ARKANSAS DEPARTMENT OF HUMAN SERVICES

Division of Medical Services
Program Planning & Development

P.O. Box 1437, Slot S-295 · Little Rock, AR 72203-1437
501-682-8368 · Fax: 501-682-2480

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

DATE: **August 1, 2009**

SUBJECT: **Provider Manual Update Transmittal #122**

REMOVE		**INSERT**	
Section	**Date**	**Section**	**Date**
203.100	1-1-07	203.100	8-1-09
218.400	10-13-03	218.400	8-1-09
222.000	10-13-03	222.000	8-1-09
242.000	1-1-07	242.000	8-1-09
244.000	10-13-03	244.000	8-1-09

Explanation of Updates

Effective for claims received on or after August 1, 2009, the following provider manual revisions are implemented.

Section 203.100 has been updated to clarify instructions for completion of Required CHMS Medical/Clinical Records and to change form AFMC-201 to DMS-201, Child Health Management Services Enrollment Orders.

Section 218.400 has been updated to add clarifying language regarding Transition and Follow-Up and to change form AFMC-202 to DMS-202, Child Health Management Services Discharge Notification Form.

Section 222.000 has been updated to add clarifying language regarding Inspection of Care.

Section 242.000 has been updated to add clarifying language regarding the Prior Authorization Request to Determine and Verify the Patient's Need for Child Health Management Services and to delete obsolete information from the section. In addition, the name of form AFMC-102 has been changed to DMS-102.

Section 244.000 has been updated to delete the obsolete flow chart and insert a new Flow Chart of Intake and Prior Authorization Process for Intervention/Treatment.

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) 682-8323 (Local); 1-800-482-5850, extension 2-8323 (Toll-Free) or obtain access to these numbers through voice relay, 1-800-877-8973 (TTY Hearing Impaired).

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 not required

203.100 Required CHMS Medical/Clinical Records 8-1-09

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, form DMS-201, 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. Services must be provided in accordance with the treatment plan, with clear documentation of the services rendered.

a. If a child does not receive all services as outlined in the treatment plan, there must be clear documentation regarding the reason the prescribed services were not provided (e.g. child absent, therapist unavailable, etc.)

b. If a child does not receive the prescribed amount of therapy due to the unavailability of CHMS therapy staff for a period of more than 2 (two) weeks, the primary care physician and the child's parent/guardian must be notified of the missed therapy and given an estimated time frame in which therapy services should resume at the prescribed rate.

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.

218.400 Transition/Follow-Up 8-1-09

When it is determined that the patient no longer has a medical need for therapy services, the treatment plan will be updated accordingly and services will be discontinued. Releases to provide copies of testing results and treatment records will be obtained, if appropriate. Follow-up with the parent/patient will be made no more than 180 days following discontinuation of therapy to determine the status of the patient. Follow-up may be as soon and as frequent as the CHMS physician determines is necessary.

When it is determined that the patient no longer has a medical need for intervention/treatment services, a transition conference will be held with the relevant CHMS providers and the patient/parents. Releases to provide copies of testing results and treatment records will be obtained, if appropriate. Follow-up with the parent will be made no more than 180 days following transition to determine the status of the patient. Follow-up may be as soon and as frequent as the CHMS physician determines is necessary.

When CHMS multidisciplinary treatment services are no longer medically necessary, or if CHMS services are discontinued for other reasons (e.g. child is moving, parental/guardian request, etc.), the CHMS Discharge Notification (DMS-202) must be completed and a copy submitted to AFMC within 30 (thirty) days of service termination.

222.000 Inspection of Care 8-1-09

Inspection of care will be performed in conjunction with the certification site visits. A team of healthcare professionals will assess the care needed by and provided to a sampling of CHMS patients.

For each inspection of care visit, AFMC will select patients currently being served by the CHMS clinic. The AFMC team will review medical records, and may interview patients, parents and staff and observe treatment in progress.

A. The medical record review will include assessment of the patient's continued medical necessity for Child Health Management Services (CHMS), determining if the treatment plan is being followed and if the therapy services are being provided as prescribed by the primary care physician (subject to applicable authorizations and utilization controls.

B. An AFMC team member (determined by the patient's diagnosis and treatment program) may interview staff and, if available, parents to assess the patient's needs, goals and progress with treatment. The same team member may also meet, assess and observe the patient in treatment.

C. In addition to focusing on selected patients, the AFMC team will observe the activities at the CHMS clinic for therapeutic function.

Any child determined to not meet the requirements for enrollment in a CHMS clinic will be decertified from the program. A written notification will be given to the clinic with a copy mailed to the parents of the patient. The clinic/parents will be allowed thirty (30) calendar days to request reconsideration of the patient decertification to AFMC. A reconsideration of the decertification will be completed with notification to the clinic and parents within fifteen (15) working days from receipt of the appeal.

A written report of the inspection of care finding will be mailed to the Division of Medical Services.

242.000 Prior Authorization Request to Determine and Verify the Patient's Need for Child Health Management Services 8-1-09

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 DMS-102 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 DMS-102 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. Prior Authorization Review Process

1. Prior authorization requests are initially screened by a CHMS review coordinator (a registered nurse). When complete documents are received, a prior authorization review of the requested services is performed. If the CHMS review coordinator cannot approve all of the services requested, the review is sent to a pediatric physician advisor for determination.
2. When the request is approved, a prior authorization number is issued along with a preliminary length of service, procedure codes and units approved. Approval notifications are mailed to the CHMS provider and the Medicaid beneficiary.

C. For any request that is denied or approved at a reduced level, a letter containing case specific rationale that explains why the request was not approved is mailed to the beneficiary and to the Medicaid provider. These notification letters also contain information regarding the beneficiary and provider's due process rights.

D. Providers may request reconsideration. Requests must be received within 35 (thirty-five) days from the date of the determination. Requests must be made in writing and include additional information to substantiate the medical necessity of the requested services. Reconsideration review will be performed by a different physician advisor.

E. The prior authorization/reconsideration process will be completed within 30 (thirty) 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.

F. The Medicaid beneficiary, the CHMS provider, or both may request a fair hearing of a denied review determination made by the Arkansas Foundation for Medical Care (AFMC). The fair hearing request must be in writing and received by the Office of Appeals and Hearings section of The Department of Human Services (DHS) within 35 (thirty-five) calendar days of the date on the denial letter.

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

244.000 Flow Chart of Intake and Prior Authorization Process for Intervention/Treatment 8-1-09

View or print Flow Chart of Intake and Prior Authorization Process for Intervention/Treatment.

View or print AFMC CHMS Request for Prior Authorization Form and instructions for completion.

ARKANSAS DEPARTMENT OF HUMAN SERVICES

Division of Medical Services

Program Development & Quality Assurance

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

501-682-8368 · Fax: 501-682-2480

TO: **Arkansas Medicaid Health Care Providers**

DATE: **February 1, 2010**

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

Provider Manual	Transmittal Number
Alternatives for Adults with Physical Disabilities Waiver	82
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REMOVE		**INSERT**	
Section	**Date**	**Section**	**Date**
—	—	DMS-201	2-1-10
—	—	DMS-202	2-1-10

Explanation of Updates

Effective February 1, 2010, forms AFMC-201, Child Health Management Services Enrollment Orders and AFMC-202, Child Health Management Services, Discharge Notification Form will be changed to DMS-201 and DMS-202 respectively. These forms are new to the DMS/HP Enterprise Services system.

The paper version of this update transmittal includes revised pages that may be filed in your provider manual. See Section I for instructions on updating the paper version of the manual. For electronic versions, these changes have already been incorporated.

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Thank you for your participation in the Arkansas Medicaid Program.

Marilyn Strickland, Assistant Director

Add the following

In order by form name:

Form Name	Form Number
Child Health Management Services Enrollment Orders	DMS-201
Child Health Management Services Discharge Notification Form	DMS-202

In order by form number:

DMS-201 DMS-202

DIVISION OF MEDICAL SERVICES

CHILD HEALTH MANAGEMENT SERVICES
ENROLLMENT ORDERS

Child Name:_____ DOB:_____

Medicaid #:_____Admission Date:_____

I have ***examined*** the above named Medicaid beneficiary and have ***reviewed*** the records of this child. Based on my examination, and the evaluations that have been performed on this child, admission to CHMS is recommended.

The following services are to be provided:

Classroom Intervention	☐	Occupational Therapy	☐
Treatment Planning	☐	Speech Therapy	☐
Brief Consultation	☐	Individual Psychotherapy	☐
Collateral Services	☐	Group Psychotherapy	☐
Nutritional Services	☐	Family Psychotherapy	☐
Nursing Services	☐	Marital/Family Counseling	☐
Physician Services	☐	Other _____	☐
Physical Therapy	☐		

_____ _____

Signature of CHMS Medical Director Date of Signature

The following to be completed by the Primary Care Physician

I have reviewed the above information and agree with the indicated treatment services.

_____ _____

Signature of Primary Care Physician Date of Signature

DIVISION OF MEDICAL SERVICES

CHILD HEALTH MANAGEMENT SERVICES
DISCHARGE NOTIFICATION FORM

Patient Name:			**Medicaid Number:**
Provider Name:			**Provider Number:**
Please indicate **ALL services that have been discontinued**			
Treatment Service:		**Date of Last Treatment:**	**Reason for Discharge:**
Classroom Intervention			
Occupational Therapy			
Physical Therapy			
Speech Therapy			
Nutritional Services			
Physician Services			
Nursing Services			
Individual Psychotherapy			
Group Psychotherapy			
Family Psychotherapy			
Crisis Management			
Other (Please describe)			

_____

Signature of Provider Date

Upon completion, please fax of mail to:

Arkansas Foundation for Medical Care, Inc.
P.O. Box 180001 Fort Smith, AR 72918
Fax: 479-649-0776

DMS-202 (2-1-10)