services Procedure Codes 8-1-05

262.110 Diagnosis and Evaluation Procedure Codes 8-1-05

The following diagnosis/evaluation procedure codes are limited to two (2) diagnosis and evaluation encounters per state fiscal year (July 1 through June 30). If diagnosis and evaluation procedures require additional services, the CHMS provider must request an extension of the benefit limit. Refer to section 220.100 for more information regarding extension of benefits.

Procedure Codes

90805	90807	90809	92506	92551
92552	92553	92555	92557	92567
92582	92585	92587	92588	96105
96111	96117	99201	99202	99203
99204	99205			

Procedure Code	Required Modifier(s)	Description
90801		Diagnostic evaluation/review of records (1 unit = 15 minutes), maximum of 3 units
90887		Interpretation of diagnosis (1 unit = 15 minutes), maximum of 3 units
96100	UA, UB Use modifiers 52 and 22 for services provided prior to November 1, 2005.	Psychological testing battery (1 unit = 15 minutes), maximum of 4 units
97001		Evaluation for physical therapy (1 unit = 30 minutes), maximum of 4 units per state fiscal year
97003		Evaluation for occupational therapy (1 unit = 30 minutes), maximum of 4 units per state fiscal year

Procedure Code	Required Modifier(s)	Description
97802		Nutrition Screening: Review of recent nutrition history, medical record, current laboratory and anthropometric data and conference with patient, caregiver or other CHMS professional (1 unit = 15 minutes). Maximum of 2 units per state fiscal year
97802	U1	Nutrition Assessment: Assessment/evaluation of current nutritional status through history of nutrition, activity habits and current laboratory data, weight and growth history and drug profile; determination of nutrition needs; formulation of medical nutrition therapy plan and goals of treatment; a conference will be held with parents and/or other CHMS professionals or a written plan for medical nutrition therapy management will be provided (1 unit = 15 minutes). Maximum of 2 units per state fiscal year
97802	U2	Comprehensive Nutrition Assessment: Assessment/evaluation of current nutritional status through initial history of nutrition, activity and behavioral habits; review of medical records; current laboratory data, weight and growth history, nutrient analysis and current anthropometric data (when available); determination of energy, protein, fat, carbohydrate and macronutrient needs; formulation of medical nutrition therapy plan and goals of treatment. May conference with parent(s)/guardian or caregivers and/or physician for implementation of medical nutrition therapy management or provide a written plan for implementation (1 unit = 15 minutes). Maximum of 4 units per state fiscal year

262.120 Treatment Procedure Codes 8-1-05

The following treatment procedures are payable for services included in the child's treatment plan. Prior authorization is required for *all* CHMS treatment procedures. See section 240.000 of this manual for prior authorization requirements.

Procedure Codes

90804	90806	90808	90847	90849
97703	99211	99212	99213	99214
99215				

Procedure Code	Required Modifier(s)	Description
T1024		Brief Consultation, on site — A direct service contact by a CHMS professional on-site with a patient for the purpose of: obtaining the full range of needed services; monitoring and supervising the patient's functioning; establishing support for the patient and gathering information relevant to the patient's individual treatment plan.

Procedure Code	Required Modifier(s)	Description
T1024	U1	Collateral Services, on site — Face-to-face contact on-site by a CHMS professional with other professionals, caregivers or other parties on behalf of an identified patient to obtain or provide relevant information necessary to the patient's assessment, evaluation or treatment.
90846	U4	Family therapy, on-site, for therapy as part of the treatment plan, without the patient present (1 unit = 15 minutes)
90847	U4	Family therapy, on site, for therapy as part of the treatment plan, with the patient present (1 unit = 15 minutes)
97150		Group occupational therapy (1 unit = 15 minutes), maximum of 4 clients per group
99361	UA Use modifier 22 for services provided prior to November 1, 2005.	Treatment Plan — Plan of treatment developed by CHMS professionals and the patient's caregiver(s). Plan must include short- and long-term goals and objectives and include appropriate activities to meet those goals and objectives (1 unit = 15 minutes).

Procedure Code	Required Modifier(s)	Description
H2011	—	Crisis Management Visit, on site — An unscheduled/ unplanned direct service contact on site with the identified patient for the purpose of preventing physical injury, inappropriate behavior or placement in a more restrictive service delivery system (one unit = 15 minutes)
S9470	—	Nutrition Counseling/Consultation — Conference with parent/guardian and/or PCP to provide results of evaluation, discuss medical nutrition therapy plan and goals of treatment and education. May provide detailed menus for home use and information on sources of special nutrition products (1 unit = 30 minutes)
90853	—	Group Psychotherapy/counseling (1 unit = 5 minutes)
92507	—	Individual Speech Session (1 unit = 15 minutes)
92507	UB	Individual Speech Therapy by Speech-Language Pathology Assistant (1 unit = 15 minutes)
92508	—	Group Speech Session (1 unit = 15 minutes), maximum of 4 clients per group
92508	UB	Group Speech Therapy by Speech-Language Pathology Assistant (1 unit = 15 minutes), maximum of 4 clients per group
97110	—	Individual Physical Therapy (1 unit = 15 minutes)

Procedure Code	Required Modifier(s)	Description
97110	UB Use modifier 52 for services provided prior to November 1, 2005.	Individual Physical Therapy by Physical Therapy Assistant (1 unit = 15 minutes)
97150	—	Group Physical Therapy (1 unit = 15 minutes), maximum of 4 clients per group
97150	U2	Group Occupational Therapy (1 unit = 15 minutes), maximum of 4 clients per group
97150	U1, UB Use modifier 52 in place of modifier UB for services provided prior to November 1, 2005.	Group Occupational Therapy by Occupational Therapy Assistant (1 unit = 15 minutes), maximum of 4 clients per group
97150	UB Use modifier 52 for services provided prior to November 1, 2005.	Group Physical Therapy by Physical Therapy Assistant (1 unit = 15 minutes), maximum of 4 clients per group
97530	—	Individual Occupational Therapy (1 unit = 15 minutes)
97530	UB Use modifier 52 for services provided prior to November 1, 2005.	Individual Occupational Therapy by Occupational Therapy Assistant (1 unit = 15 minutes)
97530	U1	Developmental Motor Activity Services — Individualized activities provided by, or under the direction of, an Early Childhood Developmental Specialist to improve general motor skills by increasing coordination, strength and/or range of motion. Activities will be directed toward accomplishment of a motor goal identified in the patient's individualized treatment plan as authorized by the responsible CHMS physician (1 unit = 15 minutes)

Procedure Code	Required Modifier(s)	Description
97532	—	Cognitive Development Services — Individualized activities to increase the patient's intellectual development and competency. Activities will be those appropriate to carry out the treatment plan for the patient as authorized by the responsible CHMS physician. Cognitive Development Services will be provided by or under the direction of an Early Childhood Developmental Specialist. Activities will address goals of cognitive and communication skills development: (1 unit = 15 minutes).
97535	UB Use modifier 52 for services provided prior to November 1, 2005.	Self Care and Social/Emotional Developmental Services — Individualized activities provided by or under the direction of an Early Childhood Developmental Specialist to increase the patient's self-care skills and/or ability to interact with peers or adults in a daily life setting/situation. Activities will be those appropriate to carry out the treatment plan for the patient as authorized by the responsible CHMS physician. (1 unit = 15 minutes).
97803	—	Nutrition follow-up: Reassess recent nutrition history, new anthropometer and laboratory data to evaluate progress toward meeting medical nutritional goals. May include a conference with parent or other CHMS professional (1 unit = 15 minutes).

262.130 CHMS Procedure Codes – Foster Care Program 8-1-05

Refer to section 202.000 of this manual for Arkansas Medicaid Participation Requirements for Providers of Comprehensive Health Assessments for Foster Children.

The following procedure codes are to be used only for the mandatory comprehensive health assessments of children entering the Foster Care Program. Claims for these codes must be billed with a type of service (TOS) code **"M"** when filled on paper. These procedures *do not* require prior authorization.

Procedure Code	Required Modifier(s)	Description
T1016		Informing (1 unit = 15 minutes), maximum of 4 units
T1023		Staffing (1 unit = 15 minutes), maximum of 4 units
T1025		Developmental Testing
90801	U1	Diagnostic Interview, includes evaluation and reports (1 unit = 15 minutes), maximum of 8 units
92506	U1	Speech Testing (1 unit = 15 minutes), maximum of 8 units
92551	U1	Audio Screen
92567	U1	Tympanometry

Procedure Code	Required Modifier(s)	Description
95961	UA Use modifier 22 for services provided prior to November 1, 2005.	Cortical Function Testing
96100	U1, UA Use modifier 22 in place of modifier UA for services delivered prior to November 1, 2005.	Psychological Testing, 2 or more (1 unit = 15 minutes), maximum of 8 units
96100	UA Use modifier 22 for services provided prior to November 1, 2005.	Interpretation (1 unit = 15 minutes), maximum of 8 units
99173		Visual Screen
99205 99215	U1 U1	High Complex medical exam