Arkansas Department of Health and Human Services

Division of Medical Services

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TO: **Arkansas Medicaid Health Care Providers**

DATE: **July 1, 2006**

SUBJECT: **Section V Provider Manual Update Transmittal**

Provider Manual	Transmittal Number
Alternatives for Adults with Physical Disabilities Waiver	36
Ambulatory Surgical Center	68
ARKids First-B	34
Certified Nurse-Midwife	72
Child Health Management Services	70
Child Health Services/Early and Periodic Screening, Diagnosis and Treatment	76
Children's Services Targeted Case Management	22
Chiropractic	65
DDS Alternative Community Services Waiver	63
Dental	88
Developmental Day Treatment Clinic Services	72
Developmental Rehabilitation Services	22
Division of Youth Services and Division of Children and Family Services Targeted Case Management	14
Domiciliary Care	50
ElderChoices Home and Community-Based 2176 Waiver	64
Federally Qualified Health Center	59
Hearing Services	61
Home Health	79
Hospice	51
Hospital/End-Stage Renal Disease	94
Hyperalimentation	77
Inpatient Psychiatric Services for Under Age 21	70
Licensed Mental Health Practitioners	54
Living Choices Assisted Living	20
Medicare/Medicaid Crossover Only	47
Nurse Practitioner	68
Occupational, Physical, Speech Therapy Services	61
Personal Care	74
Pharmacy	87

Provider Manual	**Transmittal Number**
Physician/Independent Lab/CRNA/Radiation Therapy Center	115
Podiatrist	67
Portable X-Ray Services	56
Private Duty Nursing Services	67
Prosthetics	79
Rehabilitative Hospital	64
Rehabilitative Services for Persons with Mental Illness	69
Rehabilitative Services for Persons with Physical Disabilities	42
Rehabilitative Services for Youth and Children	24
Rural Health Clinic Services	59
School-Based Mental Health Services	27
Targeted Case Management	60
Transportation	79
Ventilator Equipment	61
Visual Care	75

REMOVE		**INSERT**	
Section	**Date**	**Section**	**Date**
DMS-640	8/05	DMS-640	7/06

Explanation of Updates

Form DMS-640 has been revised to reflect the expenditure data for state fiscal year (SFY) 2005.

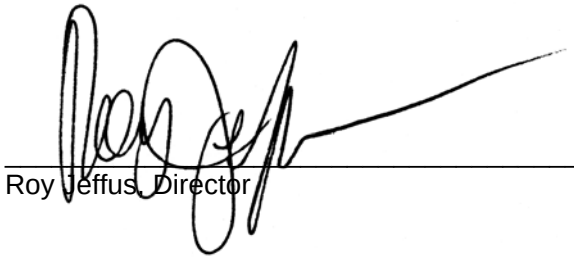
Paper versions of this update transmittal have updated pages attached to file in your provider manual. See Section I for instructions on updating the paper version of the manual. For electronic versions, these changes have already been incorporated.

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 (TDD only).

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.



Roy Jeffus, Director

Arkansas Division of Medical Services

Occupational, Physical and Speech Therapy for Medicaid Eligible Beneficiaries Under Age 21
PRESCRIPTION/REFERRAL

The PCP or attending physician must use this form to prescribe medically necessary Medicaid therapy services or must use this form to make a referral for therapy services. The provider must check the appropriate box or boxes.

☐ Referral ☐ Treatment

EVALUATE/TREAT IS NOT A VALID PRESCRIPTION

Patient Name: _____ Medicaid ID #: _____

Date Child Was Last Seen In Office: _____

Primary Diagnosis or ICD-9 code: _____

Diagnosis as Related to Prescribed Treatment: _____

_____

Complete this block if this form is a prescription		
Occupational Therapy (OT)	**Physical Therapy (PT)**	**Speech Therapy (ST)**
_____Minutes per week	_____Minutes per week	_____Minutes per week
_____Duration (months)	_____Duration (months)	_____Duration (months)
☐ Therapy Not Medically Necessary	☐ Therapy Not Medically Necessary	☐ Therapy Not Medically Necessary

Other Information: _____

_____

Note:

	OT	***PT***	***ST***
Expenditures for SFY05	****$26,619,993***	****$14,826,859***	****$26,559,204***
Average Units Per Beneficiary	***201***	***83***	***83***
Average Cost Per Beneficiary	***$2,131***	***$1,402***	***$1,378***
Total Beneficiaries Served	***12,493***	***10,576***	***19,268***

_____ _____
Primary Care Physician (PCP) Name *(Please Print)* Medicaid Provider Number

_____ _____
Attending Physician Name *(Please Print)* Medicaid Provider Number

By signing as the PCP or Attending Physician, I hereby certify that I have carefully reviewed each element of the therapy treatment plan, that the goals are reasonable and appropriate for this patient, and in the event that this prescription is for a continuing plan I have reviewed the patients progress and adjusted the plan for his or her meeting or failure to meet the plan goals.

_____ _____
Physician Signature *(PCP or attending Physician)* Date

DMS-640 (Rev. 7-2006)

Instructions for Completion

Form DMS-640 – Occupational, Physical and Speech Therapy for Medicaid Eligible Beneficiaries Under Age 21 PRESCRIPTION/REFERRAL

- If DMS-640 is used to make an initial referral for evaluation, check the referral box only. After receiving the evaluation results and determining that therapy is necessary, you must use a separate DMS-640 form to prescribe the therapy. Check the treatment box for prescription and complete the form following the instructions below. If the referral and prescription are for previously prescribed services, you may check both boxes.

- Patient Name – Enter the patient's full name.

- Medicaid ID # - Enter the patient's Medicaid ID number.

Physician/Physician's office staff must complete the following:

- Date Child Was Last Seen In Office – Enter the date of the last time you saw this child. (This could be either for a complete physical examination, a routine check-up or an office visit for other reasons requiring your personal attention.)

- Primary Diagnosis – Enter the primary medical diagnosis description or ICD-9 diagnosis code.

- Diagnosis as Related to Prescribed Treatment – Enter the diagnosis that indicates or establishes medical necessity for prescribed therapy.

- Prescription block – If the form is used for a prescription, enter the prescribed number of minutes per week and the prescribed duration (in months) of therapy.

- If therapy is not medically necessary at this time, check the box.

- Other Information – Any other information pertinent to the child's medical condition, plan of treatment, etc., may be entered.

- Primary Care Physician (PCP) Name and Medicaid Provider Number – Print the name of the prescribing PCP and his or her Medicaid provider number.

- Attending Physician Name and Medicaid Provider Number – If the Medicaid-eligible child is exempt from PCP requirements, print the name of the prescribing attending physician and his or her Medicaid provider number.

- Physician Signature and Date – The prescribing physician must sign and date the prescription for therapy in his or her original signature.

***These therapy amounts include therapy provided in a Developmental Day Treatment Center (DDTCS)**

The original of the completed form DMS-640 must be maintained in the child's medical records by the prescribing physician. A copy of the completed form DMS-640 must be retained by the therapy provider.