Arkansas Department of Health and Human Services

Division of Medical Services

P.O. Box 1437, Slot S-295
Little Rock, AR 72203-1437

Fax: 501-682-2480 **TDD: 501-682-6789** **Internet Website: www.medicaid.state.ar.us**

TO: **Arkansas Medicaid Health Care Providers**

DATE: **January 1, 2007**

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

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Alternatives for Adults with Physical Disabilities Waiver	44
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REMOVE

Section	Date
DMS-625	9/1999
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AFMC-401	9/2000
CHMSBenefitExt	
DMS-666	11/2004
DMS-667	11/2004
DMS-669	11/2004
DMS-661	11/2004
DMS-851	11/2004

INSERT

Section	Date
AFMC-101	1-1-07
AFMC-102	1-1-07

Explanation of Updates

Effective January 1, 2007, the following forms are being removed from Section V as they are obsolete: DMS-625, DMS-629, AFMC-401, CHMS Benefit Ext., DMS-666, DMS-667, DMS-669, DMS-661 and DMS-851. The CHMS Request for Prior Authorization Form (AFMC-101) and the CHMS Explanation of Benefits Request Form (AFMC-102) have been revised with newly assigned numbers.

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.

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

Arkansas Department of Health and Human Services

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Fax: 501-682-2480 **TDD: 501-682-6789** **Internet Website: www.medicaid.state.ar.us**

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

DATE: **January 1, 2007**

SUBJECT: **Provider Manual Update Transmittal #71**

REMOVE		**INSERT**	
Section	**Date**	**Section**	**Date**
201.000	8-1-05	201.000	1-1-07
203.000	10-13-03	203.000	1-1-07
—	—	203.100	1-1-07
204.000 – 212.000	10-13-03	204.000 – 212.000	1-1-07
212.300	10-1-03	212.300	1-1-07
213.000	10-13-03	213.000	1-1-07
215.000	10-13-03	215.000	1-1-07
217.000	10-13-03	217.000	1-1-07
217.110	10-13-03	217.110	1-1-07
217.140	10-13-03	217.140	1-1-07
218.100 – 218.200	10-13-03	218.100 – 218.200	1-1-07
220.300	10-13-03	220.200 – 220.210	1-1-07
240.000 – 242.000	10-13-03	240.000 – 242.000	1-1-07
246.000	10-13-03	246.000	1-1-07
252.000	10-13-03	252.000	1-1-07
261.000	8-1-05	261.000	1-1-07
262.110 – 262.130	11-1-05	262.110 – 262.130	1-1-07

Explanation of Updates

Section 201.000 has been revised to include current provider enrollment requirements applicable to all Medicaid providers. Arkansas Department of Human Services has been changed to Arkansas Department of Health and Human Services.

Section 203.000 has been revised to include current record keeping requirements applicable to all Medicaid providers. In reference to individuals receiving services, the term recipient has been changed to beneficiary. Record keeping requirements specific to CHMS have been relocated to a new section 203.100.

Section 203.100 is a new section that includes the medical/clinical records required for CHMS providers to keep. This information was previously located in section 203.000.

Section 204.000 has been revised to correct a grammatical error.

Section 205.000 has been revised to change the name of agency to Department of Health and Human Services. Minor grammatical changes have been made.

Section 206.000 has been revised to delete reference to Early Childhood Special Education Form. This form is obsolete. Minor wording changes have been made for clarity.

Section 211.000 has been revised to change references to individuals receiving services from recipients to beneficiaries.

Section 212.000 has been revised to change references to individuals receiving services from recipients to beneficiaries.

Section 212.300 has been revised to correct a grammatical error.

Section 213.000 has been revised to change the department name from Department of Human Services to Department of Health and Human Services.

Section 215.000 has been revised to correct a grammatical error.

Section 217.000 has been revised to correct a grammatical error.

Section 217.110 has been revised to change agency reference from DHS to DHHS.

Section 217.140 has been revised to change agency reference from DHS to DHHS.

Section 218.100 has been revised to correct a grammatical error.

Section 218.200 has been revised to correct a grammatical error.

Section 220.200 is a new section number. This section was incorrectly numbered in the current manual. The policy is revised to clarify procedures for requesting extension of benefits for diagnosis and evaluation services. The request form CHMS Benefit Extension for Diagnosis/Evaluation Procedures has been revised and has been assigned a number. It is now referenced as form AFMC-102.

Section 220.210 is a new section added to inform providers of administrative reconsideration of extension of benefits denial and appeal process.

Section 240.000, main section title for Prior Authorization, is included because the introductory statement is not necessary and has been deleted.

Section 241.000 has been revised to correct grammatical errors and make minor changes in format. Introductory information preceding this section number has been deleted from the manual.

Section 242.000 has been revised to correct grammatical errors and to add an introductory statement. CHMS Request for Prior Authorization form has been revised to assign a form number. It is now referenced as form AFMC-101.

Section 246.000 has been revised to change the section title by changing reference to those receiving services from recipients to beneficiaries. Agency name has been changed from Department of Human Services (DHS) to Department of Health and Human Services (DHHS).

Section 252.000 has been revised to change the agency name from Department of Human Services to Department of Health and Human Services.

Section 261.000 has been revised to change reference to those receiving services from recipients to beneficiaries.

Sections 262.110 and 262.120 have been revised to include changes in procedure codes effective for dates of service on and after March 1, 2006.

Section 262.130 has been revised to include change in procedure codes effective for dates of service on and after March 1, 2006. Effective for dates of service on and after January 1, 2007, procedure code **92587** is payable as a foster care assessment procedure.

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).

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Thank you for your participation in the Arkansas Medicaid Program.

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Roy Jeffus, Director

TOC required

201.000 Arkansas Medicaid Participation Requirements for Child Health Management Services (CHMS) Providers 1-1-07

Providers of Medicaid services must adhere to all applicable professional standards of care and conduct. 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 and 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 Health and 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. If any of the renewal documents have not been received within this time period, the provider will have an additional, and final, 30 days to comply.

E. Enrollment as a Medicaid provider is conditioned upon approval of a completed provider application and the execution of a Medicaid provider agreement.

F. Persons or entities that are excluded or debarred under any state or federal law, regulation or rule are not eligible to enroll, or remain enrolled, as Medicaid providers.

203.000 Documentation Required of All Medicaid Providers 1-1-07

A. All Medicaid providers must establish and maintain records that completely and accurately explain all evaluations, care, diagnoses and any other activities of the provider in connection with its delivery of medical assistance to any Medicaid beneficiary.

B. Providers furnishing any Medicaid-covered good or service for which a prescription, admission order, physician's order, care plan or other order for service initiation, authorization or continuation is required by law, by Medicaid rule, or both, must obtain a copy of the prescription, care plan or order within five (5) business days of the date it is written. Providers must also maintain a copy of each prescription, care plan or order in the beneficiary's medical record and follow all prescriptions, care plans, and orders as required by law, by Medicaid rule, or both.

C. The provider must make available to the Division of Medical Services, its contractors and designees and the Medicaid Fraud Control Unit all records related to any Medicaid beneficiary. When records are stored off-premise or are in active use, the provider may certify, in writing, that the records in question are in active use or in off-premise storage and may set a date and hour within 3 working days, at which time the records will be made available. However, the provider will not be allowed to delay for matters of convenience, including availability of personnel.

D. All records must be kept for a period of 5 years from the date of service or until all audit questions, appeal hearings, investigations or court cases are resolved, whichever is longer. Failure to furnish medical records upon request may result in sanctions being imposed. (See Section I of this manual.)

E. If an audit determines that recoupment is necessary, there will be only 30 days after receipt of the recoupment letter in which additional documentation will be accepted. Additional documentation will not be accepted at a later date.

203.100 Required CHMS Medical/Clinical Records 1-1-07

CHMS providers are required to maintain the following medical/clinical records.

A. A daily log of patient visits shall be maintained by the CHMS clinic. The clinic staff will record the entry and exit time of day of each client.

B. All CHMS services provided must be recorded in the patient's record, dated and signed by the person performing the service. The beginning and ending time of day of each service must be recorded.

C. For CHMS Diagnosis/Evaluation Services:

Complete and accurate clinical records must be maintained for any patient who receives direct services from the CHMS clinic. Each record must contain, at a minimum, the following information:

1. Identifying data and demographic information;
2. Consent for service and release of information forms required by law or local policy;
3. Referral source(s) as documented by a PCP referral;
4. Reason(s) for referral as documented on the PCP referral;
5. Content and results of all diagnostic work-ups and/or problem assessments, including the source documents, e.g., social history, test protocols, mental status examination, history of complaints, etc.;
6. Treatment plan signed by a CHMS clinic physician;
7. Medication record of all prescribed and/or administered medications;
8. Progress notes and/or other documentation of:
    a. Treatment received;
    b. Referral for treatment;
    c. Changes in the patient's situation or condition;
    d. Significant events in the patient's life relevant to treatment and
    e. Response to treatment.
9. Submittal of prior authorization request (including intervention/treatment needed) to CHMS prior authorization contractor when appropriate.

D. For CHMS Intervention/Treatment Services:

The following additional records must be maintained for patients receiving treatment in pediatric day programs.

1. Documentation of completion of intake process.
2. Documentation of interdisciplinary evaluation to address presenting diagnosis and establish base line of functioning and subsequent submission of prior authorization request.
3. CHMS physician's enrollment orders, signed treatment plan and 6 month records review completed and signed by a CHMS physician.
4. PCP initial referral and 6 month pediatric day treatment referral.
5. Daily or weekly treatment records documenting services provided, relation of service to treatment plan and level of completion of treatment goal.
6. Revisions of treatment plan including treatment goals will be documented at a minimum of each six months, or more often if warranted by the patient's progress or lack of progress.

204.000 The Child Health Management Services (CHMS) Provider's Role in the Child Health Services (EPSDT) Program 1-1-07

The Arkansas Medical Assistance Program includes a Child Health Services (Early and Periodic Screening, Diagnosis and Treatment) Program for Medicaid beneficiaries under 21 years of age. The purpose of this program is to detect and treat health problems in their early stages.

The Arkansas Medical Assistance Program operates under a primary care case management (PCCM) system. A primary care physician (PCP) referral is required for all services not

performed by the PCP, including an EPSDT Screen. A CHMS provider who is also a Child Health Services provider may perform an EPSDT Screen, with a PCP referral. The screen must be allowable within the periodicity schedule. However, if the EPSDT Screen is medically necessary but non-allowable due to the periodicity schedule it still may be performed with a PCP referral.

If a condition is diagnosed through a Child Health Services (EPSDT) Screen that requires treatment services not normally covered under the Arkansas Medicaid Program, those treatment services may be considered for coverage if they are medically necessary and permitted under federal Medicaid regulations. The PCP must prescribe and request consideration of coverage for services not otherwise covered in the Arkansas Medicaid State Plan by completing form DMS-693. This form must be submitted to the Utilization Review Section of the Division of Medical Services. **View or print form DMS-693. View or print Utilization Review Section contact information.**

CHMS providers interested in enrolling in the Child Health Services (EPSDT) Program should contact the Central Child Health Services Office. **View or print the Central Child Health Services Office contact information.**

If you are a Child Health Services (EPSDT) provider, please refer to the Child Health Services (EPSDT) manual for additional information.

205.000 Developmental Disabilities Services Early Intervention Requirements for Children Ages Birth to Three 1-1-07

Part C of the Individuals With Disabilities Education Act (IDEA) mandates the provision of early intervention services to infants and toddlers from birth to thirty-six months of age. Part C and subsequent state legislation require that specific rules and regulations be adhered to by providers of these services to infants and toddlers regardless of funding sources or methods of service provision. The Division of Developmental Disabilities within the Department of Health and Human Services has been designated as the lead agency for the First Connections Program (Part C) in Arkansas. As mandated by Part C, it is the responsibility of the lead agency to ensure that a statewide comprehensive system of services is in place which meets all federal, state and local rules and regulations. Therefore, the Division of Developmental Disabilities has developed the following requirements:

A. Referral Requirements

All referrals of children, from birth to thirty-six months of age, to the CHMS program must be in turn referred to First Connections, the Arkansas Infant and Toddler Program, within two working days. Referrals may be made through the DDS Service Coordinator for the child's county of residence or directly to a licensed DDS community services provider facility.

B. Evaluation Requirements

Evaluations conducted by CHMS must meet the First Connections procedural requirements as mandated by Part C of the Individuals With Disabilities Education Act and Developmental Disabilities Services Policy. Each evaluation conducted must be multi-disciplinary in nature and must include:

1. Two instruments in each area of development (cognitive, self-help/adaptive, communication, gross and fine motor).
2. Specialized evaluations as indicated by the initial evaluation process.
3. A narrative report including the following components:
   a. Individual specific background information
   b. Testing instruments used
   c. Test results

d. Areas of need
e. Areas of strength
f. Informed clinical opinion
g. Programming recommendations
    1. Specific broad goals
    2. Specific objectives to be accomplished
    3. Criteria for accomplishing specific goals and objectives
h. Specific placement recommendations, including:
    1. Type of service (example: Speech therapy)
    2. Frequency of service (example: Two sessions per day two days a week)
    3. Duration (example: Twenty minutes per session
    4. Type of session (example: Individual session)
    5. Setting (example: Home)

Upon completion of the evaluation, a copy shall be sent to the First Connections Service Coordinator or the central fax number. **View or print the Central Child Health Services number.**

C. Service Provision Requirements

Services provided under the CHMS program must meet the First Connections procedural requirements, as mandated by Part C of the Individuals With Disabilities Education Act and Developmental Disabilities Services Policy.

D. Transition Requirements

CHMS staff must participate in transition conferences scheduled for children for whom the transition process to Part B (within 180 days of the child's third birthday) has begun. Evaluations completed by CHMS and administered within the transition period must meet the requirements of the Local Educational Cooperative's Early Childhood Program.

E. Program/Service Options

Participation in the First Connections program is voluntary; however, CHMS staff may not solicit parent refusal. All family choice options for early intervention services must be presented to the family by the First Connections Service Coordinator.

F. Monitoring and Supervision

Developmental Disabilities Services, as the lead agency for First Connections, the Arkansas Infant and Toddler Program, has responsibility, as mandated by Part C of IDEA, for the monitoring and supervision of all early intervention services provided to infants and toddlers who meet the eligibility criteria for the Part C program. The First Connections staff will conduct monitoring with regularly scheduled monitoring visits and technical assistance visits as needed to assist early intervention programs in meeting federal, state and local rules and regulations governing the First Connections Program. CHMS must provide access to all records pertaining to children enrolled in the program who are ages 0-36 months. CHMS staff must implement recommendations made as a result of monitoring and technical assistance visits and will receive a written report from First Connections and, as necessary, a corrective action plan.

206.000 Coordination with Part B of the Individuals with Disabilities Education Act (IDEA) Amendments of 1997 1-1-07

Local education agencies (LEAs), either individually or through an Education Services Cooperative (ESC), have the responsibility for ensuring a free, appropriate public education to children with disabilities aged 3 to 5 years.

A. Child Health Management Services (CHMS) providers offering any services to a child aged 3 to 5 years who has, or is suspected of having, a disability under Section 619 of Part B of the IDEA '97, must refer the child to the LEA or ESC providing special education and related services to this population of children.

1. The purpose of this referral is to ensure that special education and related services meet all the requirements of the IDEA '97 including, but not limited to, the following:
   a. Are provided at no cost to the parent,
   b. Are not duplicative and
   c. Are in accordance with the child's individualized education plan.
2. A CHMS clinic that provides special education and related services to children aged 3 to 5 years with disabilities shall meet the qualified provider requirements established by the Arkansas Department of Education in accordance with the requirements of IDEA '97.

B. The CHMS provider shall enter into an interagency agreement with each ESC and/or LEA providing special education and related services to children with disabilities aged 3 to 5 years in the CHMS provider's service area. Such agreements shall address:

1. The process for making and receiving referrals between CHMS and the LEA/ESC,
2. Required due process procedures and the participation of CHMS in such process,
3. Transition planning and coordination between providers,
4. Provision of special education and related services by the LEA/ESC at the CHMS site and
5. Provision for resolution of disputes relative to implementation of the terms of the interagency agreement.

View or print the Arkansas Department of Education Special Education contact information.

211.000 Introduction 1-1-07

Medicaid (Medical Assistance) is designed to assist Medicaid beneficiaries in obtaining medical care within the guidelines specified in Section I of this manual. Reimbursement may be made for Child Health Management Services (CHMS) provided to Medicaid beneficiaries at qualified provider facilities.

212.000 Scope 1-1-07

Child Health Management Services (CHMS) comprises an array of clinic services intended to provide full medical multi-discipline diagnosis, evaluation and treatment for the purpose of intervention, treatment and prevention of long term disability for Medicaid beneficiaries.

Beneficiaries of Child Health Management Services must have a problem-related diagnosis. These services are not designed to be used as a well-child check-up.

Entry into the CHMS clinic system will begin with a referral from the patient's primary care physician (PCP). The PCP's approval of the plan for treatment must be in place to initiate care.

212.300 Supervising Physician Requirements and Duties 1-1-07

Medical personnel and health service delivery in a CHMS clinic must be under the medical supervision, control and responsibility of a physician currently licensed in the state of Arkansas. The physician must possess documentable skills in a specific CHMS sub-specialty area as documented by annual continuing medical education (CMEs) in areas relevant to developmental pediatrics, or a practice population composed of 25% patients that have developmental concerns/delays/disabilities/risks.

The supervising physician must direct the development of individualized treatment plans.

The supervising physician shall ensure that the CHMS provider has written procedures which include an outline of the medical tasks involved in patient care and specify to whom such tasks may be delegated as well as the criteria and procedures for patient referral.

The physician must make certain the procedures conform to good medical practices of the community, and must review and update the procedures at least annually. The procedures must be on file at the clinic and made available for review at all times.

213.000 Definitions 1-1-07

A. CHMS Clinic

A facility used for the provision of Child Health Management Services. Each facility must be enrolled with Medicaid to obtain a unique number for billing purposes. Administrative, financial, clinical and managerial responsibility for the clinic may rest with a provider organization.

B. Clinic Services

Clinic services are defined as preventive, diagnostic, therapeutic, rehabilitative or palliative items or services that are:

1. Provided to outpatients;
2. Furnished at the clinic by or under the direction of a physician and
3. Provided at the clinic by a facility that is not a part of a hospital but is organized and operated to provide medical care (42 Code of Federal Regulations 440.90).

C. Department

The Arkansas Department of Health and Human Services and its designated representatives.

D. Provider Organization

The entity responsible for the operation of a CHMS clinic.

215.000 General Standards 1-1-07

The following standards must be met or exceeded by all Child Health Management Services clinics in the state of Arkansas.

A. The CHMS clinic must be in compliance with all applicable federal and state statutes, rules and regulations.

B. All clinic services must be performed by licensed professional personnel as identified herein, when such services require licensure under the laws of the State of Arkansas.

C. Medical records must be established and maintained for each patient by the CHMS clinic. Records must include documentation of all services provided and the signature and title of the individuals who provided the services.

D. The CHMS clinic must utilize professionals with the qualifications necessary to perform Child Health Management Services. There must be sufficient health professionals available to ensure close and adequate supervision of all CHMS clinical activities.

E. The CHMS clinic must have adequate and appropriate general liability insurance for the protection of its patients, staff, physical facilities and the general public.

F. Medical supervisory responsibility must be vested in a physician who is licensed to practice medicine in the state of Arkansas. The physician must possess skills documented and defined by annual continuing medical education (CME units) in areas relevant to developmental pediatrics or a practice population of which 25% of the patients have developmental concerns/delays/disabilities/ risks) in the required CHMS specified sub-specialty areas. The CHMS clinic must issue policies formulated by the responsible physician, setting forth the procedures CHMS staff are to follow in the event a patient has or develops an emergency condition.

G. In the event a patient is hospitalized for a condition related to his or her CHMS outpatient treatment, the CHMS clinic will obtain written consent from the child's parent or legal guardian to release medical information; then, provide the admitting hospital with a written summary presenting the patient's history, diagnosis and significant outpatient treatment. Such information may not be provided without written consent.

H. The physician, vested with medical responsibility for the clinic, must report infectious and/or communicable diseases according to the regulations set forth by the Arkansas Division of Health. The physician must appoint a registered nurse to fulfill this requirement in his or her absence.

I. CHMS clinic staff, including a physician, must institute a quality assurance program to include a regularly scheduled examination of patient records to ensure adequate and appropriate care. Annual peer reviews must be conducted to determine that each patient is receiving appropriate diagnosis, evaluation and treatment services.

J. All policies and procedures must be reviewed annually by the supervising CHMS physician and by the clinic Administrator, signed and dated.

K. Patient Rights

The CHMS clinic must adopt policies and procedures which safeguard patient legal, civil and human rights including, but not limited to:

1. Non-discrimination in treatment as provided in Title VI of the Civil Rights Act of 1964; as amended; Section 504 of the Rehabilitation Act of 1973, as amended and the Americans with Disabilities Act of 1990;
2. Assignment to treatment solely on the basis of clinical need;
3. Maintenance of the confidentiality of clinical information;
4. Receipt of treatment in an atmosphere that enhances the dignity, self-respect and individuality of each patient;
5. Provisions to safeguard against hazardous treatment and against any risk entailed as a result of informed consent participation in research conducted in the CHMS clinic;
6. Maintenance of the right to communicate with family, friends, legal representatives and significant others and
7. Assurances that these rights are communicated to the patient prior to receipt of services.

Referral to a CHMS clinic may be made for any medically indicated reason as identified by the primary care physician (PCP). This referral can be made for diagnosis and/or treatment. The population typically served by CHMS providers is defined as follows:

"Children with Special Health Care Needs (CSHCN) are those who have or are at increased risk of chronic physical, developmental, behavioral, or emotional conditions and who require health and related services of a type or amount beyond that required by children generally," as defined by the Bureau of Maternal and Child Health.

CHMS are a combination of diagnostic and daily trans-disciplinary treatment programs and are a melding of developmental, medical, health and therapeutic services, some of which might be considered only educational or social. The medical aspect of these children's special needs and their needs for care by specially trained personnel makes these services health care.

Factors to be considered in determining the appropriateness of accepting a patient into the Intervention/Treatment Services Component of a CHMS program are provided below.

A. Children referred for intervention/treatment services at CHMS clinics present a wide variety of medical and developmental diagnoses. The services that these children need to address their special health care needs are also varied.

   An individualized treatment plan must be developed by the interdisciplinary CHMS team in order to address the varied health and developmental needs of each patient.

B. Very young children with special health care needs frequently face improved or deteriorated prognoses based on social/emotional issues of the family that provides the child's care and supervision and is responsible for compliance with the child's prescribed treatment plan. The social/emotional deprivation or neglect factor cannot be discounted in determining the appropriate treatment necessary for pediatric patients.

C. The severity of impairment of the child's ability to accomplish age-appropriate developmental skills in self-help, activities of daily living and communication has a significant impact on the supportive resources required to surround and/or be incorporated into treatment for very young children.

217.110 Medical Diagnosis Only 1-1-07

A. Listing of Medical Diagnoses

The presence of a significant medical diagnosis may be adequate to identify a child in need of Child Health Management Services. The following, though not a complete list, are examples of diagnoses that may indicate a child in need of care. The current clinical medical records relied upon to substantiate or support the diagnosis that establishes the need for services must accompany all requests for prior authorization or extension of benefits.

AIDS

Cerebral Degeneration

Child Maltreatment Syndrome (abuse or neglect) – must provide documentation of when and what events occurred and evidence of involvement of DHHS in current social situation.

Chronic Renal Failure

CMV

Congenital Heart Disease

Congenital Hypothyroidism

Cystic Fibrosis

Down's Syndrome

Encepholomalacia

Esophageal Atresia

Failure to Thrive – must provide documentation and detailed history, medical evaluation, nutritional evaluation and up-to-date growth chart.

Gastroschisis

HIV – must provide documentation of medical treatments and necessity of daily medical care.

Hydrocephaly with Shunt

Hypopituitarism

Hypoxic Hemmorraghic Encephalopathy

Lead Poisoning – must document lead level and extent of injury

Macrocephaly – must have documented head circumference on growth chart and medical evaluation with results of MRI, CT, etc.

Metabolic Disorder

Microcephaly – must have documented head circumference on growth chart and medical evaluation with results of MRI, CT, etc.

Neuroblastoma

Newborn Intraventricular Hemorrhage – document degree of hemorrhage

Periventricular Leukomalacia

Prematurity (less than 36 weeks gestation) – must include documentation of neonatal course and any additional significant medical problems for a child less than 12 months of age.

Prenatal Drug/Alcohol Exposure – documentation of extent of exposure and medical effects of exposure.

Seizure Disorder – does not include febrile seizures. Documentation to include medications, type and frequency of seizures.

Sickle Cell Disease – documentation of actual disease, not trait. Documentation should include history of treatment for the disease.

Spina Bifida

Tracheomalacia

Tuberous Sclerosis and Other Neurodermatoses

Various Syndromes/Severity Determined by Physician

B. Mechanism for Establishing Need for Care (Medical Only)

A medical diagnosis alone will not adequately document the necessity for CHMS. Documentation must include a complete medical evaluation by a pediatrician or pediatric

specialist to include a history and physical. There must be documentation to support the need for ongoing intervention by a medical multi-disciplinary diagnosis and treatment team within a CHMS clinic.

217.140 Medical-Developmental Diagnoses and/or Social-Emotional Trauma/Risk/Neglect 1-1-07

A. Discussion and Examples

This type of care is characterized by a less significant medical-developmental diagnosis which is coupled with one or more additional medical or developmental diagnoses and/or social-emotional trauma/risk/neglect.

These patients are at great risk for poor outcomes without appropriate intervention and management of the array of services they warrant. Despite multiple diagnoses, these patients respond rather quickly to appropriate treatment and may not require an extended period of services.

Documentation supporting the social-emotional trauma/risk/neglect must be furnished. If the child is documented to live in a high-risk environment, specific information regarding current living arrangements, custody issues and DHHS involvement is required. The current clinical medical records and documentation relied upon to substantiate or support the diagnosis that establishes the need for services must accompany all requests for prior authorization or extension of benefits.

Examples (not intended to be all inclusive) of combined diagnoses:

1. Hearing Loss + Developmental Language Delay
2. CROM+Reactive Airway Disease (RAD)+ Mild Developmental Language Delay or Speech Delay
3. Hypotonia + Very Low Birth Weight
4. Mild Developmental Delay + Maternal Neglect
5. Ex-premature 18 mo. old + Teen Mom + Mild Developmental Delay
6. Meconium Aspiration + Speech/Language Delay + Suspected Neglect
7. Strabismus + Speech Delay + Retinopathy of Prematurity

Children in need of this type of care require a core of services including assessment, treatment planning, developmental and medical intervention, periodic medical monitoring and may require ancillary therapy services of some sort. Parent education and service coordination are of extreme importance for those children experiencing social/emotional trauma or neglect. Without this additional service, the period of treatment services will be extended or have less likelihood of accomplishing the desired normalizing outcomes for the child.

B. Mechanism for Establishing Need for this Type of Care

Appropriate CHMS professionals may justify care authorization with medical evaluation, developmental testing and speech or psychological evaluation. Social history and/or completion of a standardized interview to determine risk factors may be indicated. Nutritional evaluation to support diagnosis and plan of care will be appropriate for some diagnoses.

218.100 Medical Multi-Disciplinary Diagnosis and Evaluation 1-1-07

Under the direction of a CHMS physician, a team of CHMS professionals will initiate an evaluation of each patient to establish a comprehensive range of diagnoses presented by the

patient. This team will be informed by the parent/patient concerns, medical history and the current physical condition of the patient. The initial diagnosis by the medical director will determine the area of expertise of the additional team members. Multi-Disciplinary Diagnosis and Evaluation services are available to patients from birth to age 21.

Initial diagnosis and evaluation services are considered to be a complete service if this is the reason for referral from the PCP. Ongoing diagnosis and evaluation are a component of the intervention/treatment services offered at clinic sites.

Completion of an adequate evaluation is necessary to justify treatment.

Prior authorization does not apply to the Medical Multi-Disciplinary Diagnosis and Evaluation. PCP referral is required.

218.200 Individual Treatment Planning 1-1-07

Under the direction of a CHMS physician and with input from the diagnostic evaluation team, an individualized treatment plan will be developed. This plan will include physician orders/prescription for services to be provided. A PCP referral/approval/prescription will be obtained when required. This includes occupational, physical and speech therapy services.

A separate PCP referral and prescription is required for occupational, physical and speech therapy services. The PCP must use form DMS-640 when making referrals and prescribing occupational, physical or speech therapy services. **View or print form DMS-640.** A copy of the prescription must be maintained in the child's record. If occupational, physical and speech therapy sessions are missed, make-up therapy services must not exceed the prescribed number of minutes per week without a PCP prescription.

The CHMS physician will determine the appropriate treatment to address the diagnosis, treatment needs and family concerns identified during evaluation.

For those children receiving intervention/treatment services on a daily/weekly basis, the individualized treatment plan will be written for a period of 12 months and will be updated as needed. The treatment plan for children birth to 3 years of age may be in the form of the state accepted Individualized Family Services Plan (IFSP). A continuing PCP referral is required every 6 months.

Prior authorization is required for admission into the CHMS program and for treatment procedures. Intervention/treatment services must be included in the individual treatment plan to be considered for coverage. Refer to Section 262.120 for a listing of the treatment procedure codes that require prior authorization.

220.200 Procedures for Extension of Benefits of CHMS Diagnosis/Evaluation 1-1-07

A. Extension of benefits for medically necessary CHMS diagnosis and evaluation procedures may be requested. To request extension of benefits, submit a completed form AFMC-102 CHMS Benefit Extension for Diagnosis/Evaluation Procedures and additional medical records including the most recent multidisciplinary evaluation to substantiate medical necessity to AFMC. **View or print CHMS Benefit Extension for Diagnosis/Evlauation Procedures form AFMC-102 and instructions for completion.** **View or print AFMC contact information.**

B. AFMC, which includes medical personnel, will review the medical records and will notify the requesting provider of the approval or denial of the request. AFMC will forward the approved Benefit Extension Numbers to the provider for the procedure codes requested.

220.210 Administrative Reconsideration for Extension of Benefits Denial 1-1-07

A. A request for administrative reconsideration of extension of benefits denial must be in writing and sent to AFMC within 30 calendar days of the denial. The request must include a copy of the denial letter and additional supporting documentation.

The deadline for receipt of the reconsideration request will be enforced pursuant to sections 190.012 and 190.013 of this manual. A request received by AFMC within 35 calendar days of a denial will be deemed timely. A request received later than 35 calendar days will be considered on an individual basis. Reconsideration requests must be mailed and will not be accepted via facsimile.

B. Please see section 190.000 of this manual for information regarding administrative appeals.

240.000 PRIOR AUTHORIZATION FOR CHILD HEALTH MANAGEMENT SERVICES 1-1-07

241.000 Intake and Diagnosis/Evaluation Process 1-1-07

A. A referral from the primary care physician (PCP) must be received by the CHMS clinic for assessment and evaluation of the patient for services. Note: If the beneficiary is exempt from the PCP process, then the referrals for services must be made by the child's attending physician.

B. The CHMS clinic must conduct an intake and assessment once the referral is received. PCP referrals should be renewed no less often than each six (6) months. **Prior authorization is not required for the diagnosis/evaluation procedure codes located in Section 262.110.**

The steps in the intake process are as follows:

1. The intake process begins with the family or referral source to identify the needs of the patient.
2. The CHMS clinic will schedule an appointment with the child's family for the intake assessment.
3. The CHMS professional staff will assess the need of the patient for the services available. History and concerns of the family will be collected and the intake process will be completed.
4. If no concerns are found, the family will be provided other service information.
5. When developmental/medical concerns are found, a CHMS pediatrician visit will be scheduled for an evaluation.
6. The CHMS pediatrician or other professional staff will evaluate the patient for medical conditions, developmental delays and other special health care needs. If additional testing is recommended, further testing will be completed.
7. After the evaluation is completed, admission for treatment services will be recommended or not recommended by the CHMS professionals.

B. CHMS procedure codes for diagnosis/evaluation listed in Section 262.110 of this manual may be billed two (2) times per state fiscal year (July 1 through June 30) without extension of benefits.

C. If these diagnosis/evaluation procedures are required for additional services, the CHMS provider must request an extension of the benefit limit. Refer to Section 220.300 of this manual for procedures to request extension of benefits for diagnosis/evaluation services.

242.000 Prior Authorization Request to Determine and Verify the Patient's Need for Child Health Management Services 1-1-07

Intervention and treatment services for Medicaid beneficiaries must be prior authorized in accordance with the following procedures.

A. When a recommendation is made for intervention/treatment services, the CHMS Request for Prior Authorization form AFMC-101 must be completed by the CHMS clinic and submitted via mail or fax to the Arkansas Foundation for Medical Care (AFMC). Fax transmission will be limited to 25 pages. For those clinics wishing to utilize electronic submission, contact AFMC and request specifics. **View or print CHMS Request for Prior Authorization form AFMC-101 and instructions for completion. View or print AFMC contact information.**

   The request must include a report of the findings from evaluations and a current plan for treatment. Review for medical necessity will be performed on the information sent by the provider. This information must substantiate the need for the child to receive services in a multidisciplinary CHMS clinic.

B. The request will be screened by the CHMS review coordinator.

   1. When completed documents are received, a review for prior authorization of requested services will be performed. If the CHMS review coordinator cannot approve all of the procedure codes requested, the request form and documentation will be sent to a physician advisor for his or her determination.
   2. There may be complete approval, partial approval or complete denial of procedure codes requested. Reconsideration may be requested within thirty (30) calendar days of the date on the denial letter.
   3. Reconsideration review will be performed by a different physician advisor.

C. If services are approved, the requesting CHMS clinic will be issued an authorization number. A preliminary length of service, procedure codes and units approved will be designated.

D. In cases where the patient could be served at either a CHMS clinic or a Developmental Day Treatment Clinic (DDTCS), AFMC will notify the parents and the patient's primary care physician (PCP) of the options for type of clinic.

E. The determination by AFMC will be pended for a maximum of 30 days to allow the parent to choose the clinic where services will be provided.

F. Once the determination has been made, the CHMS clinic will be notified of the prior authorization disposition.

G. The prior authorization process will be completed within fifteen (15) working days of receipt of all required documentation. Intervention/Treatment Services may begin prior to the receipt of prior authorization only at the financial risk of the CHMS organization.

Refer to the flow chart in Section 244.000 of this manual for the process outlined above.

246.000 Appeal Process for Medicaid Beneficiaries 1-1-07

When an adverse decision for prior authorization of services is received from AFMC, the beneficiary may request a fair hearing of the reconsideration decision of the denial of services from the Department of Health and Human Services.

The appeal request must be in writing and received by the Appeals and Hearings Section of the Department of Health and Human Services within thirty days of the date on the letter from AFMC explaining the denial.

Submit appeal requests to the Department of Health and Human Services (DHHS), Appeals and Hearings Section. **View or print Appeals and Hearings Section contact information.**

252.000 Rate Appeal Process 1-1-07

A provider may request reconsideration of a Program decision by writing to the Assistant Director, Division of Medical Services. This request must be received within 20 calendar days following the application of policy and/or procedure or the notification of the provider of its rate. Upon receipt of the request for review the Assistant Director will determine the need for a Program/Provider conference and will contact the provider to arrange a conference if needed. Regardless of the Program decision the provider will be afforded the opportunity for a conference, if he or she so wishes, for a full explanation of the factors involved and the Program decision. Following review of the matter, the Assistant Director will notify the provider of the action to be taken by the division within 20 calendar days of receipt of the request for review or the date of the Program/Provider conference.

If the decision of the Division of Medical Services Assistant Director is unsatisfactory, the provider may appeal to the standing Rate Review Panel established by the Director of the Division of Medical Services. This panel will include one member of the Division of Medical Services, a representative of the provider association and a member of the Department of Health and Human Services Management Staff, who will serve as chairman.

The request for review by the Rate Review Panel must be postmarked within 15 calendar days following the notification of the initial decision by the Assistant Director, Division of Medical Services. The Rate Review Panel will meet to consider the question(s) within 15 calendar days after receipt of a request for such appeal. The question(s) will be heard by the panel and a recommendation will be submitted to the Director of the Division of Medical Services.

261.000 Introduction to Billing 1-1-07

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

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

262.110 Diagnosis and Evaluation Procedure Codes 1-1-07

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 additional diagnosis and evaluation procedures are required, the CHMS provider must request an extension of benefits.

Procedure Codes				
90805	90807	90809	92506	92551
92552	92553	92555	92557	92567
92582	92585	92587	92588	96105
96111	96118*	99201	99202	99203
99204	99205			

*Effective for dates of service on and after March 1, 2006, procedure code **96117** was made non-payable and was replaced with procedure code **96118**.

Procedure Code	Required Modifier(s)	Description
90801		Diagnostic evaluation/review of records (1 unit = 15 minutes), maximum of 3 units; limited to 6 units per state fiscal year
90887		Interpretation of diagnosis (1 unit = 15 minutes), maximum of 3 units; limited to 6 units per state fiscal year
96101	UA, UB	Psychological testing battery (1 unit = 15 minutes), maximum of 4 units; limited to 8 units per state fiscal year Effective for dates of service on and after March 1, 2006, procedure code 96100 was replaced with procedure code 96101.
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
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; limited to 4 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; limited to 4 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; limited to 8 units per state fiscal year

262.120 Treatment Procedure Codes 1-1-07

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
97762*	99211	99212	99213	99214
99215				

*Effective for dates of service on and after March 1, 2006, procedure code **97703** was made non-payable and was replaced with procedure code **97762**.

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.
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	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).
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)

Procedure Code	Required Modifier(s)	Description
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)
97110	UB	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	Group Occupational Therapy by Occupational Therapy Assistant (1 unit = 15 minutes), maximum of 4 clients per group
97150	UB	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	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)
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).

Procedure Code	Required Modifier(s)	Description
97535	UB	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 1-1-07

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 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
92587**	U1	Evoked otoacoustic emissions; limited (single stimulus level, either transient or distortion products)
95961	UA	Cortical Function Testing
96101*	U1, UA	Psychological Testing, 2 or more (1 unit = 15 minutes), maximum of 8 units
96101*	UA	Interpretation (1 unit = 15 minutes), maximum of 8 units
99173		Visual Screen
99205 99215	U1 U1	High Complex medical exam

* Effective for dates of service on and after March 1, 2006, procedure code **96100** was made non-payable and was replaced with procedure code **96101**.

** Effective for dates of service on and after January 1, 2007, procedure code **92587** is payable as a comprehensive health assessment procedure for foster children.