Arkansas Department of Health and Human Services

Division of Medical Services

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

DATE: **December 1, 2006**

SUBJECT: **Provider Manual Update Transmittal # 90**

REMOVE		**INSERT**	
Section	**Date**	**Section**	**Date**
211.100	10-13-03	211.100	12-1-06
211.200	8-1-05	211.100	12-1-06
211.300	8-1-05	211.300	12-1-06
211.400	8-1-05	211.400	12-1-06
211.800	8-1-05	211.800	12-1-06
212.201	8-1-05	212.201	12-1-06
212.202	8-1-05	212.202	12-1-06
212.204	8-1-06	212.204	12-1-06
212.205	8-1-05	212.205	12-1-06
212.207	8-1-05	212.207	12-1-06
212.209	8-1-05	212.209	12-1-06
212.212	8-1-05	212.212	12-1-06
212.600	8-1-05	212.600	12-1-06
212.700	8-1-05	212.700	12-1-06
221.000	10-13-03	221.000	12-1-06
221.100	10-13-03	221.100	12-1-06
221.200	8-1-05	221.200	12-1-06
221.300	8-1-05	221.300	12-1-06
221.400	8-1-05	221.400	12-1-06
—	—	221.500	12-1-06
—	—	221.600	12-1-06
236.000	8-1-05	236.000	12-1-06
242.120	12-5-05	242.120	12-1-06
242.122	8-1-06	242.122	12-1-06
242.152	8-1-05	242.152	12-1-06
—	—	AFMC contact info	12-1-06

Explanation of Updates

Note:

Effective for dates of service on and after December 1, 2006, the Arkansas Foundation for Medical Care, Inc. (AFMC) will provide medically necessary determinations on all prior authorization requests for:

(1) Some medical supplies, including supplies for maintenance of the drug infusion catheter, supplies for the external drug infusion pump and for compression burn garments, and gradient compression stockings,

(2) Orthotic appliances,

(3) Prosthetic devices, and

(4) Durable medical equipment, excluding wheelchairs, wheelchair seating systems and wheelchair repair.

Providers must submit requests for prior authorization to AFMC on form AFMC-103, titled "Prescription & Prior Authorization Request for Medical Equipment Excluding Wheelchairs & Components".

Section 211.100 has been revised to include information about the use of the form AFMC-103, which is titled "Prescription & Prior Authorization Request for Medical Equipment Excluding Wheelchairs & Wheelchair Components". Information is included to advise that the DMS-679 will now be used for prior authorization of wheelchairs, wheelchair seating systems and wheelchair repairs. The DMS-699 will be used for extension of benefits for diapers and underpads for beneficiaries age three and older. Minor text changes have been made that do not affect policy.

Sections 211.200 through 211.400 have been included to add information about the revised use of form DMS-679 and the use of the AFMC-103. Minor text changes have been made that do not affect policy.

Section 211.800 has been included to advise that form DMS-699 for extension of benefits will be used to file extension of benefits only for diapers and underpads by Utilization Review. Form AFMC-103 will be used by AFMC to request extensions for the augmentative communication device. AFMC will notify providers of approval or denial by letter. Minor text changes have been made that do not affect policy.

Section 212.201 has been included to advise that the AFMC-103 will be used for prior authorization requests for apnea monitors for infants under age 1.

Section 212.202 has been included to advise that the AFMC-103 will be used for prior authorization requests for the augmentative communication device (ACD) for beneficiaries of all ages. The form will also be used for the request for benefit extensions for the ACD. Providers will be notified in writing for the approval or denial of the request. Minor text changes have been made that do not affect policy. Section 212.204 has been included to advise that the AFMC-103 will be used for prior authorization requests for the electronic blood pressure monitor for beneficiaries of all ages.

Section 212.205 has been included to change the heading title and to advise that the AFMC-103 will be used for prior authorization requests for the enteral nutrition infusion pump for beneficiaries under age 21. Minor text changes have been made that do not affect policy.

Section 212.207 has been included to advise that the AFMC-103 will be used for prior authorization requests for the insulin pump and supplies for beneficiaries of all ages. Minor text changes have been made that do not affect policy.

Section 212.209 has been included to change the heading title and to advise that the AFMC-103 will be used for prior authorization requests for the MIC-KEY skin level gastrostomy tube and supplies for beneficiaries under age 21. Minor text changes have been made that do not affect policy.

Section 212.212 has been included to advise that the AFMC-103 will be used for prior authorization requests for specialized rehabilitative equipment for beneficiaries of all ages. Minor text changes have been made that do not affect policy. Section 212.600 has been included to advise that the AFMC-103 will be used for prior authorization requests for orthotic appliances and prosthetic devices for beneficiaries of all ages.

Section 212.700 has been included to advise that the AFMC-103 will be used for prior authorization requests for oxygen and oxygen supplies for beneficiaries of all ages.

Section 221.000 has been included to clarify information about prior authorization.

Section 221.100 has been included to change the heading title and to advise that **effective for dates of service on and after December 1, 2006, that the Arkansas Foundation for Medical Care Inc. (AFMC) will provide prior authorization for some medical supplies (i.e.: compression burn garments) orthotic appliances, prosthetic devices and all durable medical equipment, excluding wheelchairs, wheelchair seating systems and wheelchair repairs**. The Utilization Review Section will continue to provide prior authorization for wheelchairs, wheelchair seating systems and wheelchair repairs.

Section 221.200 has been revised to include information that **effective for dates of service on and after December 1, 2006, providers must submit requests for prior authorization to AFMC on form AFMC-103, titled "Prescription & Prior Authorization Request for Medical Equipment Excluding Wheelchairs & Components"**. Requests for prior authorization for wheelchairs, wheelchair seating systems and wheelchair repairs may continue to be requested from the Utilization Review Section using form DMS-679.

Section 221.300 has been revised to include information about the approval process for prior authorizations by AFMC. Information is also included to advise of the process for prior authorization by the Utilization Review Section.

Section 221.400 has been included to advise of denials of a prior authorization request. Obsolete information has been removed from the section.

Section 221.500 has been developed to inform providers of the reconsideration of denied claims.

Section 221.600 has been developed to inform providers of fair hearing requests.

Section 236.000 has been included to advise that the AFMC-103 will be used for prior authorization requests for repairs of the enteral nutrition pump.

Section 242.120 has been included to advise that the AFMC-103 will be used for prior authorization requests for some medical supplies, including supplies for the maintenance of the drug infusion catheter, for the external drug infusion pump and for burn garments. Obsolete information has been removed from the section.

Section 242.122 has been included to advise that the AFMC-103 will be used for prior authorization requests for the gradient compression stocking (Jobst).

Section 242.152 has been included to advise that AFMC must be contacted for requests to prior authorize the use of the enteral nutrition pump and enteral feeding pump supply kit.

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.

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Roy Jeffus, Director

TOC required

211.100 Condition for Provision of Services 12-1-06

The following conditions must be met for the provision of services:

A. The patient must reside in the state of Arkansas.

B. The patient must be an Arkansas Medicaid beneficiary.

C. Services must be medically necessary and prescribed by the beneficiary's primary care physician (PCP) unless the patient is exempt from PCP requirements.

D. Patients are accepted for services on the basis of a reasonable expectation that his or her medical needs can be adequately met by the provider.

E. When applicable, Form DMS-679, titled Medical Equipment Request for Prior Authorization and Prescription, must be utilized when requesting prior authorization for wheelchairs, wheelchair seating systems, wheelchair repairs, for eligible Medicaid beneficiaries. **View or print form DMS-679 and instructions for completion**.

F. When applicable, form AFMC-103, titled Prescription & Prior Authorization Request for Medical Equipment Excluding Wheelchairs & Wheelchair Components, must be utilized when requesting prior authorization for some medical supplies (i.e.: compression burn garments), orthotics appliances, prosthetic devices and durable medical equipment, excluding wheelchairs, wheelchair seating systems or wheelchair repairs, when these items are prescribed for eligible Medicaid beneficiaries. **View or print form AFMC-103 and instructions for completion.**

G. When applicable, form DMS-602, titled Request for Extension of Benefits for Medical Supplies for Medicaid Recipients Under Age 21, must be utilized when requesting extension of benefits for medical supplies for beneficiaries under age 21. **View or print form DMS-602 and instructions for completion**.

H. When applicable, form DMS-699, titled Request for Extension of Benefits, must be utilized when requesting extension of benefits for diapers and underpads for eligible beneficiaries ages three and older. **View or print form DMS-699**.

I. The beneficiary must reside in his or her own dwelling, an apartment, relative's or friend's home, boarding home, residential care facility or any other type of supervised living situation that is not required to provide prosthetics services as part of the facility's participation agreement as a service provider.

A beneficiary's place of residence for services may not include a hospital, skilled nursing facility, intermediate care facility or any other supervised living situation that is required to provide prosthetics services under a provider agreement or contract as required by federal, state or local regulation.

211.200 Physician's Role in the Prosthetics Program 12-1-06

At least once every 6 months, the primary care physician must certify the medical necessity for services and prescribe them by signing and dating a prescription. When applicable, the primary care physician must complete a prior authorization form; either a Medical Equipment Request for Prior Authorization and Prescription Form (form DMS-679) when prescribing services for wheelchairs and wheelchair seating systems, or wheelchair repairs or a form AFMC-103, titled Prescription & Prior Authorization Request for Medical Equipment Excluding Wheelchairs & Wheelchair Components when prescribing orthotic appliances, prosthetic devices or durable medical equipment. **View or print form DMS-679 and instructions for completion. View or print form AFMC-103 and instructions for completion.**

211.300 Prosthetics Service Provision 12-1-06

At least once every 6 months, the prosthetics provider must receive a prescription for prosthetics services from the beneficiary's primary care physician and, when applicable:

A. Prepare a Medical Equipment Request for Prior Authorization and Prescription Form (form DMS-679) for wheelchairs, wheelchair seating systems or wheelchair repairs for beneficiaries 21 years of age or older and for specified services for beneficiaries under age 21. **View or print form DMS-679 and instructions for completion.**

B. Prepare a Prescription & Prior Authorization Request for Medical Equipment Excluding Wheelchairs & Wheelchair Components for some medical supplies (i.e.: compression burn garments), orthotic appliances, prosthetic devices and durable medical equipment for beneficiaries 21 years of age or older and for specified services for beneficiaries under age 21. **View or print form AFMC-103 and instructions for completion.**

C. Send the prepared request for prior authorization to the beneficiary's primary care physician for prescription and

D. Send the completed Medical Equipment Request for Prior Authorization and Prescription Form (form DMS-679) to the Utilization Review Section for prior authorization. **View or print Utilization Review Section contact information.**

E. Send the Prescription & Prior Authorization Request for Medical Equipment Excluding Wheelchairs & Wheelchair Components to the Arkansas Foundation for Medical Care, Inc. (AFMC) for prior authorization. **View or print the AFMC contact information.**

As necessary, the provider must:

A. Deliver and set up the prescribed equipment in the beneficiary's home,

B. Teach the beneficiary, families and caregivers the correct use and maintenance of equipment,

C. Repair equipment within 3 working days of notification,

D. Retrieve from the beneficiary's home equipment no longer prescribed for the beneficiary and

E. Provide necessary documentation.

211.400 Prescription and Referral Renewal 12-1-06

At least once every 6 months, but within 30 working days before the end of currently prescribed or prior authorized prosthetics services, the prosthetics provider must obtain a new prescription from the beneficiary's primary care physician and, if applicable, send a new prior authorization form to the applicable entity. The primary care physician must initially review either form DMS-679 or form AFMC-103, and, based upon the physician's certification of medical necessity, prescribe services. Form DMS-679 or form AFMC-103 must then be reviewed by the applicable entity and services must be prior authorized. If services are prescribed, and when applicable, prior authorized, services may be furnished for a maximum of 6 months from the date of the prescription.

211.800 Electronic Filing of Extension of Benefits 12-1-06

Form DMS-699, titled Request for Extension of Benefits, serves as both a request form and a notification of approval or denial of extension of benefits when requesting diapers and underpads for beneficiaries age 3 and older. If the benefit extension is approved, the form returned to the provider will contain a Benefit Extension Control Number. The approval notification will also list the procedure codes approved for benefit extension, the approved dates or date-of-service range and the number of units of service (or dollars, when applicable) authorized.

Upon notification of a benefit extension approval, providers may file the benefit extension claims electronically, entering the assigned Benefit Extension Control Number in the Prior Authorization (PA) number field. Subsequent benefit extension requests to the Utilization Review Section will be necessary only when the Benefit Extension Control Number expires or when a beneficiary's need for services unexpectedly exceeds the amount or number of services granted under the benefit extension.

Form AFMC-103, titled Prescription and Prior Authorization Request for Medical Equipment Excluding Wheelchairs & Wheelchair Components serves as a request form when requesting extension of benefits for the augmentative communication device. AFMC will notify providers of approval or denial by letter.

212.201 (DME) Apnea Monitors for Infants Under Age 1 12-1-06

Arkansas Medicaid covers apnea monitors only for infants less than one (1) year of age. Use of the apnea monitor must be medically necessary and prescribed by a physician.

A primary care physician (PCP) is not required until an infant's Medicaid eligibility has been determined. No PCP referral for medical services is required for retroactive eligibility periods.

Prior authorization is not required for the initial one-month period of use of the monitor. If the apnea monitor is needed longer than an initial one-month period, prior authorization will be required.

Prior authorization of the apnea monitor is required after an infant has been monitored for one month. A new referral and prescription is required. Compliance during the initial thirty-day period and proof of medical necessity for the continuation of monitoring must be documented.

After the initial thirty-day period, the prescribing physician must sign form AFMC-103, Prescription & Prior Authorization Request for Medical Equipment Excluding Wheelchairs & Wheelchair Components. The physician's signature must be an original, not a stamp. When an apnea monitor is prescribed during a hospital discharge, the physician ordering the apnea monitor must be a neonatologist or pulmonologist.

As necessary, the PCP's name and provider number must also be indicated on form AFMC-103. The PCP's signature is not required on the initial certification but he or she must sign all re-certifications.

Documentation from the physician describing the education of the family regarding their understanding of the importance of the apnea monitor must be included after the initial one-month period.

The following criteria, which follow the guidelines set by the *National Institute of Health Consensus Statement on Infantile Apnea on Home Monitoring, Consensus Development Conference Statement, September 29-October 1, 1986*, will be utilized in evaluating the need for an apnea monitor after the initial one-month period:

A. Cardio-respiratory monitoring for certain groups of infants at high risk for sudden death is medically indicated. The following indications will determine medical necessity.
    1. Infants with one or more severe Apparent Life Threatening Events (ALTEs) requiring mouth-to-mouth resuscitation or vigorous stimulation
    2. Symptomatic pre-term infant
    3. Siblings with two or more SIDS victims
    4. Infants with central hypoventilation

B. Other groups with the following indications will be considered on a case-by-case basis:
    1. Infants with less severe ALTEs
    2. Infants with tracheotomies
    3. Infants born of cocaine- or opiate-abusing mothers
    4. Asymptomatic pre-term infants with certain residual diseases may be considered for monitoring

C. Pneumograms will not be considered as screening tools.

D. Caregivers should receive:
    1. A psychosocial assessment of the caregiver
    2. Informed consent process

3. Guidance to help prepare the caregiver for the demands of home monitoring
4. Training and demonstrated proficiency in infant CPR and resuscitation methods
5. Written guidelines on home monitoring
6. Discharge planning, including discussion of follow-up services and procedures for discontinuation

E. For an apnea monitor to be discontinued in the home, one or more of the following conditions must be met:

1. Four (4) weeks apnea free or one normal download
2. Patient off respiratory stimulants for two consecutive weeks
3. 48-week adjusted gestational age

F. The caregiver must understand that he or she will be financially liable if he or she does not return the equipment to the DME company when the infant no longer requires monitoring according to the discontinuation criteria listed above.

Prior authorization for the apnea monitor must be submitted to AFMC on form AFMC-103, Prescription & Prior Authorization Request for Medical Equipment Excluding Wheelchairs & Wheelchair Components. **View or print form AFMC-103 and instructions for completion.** **View or print AFMC contact information.**

212.202 (DME) Augmentative Communication Device (ACD), All Ages 12-1-06

The augmentative communication device (ACD) is covered for beneficiaries of all ages. Coverage for beneficiaries under 21 years of age must result from an EPSDT screen. There is a $7,500.00 lifetime benefit for augmentative communication devices. When a beneficiary who is under age 21 has met the lifetime benefit and it is determined that additional equipment is medically necessary, the provider may request an extension of benefits by submitting form AFMC-103. **View or print form AFMC-103.**

The ACD is also covered for Medicaid beneficiaries 21 years old and older. Prior authorization is required on the device and on repairs of the device. For beneficiaries who are age 21 and above, there is a $7,500.00 lifetime benefit without benefit extensions.

The Arkansas Medicaid Program will not cover ACDs that are prescribed solely for social or educational development.

Training in the use of the device is not included and is not a covered cost.

Prior authorization **must** be requested for repairs of equipment or associated items after the expiration of the initial maintenance agreement.

The following information must be submitted when requesting prior authorization for ACDs for Medicaid beneficiaries.

Submit form AFMC-103, Prescription & Prior Authorization Request for Medical Equipment Excluding Wheelchairs & Wheelchair Components. **View or print form AFMC-103 and instructions for completion.** The form should be accompanied by:

A. A current augmentative communication evaluation completed by a multidisciplinary team consisting of, at least, a speech/language pathologist and an occupational therapist. The team may consist of a physical therapist, regular and special educators, caregivers and parents. The speech-language pathologist must lead the team and sign the ACD evaluation report. (For the qualifications of the team members, see the Hospital/Critical Access Hospital/End Stage Renal Disease provider manual.)

1. The team must use an interdisciplinary approach in the evaluation, incorporating the goals, objectives, skills and knowledge of various disciplines. The team must use at least three ACD systems, with written documentation of each usage included in the ACD assessment.

2. The evaluation report must indicate the medical reason for the ACD. The report must give specific recommendations of the system and justification of why one system is more appropriate than another.
3. The evaluation report must be submitted to the prosthetics provider who will request prior authorization for the ACD.

B. Written denial from the insurance company if the individual has other insurance.

This information **must** be submitted to AFMC. **View or print AFMC contact information.**

Benefit Limit

There is a $7500 lifetime benefit for augmentative communication devices. When the beneficiary under age 21 has met the limit and it is determined that additional equipment is necessary, the provider may request an extension of benefits.

In order to obtain an extension of the $7,500.00 lifetime benefit for beneficiaries under 21 years of age, a medical necessity determination for additional equipment is required. The provider must submit a form AFMC-103, a completed Medicaid claim and medical records substantiating medical necessity that the beneficiary cannot function using his or her existing equipment and whether the equipment can be repaired or needs repair. The information must be sent to AFMC. **View or print form AFMC-103, titled Prescription & Prior Authorization Request for Medical Equipment Excluding Wheelchairs & Wheelchair Components.** **View or print the AFMC contact information**.

The provider will be notified in writing of the approval or denial of the request for extended benefits.

212.204 (DME) Electronic Blood Pressure Monitor and Cuff for Beneficiaries of All Ages — 12-1-06

Arkansas Medicaid covers the automatic electronic blood pressure monitor for beneficiaries of all ages as a rental-only item. A provider must substantiate that an accurate blood pressure reading cannot be obtained by using a regular blood pressure monitor. Providers must also supply one disposable blood pressure cuff each month.

Prior authorization is required for the use of this item. Providers may request prior authorization by submitting form AFMC-103, Prescription & Prior Authorization Request for Medical Equipment Excluding Wheelchairs & Wheelchair Components to AFMC. **View or print form AFMC-103 and instructions for completion.** **View or print AFMC contact information.**

212.205 (DME) Enteral Nutrition Infusion Pump and Enteral Feeding Pump Supply Kit for Beneficiaries Under Age 21 — 12-1-06

The request for an enteral nutrition pump is covered on a case-by-case basis for beneficiaries under age 21 who require supplemental feeding because of medical necessity. Sufficient medical documentation must be provided to establish that the enteral nutrition infusion pump is medically necessary (e.g., supplemental feeding must be given over an extended period of time due to reflux, cystic fibrosis, etc.). The PCP or appropriate physician specialist must prescribe the pump, citing the medical reason that bolus feeds are inappropriate.

Reimbursement for use in the home may be made for the pump supply kit when the feeding method involves an enteral nutrition infusion pump. The pump supply kit and the infusion pump require prior authorization from AFMC using form AFMC-103, Prescription & Prior Authorization Request for Medical Equipment Excluding Wheelchairs & Wheelchair Components. **View or print AFMC contact information.** **View or print form AFMC-103 and instructions for completion.**

The enteral feeding pump supply kit, necessary for the administration of the nutrients when the feeding method involves an enteral nutrition infusion pump, is reimbursed on a per-unit basis with 1 day equaling 1 unit of service. A maximum of 1 unit per day is allowed. The pump supply kit includes pump sets, containers and syringes necessary for administration of the nutrients.

Reimbursement for the enteral nutrition infusion pump is based on a rent-to-purchase methodology. Each unit reimbursed by Medicaid will apply towards the purchase price established by Medicaid. Reimbursement will only be approved for new equipment. Used equipment will not be prior authorized. **View or print form AFMC-103 and instructions for completion.**

Requests for prior authorization for enteral pump repairs must be mailed to AFMC. Form AFMC-103, Prescription & Prior Authorization Request for Medical Equipment Excluding Wheelchairs & Wheelchair Components, must be used to request prior authorization. **View or print form AFMC-103 and instructions for completion.**

212.207 (DME) Insulin Pump and Supplies, All Ages 12-1-06

Insulin pumps and supplies are covered by Arkansas Medicaid for beneficiaries of all ages.

Prior authorization is required for the insulin pump. A prescription and proof of medical necessity are required. The patient must be educated on the use of the pump, but the education is not a covered service.

Insulin is also not covered because it is covered in the prescription drug program.

The following criteria will be utilized in evaluating the need for the insulin pump:

A. Insulin-dependent diabetes that is difficult to control.

B. Fluctuation in blood sugars causing both high and low blood sugars in a patient on at least 3, if not 4, injections per day.

C. Patient's motivation level in controlling diabetes and willingness to do frequent blood glucose monitoring.

D. Patient's ability to learn how to use the pump effectively. This will have to be evaluated and documented by a professional with experience in the use of the pump.

E. Determination of the patient's suitability to use the pump should be made by a diabetes specialist or endocrinologist.

F. Patients not included in one of these categories will be considered on an individual basis.

Prior authorization requests for the insulin pump and supplies must be submitted on form AFMC-103, Prescription & Prior Authorization Request for Medical Equipment Excluding Wheelchairs & Wheelchair Components, to AFMC. **View or print form AFMC-103 and instructions for completion.** **View or print AFMC contact information.**

212.209 (DME) MIC-KEY Skin Level Gastrostomy Tube (Mic-Key Button) and Supplies for Beneficiaries Under Age 21 12-1-06

The Arkansas Medicaid Program reimburses for the MIC-KEY Skin Level Gastrostomy Tube (Mic-Key button) and supplies for Medicaid-eligible beneficiaries under age 21. Prior authorization (PA) from AFMC is required.

The procedure codes may also be authorized for Medicaid-eligible children ages 0 through 5 years who receive their sole-source enteral formula through the Women, Infants and Children (WIC) Program. AFMC must be contacted to receive the prior authorization.

When requesting prior authorization, form AFMC-103, Prescription & Prior Authorization Request for Medical Equipment Excluding Wheelchairs & Wheelchair Components, must be completed and sent, along with sufficient medical documentation, to AFMC.

The MIC-KEY Kit is benefit limited to 2 per state fiscal year (SFY). The accessories, extension sets and adapters are covered under the $250 medical supply benefit limit.

Benefit extensions will be considered on a case-by-case basis if proven to be medically necessary. Prior authorization must be obtained from AFMC for any extensions using form AFMC-103. **View or print AFMC contact information.** **View or print form AFMC-103 and instructions for completion.**

212.212 (DME) Specialized Rehabilitative Equipment, All Ages 12-1-06

Arkansas Medicaid covers specialized rehabilitative equipment for Medicaid-eligible beneficiaries of all ages.

Some items of specialized equipment require prior authorization from AFMC. **View or print form AFMC-103 and instructions for completion.** **View or print AFMC contact information.**

212.600 Orthotic Appliances and Prosthetic Devices, All Ages 12-1-06

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

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

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

1. Prior authorization is required for orthotic appliances valued at or above the Medicaid maximum allowable reimbursement rate of $500.00 per item for use by beneficiaries age 21 and over. Prior authorization may be requested by submitting form AFMC-103, Prescription & Prior Authorization Request for Medical Equipment Excluding Wheelchairs & Wheelchair Components to AFMC. **View or print form AFMC-103 and instructions for completion.** **View or print AFMC contact information.**
2. For beneficiaries age 21 and over, a benefit limit of $3,000 per state fiscal year (SFY; July 1 through June 30) has been established for reimbursement for orthotic appliances. No extension of benefits will be granted.

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

   a. Orthotic appliances may not be replaced for 12 months from the date of purchase. If a patient's condition warrants a modification or replacement and the $3000.00 SFY benefit limit has not been met, the provider may submit documentation to AFMC, to substantiate medical necessity**. If approved, AFMC will issue a prior authorization number.** Section 221.000 of this provider manual may be referenced for information regarding prior authorization procedures.
   b. Custom-molded orthotics are not covered for a diagnosis of carpal tunnel syndrome prior to surgery.

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

1. Prior authorization will be required for prosthetic device items valued at or in excess of the $1000.00 per item Medicaid maximum allowable reimbursement rate for use by beneficiaries age 21 and over. Prior authorization may be requested by submitting form AFMC-103, Prescription & Prior Authorization Request for Medical Equipment Excluding Wheelchairs & Wheelchair Components to AFMC. **View or print form AFMC-103 and instructions for completion.**
2. For beneficiaries age 21 and over, a benefit limit of $20,000 per SFY has been established for reimbursement for prosthetic devices. No extension of benefits will be granted.

3. The following restrictions apply to coverage of prosthetic devices for beneficiaries age 21 and over:
   a. Prosthetic devices may be replaced only after five years have elapsed from their date of purchase. If the patient's condition warrants a modification or replacement, and the $20,000 SFY benefit limit has not been met, the provider may submit documentation to AFMC to substantiate medical necessity. **If approved, AFMC will issue a prior authorization number.** Section 220.000 of this provider manual may be referenced for information regarding prior authorization procedures.
   b. Myoelectric prosthetic devices may be purchased only when needed to replace myoelectric devices received by beneficiaries who were under age 21 when they received the original device.

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

The appropriate forms (or the required information in a different format) must accompany the form AFMC-103. **View or print AFMC-103, Prescription & Prior Authorization Request for Medical Equipment Excluding Wheelchairs & Wheelchair Components and instructions for completion.**

The forms and their titles are as follows:

1. DMS-646 Evaluation Form Lower Limb. **View or print form DMS-646**.
2. DMS-647 Gait Analysis: Full Body. **View or print form DMS-647.**
3. DMS-648 Prosthetic-Orthotic Upper-Limb Amputee Evaluation. **View or print form DMS-648**.
4. DMS-649 Upper-Limb Prosthetic Prescription. **View or print form DMS-649**.
5. DMS-650 Prosthetic-Orthotic Lower-Limb Amputee Evaluation. **View or print form DMS-650**.
6. DMS-651 Lower-Limb Prosthetic Prescription. **View or print form DMS-651**.

212.700 Oxygen and Oxygen Supplies, All Ages 12-1-06

A prescription for oxygen must be accompanied by a current arterial blood gas (ABG) laboratory report from a certified laboratory or the patient's attending physician. A current laboratory report is defined as one performed within a maximum of 30 days prior to the prescription for oxygen.

A prescription for oxygen must specify the oxygen flow rate, frequency and duration of use, estimate of the period of need for oxygen and method of delivery of oxygen to the patient (e.g., two liters per minute, 10 minutes per hour, by nasal cannula for a period of two months). A prescription containing only "oxygen PRN" is not sufficient.

The following medical criteria will be utilized in evaluating coverage of oxygen:

A. Chronic Respiratory Disease
   1. Continuous oxygen therapy
      Resting Pa02 less than 55 mm Hg
   2. Nocturnal oxygen therapy
      Resting Pa02 less than 60 mm Hg
   3. Exercise oxygen therapy
      Pa02 with exercise less than 55 mm Hg

B. Congestive Heart Failure
   Symptomatic at rest, with Pa02 less than 60 mm Hg

C. Carcinoma of the Lung
Resting Pa02 less than 60 mm Hg

D. Others
Reviewed on an individual basis

E. Children
O2 saturation below 94% by pulse oximeter with elevated PCO2 by capillary blood gas or end-tidal CO2 on two separate occasions.

The prior authorization request for all oxygen and respiratory equipment must be submitted on form AFMC-103, Prescription & Prior Authorization Request for Medical Equipment Excluding Wheelchairs & Wheelchair Components to AFMC for beneficiaries of all ages. **View or print form AFMC-103 and instructions for completion.**

220.000 PRIOR AUTHORIZATION 12-1-06

221.000 Prosthetics Services Prior Authorization 12-1-06

Reimbursement for specified prosthetics services must be prior authorized. Prior authorization is required on items indicated (e.g., oxygen) or if the reimbursement for an item or items is $1000.00 or more (e.g., wheelchair and/or components).

221.100 Request for Prior Authorization 12-1-06

The request for prior authorization must originate with the prosthetics provider. The provider is responsible for obtaining the required medical information and prescription needed for completion of the prior authorization request form.

A. The Medical Equipment Request for Prior Authorization and Prescription Form (Form DMS-679) will be used when requesting prior authorization for wheelchairs, wheelchair seating systems and wheelchair repairs. The primary care physician must sign the DMS-679. The primary care physician's signature must be an original, not a stamp.

The Medical Equipment Request for Prior Authorization and Prescription Form (Form DMS-679) must contain a diagnosis of the disease(s) necessitating use of prosthetics services. **View or print form DMS-679 and instructions for completion.**

B. Effective for dates of service on and after December 1, 2006, the Arkansas Foundation for Medical Care, Inc., (AFMC) will review requests for prior authorization for some medical supplies (i.e.: compression burn garments), orthotic appliances, prosthetic devices and durable medical equipment, excluding wheelchairs, wheelchair seating systems and wheelchair repairs. Form AFMC-103, titled "Prescription and Prior Authorization Request for Medicaid Equipment Excluding Wheelchairs & Wheelchair Components" will be completed for use with those items of durable medical equipment, excluding wheelchairs, wheelchair seating systems and wheelchair repairs.

221.200 Filing for Prior Authorization 12-1-06

Requests for prior authorization will be handled by either Utilization Review with the Division of Medical Services or by the Arkansas Foundation for Medical Care, depending on the service field that is being requested.

A. To request prior authorization for wheelchair and wheelchair seating systems, providers must continue to use form DMS-679 and send the information to the Utilization Review Section. The original and the first copy of the Medical Equipment Request for Prior Authorization and Prescription Form (form DMS-679) must be forwarded to the Division of Medical Services, Utilization Review Section. The third copy of the form must be retained in the provider's records. **View or print Utilization Review Section contact information.**

B. Requests for prior authorization of some medical supplies (i.e.: compression burn garments), orthotic appliances, prosthetic devices and all durable medical equipment, excluding wheelchairs and wheelchair seating systems, must be submitted to AFMC on the Prescription & Prior Authorization Request for Medical Equipment Excluding Wheelchairs & Wheelchair Components Form (AFMC-103). **View or print form AFMC-103.**

221.300 Approvals of Prior Authorization 12-1-06

A. The Utilization Review Section reviews requests for prior authorization for wheelchair and wheelchair seating systems. If necessary, the Utilization Review Section may request additional information.

1. When a request is approved for wheelchairs, wheelchair seating systems or wheelchair repair, a prior authorization control number will be assigned by the Utilization Review Section. Determination of "purchase," "rental only," or "capped rental" will be made and an expiration date for "rental only" and "capped rental" items will be assigned. This information will be indicated on the copy of the form DMS-679 that is returned to the provider from Utilization Review within 30 working days of receipt of the prior authorization request.
2. Prior authorization may only be approved for a maximum of six (6) months (180 days) for beneficiaries of all ages. Within 30 working days before the end of currently prior authorized prosthetics services, the prosthetics provider must obtain a new prescription. If applicable, the provider must prepare and send a new Medical Equipment Request for Prior Authorization and Prescription Form (Form DMS-679), signed by the physician, to the Utilization Review Section.
3. The effective date of the prior authorization will be the date on which the beneficiary's physician prescribed prosthetics services or the day following the last day of the previously prior authorized time period, whichever comes last.

B. **Consideration of prior authorization requests by AFMC requires correct completion of all fields on the request form**. The prior authorization request form must contain current medical documentation necessitating use of the required prosthetics. **If necessary, AFMC may request additional information**.

1. When a PA request is approved, a prior authorization control number will be assigned by AFMC. **View or print AFMC contact information.** Prior authorization approvals will be authorized for a maximum of six (6) months (180 days) for beneficiaries of all ages. The effective date of the prior authorization will be the date on which the beneficiary's physician prescribed prosthetics services or the day following the last day of the previously prior authorized time period, whichever comes last.
2. Within 30 working days before the end of currently authorized prosthetics services, the provider must obtain a new prescription. If applicable, the provider must prepare and submit a new Prescription and Prior Authorization Request for Medical Equipment Excluding Wheelchairs & Wheelchair Components (form AFMC-103) signed by the prescribing physician.

C. Providers should note the following authorization process exception.

1. Prior authorization numbers for "capped rental" items will be effective for the entire "capped rental" time period of 15 months. Therefore, only one prior authorization number is needed.
   a. Providers may use the one prior authorization number for billing of "capped rental" items for all 15 months.
   b. Previous prior authorization for an item will count toward the total 15-month period.
   c. Providers must resubmit a request for prior authorization after the first 180 days.
   d. Necessary information will be indicated on the copy of the notification letter

sent to the provider within 30 working days of receipt of the prior authorization request.

221.400 Denial of Prior Authorization Request 12-1-06

For denied cases, both Utilization Review and AFMC will mail a letter containing case specific rationale that explains why the request was not approved to the requesting provider and to the Medicaid beneficiary within 30 working days of receipt of the prior authorization request.

The provider may request reconsideration of the denial within thirty-five calendar days of the denial date. Requests must be made in writing and include additional documentation to substantiate the medical necessity of the requested services. Requests received after thirty-five calendar days of the denial date will not be accepted for reconsideration.

221.500 Reconsideration of Denials 12-1-06

If the denial decision is reversed during the reconsideration review, an approval is forwarded to the provider specifying the approved units and services. If the denial decision is upheld, the provider and the Medicaid beneficiary will be notified in writing of the review determination.

Reconsideration is available only once per prior authorization request. However, if the denial is upheld during the reconsideration process, the provider may submit a new prior authorization request, for different dates of service, providing new supporting documentation is available. **A subsequent prior authorization request will not be reviewed if it contains the same documentation submitted with the previous authorization and reconsideration requests.**

221.600 Fair Hearing Request 12-1-06

The Medicaid beneficiary may request a fair hearing of a denied review determination made by either Utilization Review, Department of Health and Human Services (DHHS) or the Arkansas Foundation for Medical Care (AFMC). The fair hearing request must be in writing and sent to the Appeals and Hearings Section of DHHS within thirty-five calendar days of the date on the denial letter. **View or print the Department of Health and Human Services Appeals and Hearings Section contact information.** Providers may refer to section 190.000 for information regarding provider appeals through the Medicaid Fairness Act.

236.000 Reimbursement for Repair of the Enteral Nutrition Pump 12-1-06

Reimbursement for repairs to the enteral nutrition infusion pump requires prior authorization. Repairs will be approved only on equipment purchased by Medicaid. Therefore, no repairs will be reimbursable prior to the equipment becoming the property of the Medicaid beneficiary.

Requests for prior authorization for enteral pump repairs must be mailed to AFMC. (**View or print AFMC contact information**) on form AFMC-103, Prescription & Prior Authorization Request for Medical Equipment Excluding Wheelchairs & Wheelchair Components. (**View or print form AFMC-103 and instructions for completion.**)

The repair invoice and the serial number of the equipment must accompany the prior authorization request form. Total repair costs to an infusion pump may not exceed $290.93. Medicaid will not reimburse for additional repairs to an infusion pump after the provider has billed repair invoices totaling $290.93. If the equipment is still not in proper working order after the provider has billed the Medicaid maximum allowed for repairs, the provider must supply the beneficiary with a new infusion pump and may bill either procedure code B9000 or B9002 after receiving prior authorization for the new piece of equipment.

242.120 Medical Supplies, All Ages 12-1-06

Procedure codes found in this section must be billed either electronically or on paper with modifier NU for individuals of all ages. When a second modifier is listed, that modifier must be used in conjunction with the modifier NU.

Additionally, when billed on paper, procedure codes must be billed with a type of service (TOS) code "H" for individuals of all ages.

Modifiers in this section are indicated by the headings M1 and M2. Type of service is indicated by the heading TOS.

1 These supplies must be prior authorized. Form AFMC-103 may be used for the request for prior authorization. **View or print form AFMC-103 and instructions for completion.** Please note: Compression burn garments are manually priced.

Medical Supplies, All Ages (section 242.120)

Procedure Code	M1	M2	TOS	Description
A4206	NU		H	Syringe with needle, sterile, 1 cc, ea
A4207	NU			Syringe with needle, sterile, 2 cc, ea
A4209	NU			Syringe with needle, sterile, 5 cc or greater, ea
A4216	NU		H	Sterile water/saline, 10 ml
A4217	NU		H	Sterile water/saline, 500 ml
A4221[1]	NU			Supplies for maintenance of drug infusion catheter, per week (list drug separately)
A4222[1]	NU			Supplies for external drug infusion pump, per cassette or bag (list drug separately)
A4253	NU			Blood glucose test or reagent strips for home blood glucose monitor, per 50 strips
A4253	NU	UB	H	Blood glucose test or reagent strips for home blood glucose monitor, per 50 strips
A4256	NU			Normal, low, and high calibrator solution/chips
A4259	NU			Lancets, per box of 100
A4265	NU			Paraffin, per pound
A4310	NU			Insertion tray without drainage bag and without catheter (accessories only)
A4311	NU			Insertion tray without drainage bag with indwelling catheter, Foley type, two-way latex with coating (Teflon, silicone, silicone elastomer or hydrophilic, etc.)
A4312	NU			Insertion tray without drainage bag with indwelling catheter, Foley type, two-way, all silicone
A4313	NU			Insertion tray without drainage bag with indwelling catheter, Foley type, three-way, for continuous irrigation

Medical Supplies, All Ages (section 242.120)

Procedure Code	M1	M2	TOS	Description
A4314	NU			Insertion tray with drainage bag with indwelling catheter, Foley type, two-way latex with coating (Teflon, silicone, silicone elastomer or hydrophilic, etc.
A4315	NU			Insertion tray with drainage bag with indwelling catheter, Foley type, two-way, all silicone
A4316	NU			Insertion tray with drainage bag with indwelling catheter, Foley type, three-way, for continuous irrigation
A4320	NU			Irrigation tray with bulb or piston syringe, any purpose
A4322	NU			Irrigation syringe, bulb or piston, each
A4326	NU			Male external catheter specialty type with intergral collection chamber, each
A4327	NU			Female external urinary collection device; metal cup, each
A4328	NU			Female external urinary collection device; pouch, each
A4330	NU			Perianal fecal collection pouch with adhesive, each
A4331	NU			Extension drainage tubing, any type, any length, with connector/adaptor, for use with urinary leg bag or urostomy pouch, each
A4338	NU			Indwelling catheter, Foley type, two-way latex with coating (Teflon, silicone, silicone elastomer or hydrophilic, etc), each
A4340	NU			Indwelling catheter; specialty type (e.g., coude, mushroom, wing, etc.), each
A4344	NU			Indwelling catheter, Foley type, two-way, all silicone, each
A4346	NU			Indwelling catheter, Foley type, three-way for continuous irrigation, each
A4348	NU			Male external catheter with integral collection compartment, extended wear, each (e.g., 2 per month)
A4349	NU			Male external catheter with or without adhesive, disposable, each
A4351	NU			Intermittent urinary catheter; straight tip, with or without coating (Teflon, silicone, silicone elastomer or hydrophilic, etc.), each
A4351	NU	U1		Intermittent urinary catheter; straight tip, with or without coating (Teflon, silicone, silicone elastomer or hydrophilic, etc.), each
A4352	NU			Intermittent urinary catheter; coude (curved) tip, with or without coating (Teflon, silicone, silicone elastomeric or hydrophilic, etc.), each
A4352	NU	U1		Intermittent urinary catheter; coude (curved) tip, with or without coating (Teflon, silicone, silicone elastomeric or hydrophilic, etc.), each
A4353	NU	U2	H	Intermittent urinary catheter, with insertion supplies (tray)
A4354	NU			Insertion tray with drainage bag but without catheter

Medical Supplies, All Ages (section 242.120)

Procedure Code	M1	M2	TOS	Description
A4355	NU			Irrigation tubing set for continuous bladder irrigation through a three-way indwelling Foley catheter, each
A4356	NU			External urethral clamp or compression device (not to be used for catheter clamp), each
A4357	NU			Bedside drainage bag, day or night, with or without anti-reflux device, with or without tube, each
A4358	NU			Urinary drainage bag, leg or abdomen, vinyl, with or without tube, with straps, each
A4359	NU			Urinary suspensory without leg bag, each
A4361	NU			Ostomy faceplate, each
A4362	NU			Skin barrier; solid, four by four or equivalent; each
A4364	NU			Adhesive, liquid, or equal, any type, per ounce
A4365	NU		H	Adhesive remover wipes, any type, per 50
A4367	NU			Ostomy belt, each
A4368	NU		H	Ostomy filter, any type, each
A4369	NU			Ostomy skin barrier, liquid, (spray, brush, etc), per oz
A4371	NU			Ostomy skin barrier, power, per oz
A4394	NU		H	Ostomy deodorant for use in ostomy pouch, liquid, per fluid ounce
A4397	NU			Irrigation supply; sleeve, each
A4398	NU			Ostomy irrigation supply; bag, each
A4399	NU			Ostomy irrigation supply; cone/catheter, including brush
A4400	NU			Ostomy irrigation set
A4402	NU			Lubricant, per ounce
A4404	NU			Ostomy ring, each
A4405	NU			Ostomy skin barrier, non-pectin based, paste, per ounce
A4406	NU			Ostomy skin barrier, pectin based, paste, per ounce
A4414	NU			Ostomy skin barrier, with flange (solid, flexible or accordion), without built-in convexity, 4 x 4 inches or smaller, each
A4450	NU	U1		Tape, non-waterproof, per 18 square inches
A4450	NU		H	Tape, non-waterproof, per 18 square inches
A4452	NU			Tape, waterproof, per 18 square inches
A4455	NU			Adhesive remover or solvent (for tape, cement or other adhesive), per ounce
A4483	NU		H	Moisture exchanger, disposable, for use with invasive mechanical ventilation
A4558	NU			Conductive paste or gel

Medical Supplies, All Ages (section 242.120)

Procedure Code	M1	M2	TOS	Description
A4561	NU	U1		Pessary, rubber, any type
A4562	NU			Pessary, non rubber, any type
A4623	NU			Tracheostomy, inner cannula
A4625	NU			Tracheostomy care kit for new tracheostomy
A4626	NU			Tracheostomy cleaning brush, each
A4628	NU			Oropharyngeal suction catheter, each
A4629	NU			Tracheostomy care kit for established tracheostomy
A4772	NU			Blood glucose test strips, for dialysis, per 50
A4927	NU			Gloves, non-sterile, per 100
A5051	NU			Ostomy pouch, closed; with barrier attached (one piece), each
A5052	NU			Ostomy pouch, closed; without barrier attached (one piece), each
A5053	NU			Ostomy pouch, closed; for use on faceplate, each
A5054	NU			Ostomy pouch, closed; for use on barrier with flange (two piece), each
A5055	NU			Stoma cap
A5061	NU	U1		Ostomy pouch, drainable; with barrier attached (one piece), each
A5062	NU			Ostomy pouch, drainable; without barrier attached (one piece), each
A5063	NU			Ostomy pouch, drainable; for use on barrier with flange (two piece system), each
A5071	NU			Ostomy pouch, urinary; with barrier attached (one piece), each
A5072	NU			Ostomy pouch, urinary; without barrier attached (one piece), each
A5073	NU			Ostomy pouch, urinary; for use on barrier with flange (two piece), each
A5081	NU			Continent device; plug for continent stoma
A5082	NU			Continent device; catheter for continent stoma
A5093	NU			Ostomy accessory; convex insert
A5102	NU			Bedside drainage bottle, with or without tubing, rigid or expandable, each
A5105	NU			Urinary suspensory; with leg bag, with or without tube
A5112	NU			Urinary leg bag; latex
A5113	NU			Leg strap; latex, replacement only, per set
A5114	NU			Leg strap; foam or fabric, replacement only, per set
A5119	NU			Skin barrier; wipes, box per 50

Medical Supplies, All Ages (section 242.120)

Procedure Code	M1	M2	TOS	Description
A5121	NU			Skin barrier; solid, 6 x 6 or equivalent, each
A5122	NU			Skin barrier; solid, 8 x 8 or equivalent, each
A5126	NU			Adhesive or non-adhesive; disk or foam pad
A5131	NU			Appliance cleaner, incontinence and ostomy appliances, per 16 oz.
A6154	NU			Wound pouch, each
A6196	NU		H	Alginate or other fiber gelling dressing, wound cover, pad size 16 sq. in. or less, each dressing
A6197	NU	UB	H	Alginate or other fiber gelling dressing, wound cover, pad size more than 16 sq. in. but less than or equal to 48 sq. in, each dressing
A6197	NU	UB	H	Alginate or other fiber gelling dressing, wound cover, pad size more than 16 sq. in. but less than or equal to 48 sq. in, each dressing (1 linear yard)
A6198	NU		H	Alginate or other fiber gelling dressing, wound cover, pad size more than 48 sq. in., each dressing
A6203	NU		H	Composite dressing, pad size 16 sq. in. or less, with any size adhesive border, each dressing
A6204	NU		H	Composite dressing, pad size more than 16 sq. in. but less than 48 sq. in., with any size adhesive border, each dressing
A6205	NU		H	Composite dressing, pad size more than 48 sq. in., with any size adhesive border, each dressing
A6211	NU		H	Foam dressing, wound cover, pad size more than 48 sq. in., without adhesive border, each dressing
A6212	NU		H	Foam dressing, wound cover, pad size 16 sq. in. or less, with any size adhesive border, each dressing
A6213	NU		H	Foam dressing, wound cover, pad size more than 16 sq. in but less than or equal to 48 sq. in., with any size adhesive border, each dressing
A6216	NU		H	Gauze, non-impregnated, non-sterile, pad size 16 sq. in. or less, without adhesive border, each dressing
A6219	NU		H	Gauze, non-impregnated, 16 sq. in. or less with any size adhesive border, each dressing
A6220	NU		H	Gauze, non-impregnated, pad more than 16 sq. in., but less than or equal to 48 sq. in., with any size adhesive border, each dressing
A6221	NU		H	Gauze, non-impregnated, pad size more than 48 sq. in., with any size adhesive border, each dressing
A6228	NU		H	Gauze, impregnated, water or normal saline, pad, size 16 sq. in. or less, without adhesive border, each dressing

Medical Supplies, All Ages (section 242.120)

Procedure Code	M1	M2	TOS	Description
A6229	NU		H	Gauze, impregnated, water or normal saline, pad size more than 16 sq. in., but less than or equal to 48 sq. in., without adhesive border, each dressing
A6230	NU		H	Gauze, impregnated, water or normal saline, pad more than 48 sq. in., without adhesive border, each dressing
A6234	NU	U1		Hydrocolloid dressing, wound cover, pad size 16 sq. in. or less, without adhesive border, each dressing
A6234	NU		H	Hydrocolloid dressing, wound cover, pad size 16 sq. in. or less, without adhesive border, each dressing
A6235	NU		H	Hydrocolloid dressing, wound cover, pad size more than 16 sq. in., but less than or equal to 48 sq. in., without adhesive border, each dressing
A6236	NU		H	Hydrocolloid dressing, wound cover, pad size more than 48 sq. in., without adhesive border, each dressing
A6237	NU		H	Hydrocolloid dressing, wound cover, pad size 16 sq. in. or less, with any size adhesive border, each dressing
A6238	NU		H	Hydrocolloid dressing, wound cover, pad size more than 16 sq. in. but less than or equal to 48 sq. in., with any size adhesive border, each dressing
A6238	NU	U1	H	Hydrocolloid dressing, wound cover, pad size more than 16 sq. in. but less than or equal to 48 sq. in., with any size adhesive border, each dressing
A6239	NU		H	Hydrocolloid dressing, wound cover, pad size more than 48 sq. in., with any size adhesive border, each dressing
A6241	NU			Hydrocolloid dressing, wound filler, dry form, per gram
A6242	NU			Hydrocolloid dressing, wound cover, pad size 16 sq. in. or less, without adhesive border, each dressing
A6242	NU	U1		Hydrocolloid dressing, wound cover, pad size 16 sq. in. or less, without adhesive border, each dressing
A6242	NU		H	Hydrogel dressing, wound cover, pad size 16 sq. in. or less, without adhesive border, each dressing
A6243	NU		H	Hydrogel dressing, wound cover, pad size more than 16 sq. in., but less than or equal to 48 sq. in., without adhesive border, each dressing
A6244	NU		H	Hydrogel dressing, wound cover, pad size more than 48 sq. in. without adhesive border, each dressing
A6245	NU		H	Hydrogel dressing, wound cover, pad size 16 sq. in. or less, with any size adhesive border, each dressing
A6246	NU		H	Hydrogel dressing, wound cover, pad size more than 16 sq. in., but less than or equal to 48 sq. in., with any size adhesive border, each dressing
A6247	NU		H	Hydrogel dressing, wound cover, pad size more than 48 sq. in. with any size adhesive border, each dressing

Medical Supplies, All Ages (section 242.120)

Procedure Code	M1	M2	TOS	Description
A6248	NU			Hydrogel dressing, wound filler, gel, per fluid ounce
A6248	NU	U1		Hydrogel dressing, wound filler, gel, per fluid ounce
A6248	NU		H	Hydrogel dressing, wound filler, gel, per fluid ounce
A6257	NU		H	Transparent film, 16 sq. in. or less, each dressing
A6258	NU		H	Transparent film, more than 16 sq. in., but less than or equal to 48 sq. in., each dressing
A6259	NU		H	Transparent film, more than 48 sq. in., each dressing
A6403	NU		H	Gauze, non-impregnated, sterile, pad size more than 16 sq. in. but less than 48 sq. in., without adhesive border, each dressing
A6404	NU		H	Gauze, non-impregnated, sterile, pad size more than 48 sq. in., without adhesive border, each dressing
A6441	NU		H	Padding bandage, non-elastic, non-woven/non-knitted, width > or = 3 inches & < 5 in, per yd
A6442	NU			Conforming bandage, non-elastic, knitted/woven, non-sterile, width < 3 in, per yd
A6443	NU		H	Conforming bandage, non-elastic, knitted/woven, non-sterile, width > or = 3 in & < 5 in, per yd
A6444	NU		H	Conforming bandage, non-elastic, knitted/woven, non-sterile, width > or = 5 in, per yd
A6445	NU			Conforming bandage, non-elastic, knitted/woven sterile, width <3 in, per yd
A6446	NU		H	Conforming bandage, non-elastic, knitted/woven, sterile, width > or = 3 in & < 5 in, per yd
A6447	NU		H	Conforming bandage, non-elastic, knitted/woven, sterile, width > or = 5 in, per yd
A6448	NU			Light compression bandage, elastic, knitted/woven width<3in, per yd
A6449	NU		H	Light compression bandage, elastic, knitted/woven, width > or = 3 in & < 5 in, per yd
A6450	NU		H	Light compression bandage, elastic, knitted/woven, width > or = 5 in, per yd
A6451	NU		H	Moderate compress bandage, elastic, knitted/woven load resistance of 1.25 to 1.34 foot pounds at 50% maximum stretch, width > or = 3 in & < 5 in, per yd
A6452	NU		H	High compress bandage, elastic, knitted/woven, load resistance greater than or equal to 1.35 foot pounds at 50 % maximum stretch, width > or = 3 in & < 5 in, per yd
A6453	NU			Self-adherent bandage, elastic, non-knitted/non-woven, width<3in, per yd
A6454	NU			Self-adherent bandage, elastic, non-knitted/non-woven, width > or = 3 in & < 5 in, per yd

Medical Supplies, All Ages (section 242.120)

Procedure Code	M1	M2	TOS	Description
A6455	NU			Self-adherent bandage, elastic, non-knitted/non-woven, width > or = 5 in, per yd
A6501[1]	NU			Compression burn garment, body suit (head to foot), custom fabricated
A6502[1]	NU			Compression burn garment, chin strap, custom fabricated
A6503[1]	NU			Compression burn garment, facial hood, custom fabricated
A6504[1]	NU			Compression burn garment, glove to wrist, custom fabricated
A6505[1]	NU			Compression burn garment, glove to elbow, custom fabricated
A6506[1]	NU			Compression burn garment, glove to axilla, custom fabricated
A6507[1]	NU			Compression burn garment, foot to knee length, custom fabricated
A6508[1]	NU			Compression burn garment, foot to thigh length, custom fabricated
A6509[1]	NU			Compression burn garment, upper trunk to waist including arm openings (vest), custom fabricated
A6510[1]	NU			Compression burn garment, trunk including arms down to leg openings (leotard), custom fabricated
A6511[1]	NU			Compression burn garment, lower trunk including leg openings (panty), custom fabricated
A6512[1]	NU			Compression burn garment, not otherwise classified
A7520	NU			Trachestomy/Laryngectomy tube, non-cuffed, PVC, silicone or equal, each
A7521				Trachestoomy/Laryngectomy tube, cuffed, PVC, silicone or equal, each
A7522				Trachestomy/Laryngectomy tube, stainless steel or equal, (sterilizable and reusable), each
A7524				PO-Tracheostoma stent/stud/button, each
A7525				Tracheostomy mask, each
B4086	NU			Gastrostomy/jejunostomy tube, any material, any type, (standard or low profile), each
E0776	NU			IV pole

242.122 Jobst Stocking, All Ages 12-1-06

The gradient compression stocking (Jobst) is payable for individuals of all ages. However, before supplying the item, the Jobst stocking must be prior authorized by AFMC. **View or print form AFMC-103 and instructions for completion.** Documentation accompanying form AFMC-103 must indicate that the patient has severe varicose veins with edema, or a venous statis ulcer, unresponsive to conventional therapy such as wrappings, over-the-counter stockings and Unna boots. The documentation must include clinical medical records from a physician detailing the failure of conventional therapy.

Procedure Code	M1	M2	TOS	Description	Maximum Units
A6549	NU		H	Gradient compression stocking, NOS (Jobst); 1 unit = 1 stocking	Maximum 4 units per date of service

242.152 Enteral Nutrition Infusion Pump and Enteral Feeding Pump Supply Kit 12-1-06

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

Additionally, when billed on paper, procedure codes must be billed with a type of service (TOS) code "6" for beneficiaries under age 21.

The procedure codes will require prior authorization from AFMC.

Modifiers in this section are indicated by the headings M1 and M2. Type of service is indicated by the heading TOS. 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.

⁂(…) This symbol, along with text in parentheses, indicates the Arkansas Medicaid description of the product.

Procedure Code	M1	M2	TOS	Description	Maximum Units	PA	Payment Method
B4035	EP		6	Enteral feeding supply kit, pump fed, per day (1 unit = 1 day)	1 per day	Y	Purchase
B9000	EP		6	Enteral nutrition infusion pump – without alarm (1 day = 1 unit)	1 per day	Y	Rent to Purchase
B9002	EP		6	Enteral nutrition infusion pump – with alarm (1 day = 1 unit)	1 per day	Y	Rent to Purchase
E1340	EP	U2	6	⁂(Repair – Enteral nutrition infusion pump) Repair or nonroutine service for durable medical equipment requiring the skill of a technician, labor component		Y	

Enteral Nutrition Infusion Pump

Reimbursement for the enteral nutrition infusion pump is based on a rent-to-purchase methodology. Each unit reimbursed by Medicaid will apply towards the purchase price established by Medicaid. Reimbursement will only be approved for new equipment. Used equipment will not be prior authorized. Procedure codes **B9000** and **B9002** represent a new piece of equipment being reimbursed by Medicaid on the rent-to-purchase plan. Codes **B9000** and **B9002** are reimbursed on a per unit basis with 1 day equaling 1 unit of service per day. Medicaid will reimburse on the rent-to-purchase plan for a total of 304 units of service. After reimbursement has been made for 304 units, the equipment will become the property of the

Medicaid beneficiary. Prior authorization is required for codes **B9000** and **B9002**. The prior authorization request must include the serial number of the infusion pump being provided to the beneficiary.

See section 236.000 for reimbursement when the Medicaid Program is billed for repairs made to the enteral infusion pump.

Arkansas Foundation for Medical Care Contact Information:

In-state and Out-of-state Toll Free:	1-877-650-2362
Fort Smith Exchange:	(479) 649- 8501
Fax Number:	(479) 649-0776
Mailing Address:	Arkansas Foundation for Medical Care, Inc. PO Box 180001 Fort Smith, AR 72918-0001
Physical Site Location:	2201 Brooken Hill Drive Fort Smith, AR 72908
Office Hours.	8:30 a.m. until 5:00 p.m. (Central Time), Monday through Friday, except holidays

Arkansas Foundation for Medical Care, Inc.

PRESCRIPTION & PRIOR AUTHORIZATION REQUEST FOR MEDICAL EQUIPMENT

EXCLUDING Wheelchairs & Wheelchair Components

SECTION A - TO BE COMPLETED BY THE PROVIDER					
☐ **INITIAL** ☐ **RECERT** ☐ **MODIFICATION** ☐ **EXT OF BENEFITS**			**START DATE:**		
PROVIDER NAME:			**PROVIDER MAILING ADDRESS:**		
MEDICAID PROVIDER #:			**PROVIDER PHONE & CONTACT PERSON:**		
BENEFICIARY NAME: (LAST, FIRST, MI)			**BENEFICIARY MEDICAID ID #:**		
BENEFICIARY MAILING ADDRESS:			**DATE of BIRTH:**	**SEX:** ☐ **MALE** ☐ **FEMALE**	
PRESCRIBING PHYSICIAN:			**PHYSICIAN MCD PROVIDER #:**		
PROCEDURE CODE	**MOD 1**	**MOD 2**	**TOS**	**DESCRIPTION OF ITEMS REQUESTED**	**UNITS REQUESTED**

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

_____ _____

PROVIDER SIGNATURE **DATE**

SECTION B - TO BE COMPLETED BY THE PHYSICIAN			
EST. LENGTH OF NEED:	**EPSDT REFERRAL:**	**CURRENT HEIGHT:**	**CURRENT WEIGHT:**
_____WKS _____ MONTHS _____PERM	☐ **YES** ☐ **NO** ☐ **N/A**	**INCHES**	**LBS**

DIAGNOSIS & ICD-9 CODE:	**DIAGNOSIS & ICD-9 CODE:**	**DIAGNOSIS & ICD-9 CODE:**

IS THIS EQUIPMENT BEING SUPPLIED FOR USE IN THE BENEFICIARY'S HOME? ☐ **YES** ☐ **NO**

MEDICAL NECESSITY FOR REQUESTED SERVICES:

_____ _____

PHYSICIAN SIGNATURE **DATE**

****A prescription for the requested items MUST be documented above or a separate prescription MUST be submitted. If the above documentation is insufficient to justify the requested items, a letter of medical necessity from the prescribing physician WILL be required. Please retain a copy of this form in your files.**

Send completed form to:

Arkansas Foundation for Medical Care, Inc., (AFMC) – Attn: Ami Winters

PO Box 180001

Fort Smith, AR 72918

AFMC-103(12-06)

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.
PROVIDER INFORMATION:	Enter the provider name, address, assigned nine-(9) digit Arkansas Medicaid provider number, telephone number, and contact person.
PATIENT INFORMATION:	Enter the beneficiary's full name (Last, First, MI), ten-(10) digit Medicaid ID number, mailing address, date of birth (MM/DD/YYYY), and sex (male or female).
PHYSICIAN INFORMATION:	Enter the prescribing physician's name and assigned nine-(9) digit Arkansas Medicaid provider number.
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 being 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-9 CODES:	In the first space, list the diagnosis & ICD9 code that represents the primary reason for ordering this item. List any additional diagnosis & ICD9 codes that would further describe the medical need for the item (up to 3 codes).
QUESTION SECTION:	Answer the question by checking the appropriate "YES" or "NO" box.
MEDICAL NECESSITY:	The physician must document medical necessity for the requested services and sign/date in the space indicated. Signature and date stamps are not acceptable.
**PRESCRIPTION:	A written prescription MUST be submitted with all requests. This can be documented on the request form or a separate prescription may be attached.
**LETTER OF MEDICAL NECESSITY:	If the information provided on the request form is insufficient to justify the requested items, a letter of medical necessity from the prescribing physician WILL be required.