TOC not required

212.600 Orthotic Appliances and Prosthetic Devices, All Ages 7-1-12

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 DMS-679A titled *Prescription & Prior Authorization Request for Medical Equipment Excluding Wheelchairs & Wheelchair Components* to AFMC. **View or print form DMS-679A 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 beneficiary's condition warrants a modification or replacement and the $3,000.00 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 orthotic appliances 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 $1,000.00 per item Medicaid maximum allowable reimbursement rate for use by beneficiaries age 21 and over. Prior authorization may be requested by submitting form DMS-679A titled *Prescription & Prior Authorization Request for Medical Equipment Excluding Wheelchairs & Wheelchair Components* to AFMC. **View or print form DMS-679A 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 beneficiary'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. The 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 DMS-679A. **View or print DMS-679A *titled 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-647 Gait Analysis: Full Body. **View or print form DMS-647.**
2. DMS-648 Upper-Limb Prosthetic Evaluation. **View or print form DMS-648**.
3. DMS-649 Upper-Limb Prosthetic Prescription. **View or print form DMS-649**.
4. DMS-650 Lower-Limb Prosthetic Evaluation. **View or print form DMS-650**.
5. DMS-651 Lower-Limb Prosthetic Prescription. **View or print form DMS-651**.

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 – Prosthetics**

DATE: **July 1, 2012**

SUBJECT: **Provider Manual Update Transmittal PROSTHET-1-12**

REMOVE		**INSERT**	
Section	**Date**	**Section**	**Date**
212.600	4-1-09	212.600	7-1-12

Explanation of Updates

Section 212.600 is updated to indicate that Form DMS-648 has been renamed to Upper-Limb Prosthetic Evaluation and Form DMS-650 has been renamed to Lower-Limb Prosthetic Evaluation. This section is also updated to indicate that Form DMS-646 (Evaluation Form Lower Limb) has been discontinued. Providers should use Form DMS-650 in place of Form DMS-646.

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.

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

If you need this material in an alternative format, such as large print, please contact our Americans with Disabilities Act Coordinator at 501-682-0593 (Local); 1-800-482-5850, extension 2-0593 (Toll-Free) or to obtain access to these numbers through voice relay, 1-800-877-8973 (TTY Hearing Impaired).

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.

Andrew Allison, PhD
Director

SECTION V – FORMS

500.000

Claim Forms

Red-ink Claim Forms

The following is a list of the red-ink claim forms required by Arkansas Medicaid. The forms below cannot be printed from this manual for use. Information about where to get the forms and links to samples of the forms is available below. To view a sample form, click the form name.

Claim Type	Where To Get Them
Professional – CMS-1500	Business Form Supplier
Institutional – CMS-1450*	Business Form Supplier
Visual Care – DMS-26-V	1-800-457-4454
Inpatient Crossover – HP-MC-001	1-800-457-4454
Long Term Care Crossover – HP-MC-002	1-800-457-4454
Outpatient Crossover – HP-MC-003	1-800-457-4454
Professional Crossover – HP-MC-004	1-800-457-4454

* For dates of service after 11/30/07 – ALL HOSPICE PROVIDERS USE ONLY FORM CMS-1450 (formerly UB-04) for billing.

Claim Forms

The following is a list of the non-red-ink claim forms required by Arkansas Medicaid. Information about where to get a supply of the forms and links to samples of the forms is available below. To view a sample form, click the form name.

Claim Type	Where To Get Them
Alternatives Attendant Care Provider Claim Form - AAS-9559	Client Employer
Dental – ADA-J400	Business Form Supplier

Arkansas Medicaid Forms

The forms below can be printed from this manual for use.

In order by form name:

Form Name	Form Link
Acknowledgement of Hysterectomy Information	DMS-2606
Address Change Form	DMS-673
Adjustment Request Form – Medicaid XIX	HP-AR-004

Form Name	Form Link
AFMC Prescription & Prior Authorization Request for Medical Equipment Excluding Wheelchairs & Wheelchair Components	DMS-679A
Amplification/Assistive Technology Recommendation Form	DMS-686
Application for WebRA Hardship Waiver	DMS-7736
Approval/Denial Codes for Inpatient Psychiatric Services	DMS-2687
Arkansas Early Intervention Infant & Toddler Program Intake/Referral/Application for Services	DDS/FS#0001.a
ARKids First Mental Health Services Provider Qualification Form	DMS-612
Assisted Living Waiver Plan of Care	AAS-9565
Authorization for Automatic Deposit	autodeposit
Authorization for Payment for Services Provided	MAP-8
Certification of Need – Medicaid Inpatient Psychiatric Services for Under Age 21	DMS-2633
Certification of Schools to Provide Comprehensive EPSDT Services	CSPC-EPSDT
Certification Statement for Abortion	DMS-2698
Change of Ownership Information	DMS-0688
Child Health Management Services Enrollment Orders	DMS-201
Child Health Management Services Discharge Notification Form	DMS-202
CHMS Benefit Extension for Diagnosis/Evaluation Procedures	DMS-699A
CHMS Request for Prior Authorization	DMS-102
Claim Correction Request	DMS-2647
Consent for Release of Information	DMS-619
Contact Lens Prior Authorization Request Form	DMS-0101
Contract to Participate in the Arkansas Medical Assistance Program	DMS-653
DDTCS Transportation Log	DMS-638
DDTCS Transportation Survey	DMS-632
Dental Treatment Additional Information	DMS-32-A
Disclosure of Significant Business Transactions	DMS-689
Disproportionate Share Questionnaire	DMS-628
Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Prescription/Referral For Medically Necessary Services/Items Not Specifically Included in the Medicaid State Plan	DMS-693
Early Childhood Special Education Referral Form	ECSE-R
EPSDT Provider Agreement	DMS-831
Explanation of Check Refund	HP-CR-002
Gait Analysis Full Body	DMS-647

Form Name	Form Link
Home Health Certification and Plan of Care	CMS-485
Hospital/Physician/Certified Nurse Midwife Referral for Newborn Infant Medicaid Coverage	DCO-645
Inpatient Psychiatric Medicaid Agency Review Team Transmittal Sheet	DMS-2685
Individual Renewal Form for School-Based Audiologists	DMS-7782
Lower-Limb Prosthetic Evaluation	DMS-650
Lower-Limb Prosthetic Prescription	DMS-651
Media Selection/E-Mail Address Change Form	HP-MS-005
Medicaid Claim Inquiry Form	HP-CI-003
Medicaid Form Request	HP-MFR-001
Medical Assistance Dental Disposition	DMS-2635
Medical Equipment Request for Prior Authorization & Prescription	DMS-679
Medical Transportation and Personal Assistant Verification	DMS-616
Mental Health Services Provider Qualification Form for LCSW, LMFT and LPC	DMS-633
Notice Of Noncompliance	DMS-635
NPI Reporting Form	DMS-683
Occupational, Physical and Speech Therapy for Medicaid Eligible Beneficiaries Under Age 21 Prescription/Referral	DMS-640
Ownership and Conviction Disclosure	DMS-675
Personal Care Assessment and Service Plan	DMS-618 English DMS-618 Spanish
Practitioner Identification Number Request Form	DMS-7708
Prescription & Prior Authorization Request For Nutrition Therapy & Supplies	DMS-2615
Primary Care Physician Managed Care Program Referral Form	DMS-2610
Primary Care Physician Participation Agreement	DMS-2608
Primary Care Physician Selection and Change Form	DMS-2609
Prior Authorization (PA) Request for Extension of Benefits-Prescription Drugs	DMS-0685-14
Procedure Code/NDC Detail Attachment Form	DMS-664
Provider Application	DMS-652
Provider Communication Form	AAS-9502
Provider Data Sharing Agreement – Medicare Parts C & D	DMS-652-A
Provider Enrollment Application and Contract Package	AppMaterial
Referral for Audiology Services – School-Based Setting	DMS-7783

Form Name	Form Link
Referral for Certification of Need Medicaid Inpatient Psychiatric Services for Under Age 21	DMS-2634
Referral for Medical Assistance	DMS-630
Request for Appeal	DMS-840
Request for Extension of Benefits	DMS-699
Request for Extension of Benefits for Clinical, Outpatient, Laboratory and X-Ray Services	DMS-671
Request for Extension of Benefits for Medical Supplies for Medicaid Beneficiaries Under Age 21	DMS-602
Request For Orthodontic Treatment	DMS-32-0
Request for Private Duty Nursing Services Prior Authorization and Prescription – Initial Request or Recertification	DMS-2692
Request for Targeted Case Management Prior Authorization for Beneficiaries Under Age 21	DMS-601
Research Request Form	HP-0288
Service Log – Personal Care Delivery and Aides Notes	DMS-873
Sterilization Consent Form	DMS-615 English DMS-615 Spanish
Sterilization Consent Form – Information for Men	PUB-020
Sterilization Consent Form – Information for Women	PUB-019
Upper-Limb Prosthetic Evaluation	DMS-648
Upper-Limb Prosthetic Prescription	DMS-649
Vendor Performance Report	Vendorperformreport
Verification of Medical Services	DMS-2618

In order by form number:

AAS-9502
AAS-9559
AAS-9565
Address Change
Autodeposit
CMS-485
CSPC-EPSDT
DCO-645
DDS/FS#0001.a
DMS-0101
DMS-0685-14
DMS-0688
DMS-102
DMS-201
DMS-202
DMS-2606
DMS-2608
DMS-2609
DMS-2610
DMS-2615
DMS-2618
DMS-2633
DMS-2634
DMS-2635
DMS-2647
DMS-2685
DMS-2687
DMS-2692
DMS-2698
DMS-32-A
DMS-32-0
DMS-601
DMS-602
DMS-612
DMS-615 English
DMS-615 Spanish
DMS-616
DMS-618 English
DMS-618 Spanish
DMS-619
DMS-628
DMS-630
DMS-632
DMS-633
DMS-635
DMS-638
DMS-640
DMS-647
DMS-648
DMS-649
DMS-650
DMS-651
DMS-652
DMS-652-A
DMS-653
DMS-664
DMS-671
DMS-675
DMS-673
DMS-679
DMS-679A
DMS-683
DMS-686
DMS-689
DMS-693
DMS-699
DMS-699A
DMS-7708
DMS-7736
DMS-7782
DMS-7783
DMS-831
DMS-840
DMS-873
ECSE-R
HP-0288
HP-AR-004
HP-CI-003
HP-CR-002
HP-MFR-001
HP-MS-005
MAP-8
Performance Report
Provider Enrollment Application and Contract Package
PUB-019
PUB-020

Arkansas Medicaid Contacts and Links

Click the link to view the information.

American Hospital Association
Americans with Disabilities Act Coordinator
Arkansas Department of Education, Health and Nursing Services Specialist
Arkansas Department of Education, Special Education
Arkansas Department of Human Services, Division of Aging and Adult Services
Arkansas Department of Human Services, Appeals and Hearings Section
Arkansas Department of Human Services, Division of Behavioral Health Services
Arkansas Department of Human Services, Division of Child Care and Early Childhood Education, Child Care Licensing Unit
Arkansas Department of Human Services, Division of Children and Family Services, Contracts Management Unit
Arkansas Department of Human Services, Children's Services

HP Enterprise Services Provider Assistance Center (PAC)

HP Enterprise Services Supplied Forms

Example of Beneficiary Notification of Denied ARKids First-B Claim

Example of Beneficiary Notification of Denied Medicaid Claim

First Connections Infant & Toddler Program, Developmental Disabilities Services

Flow Chart of Intake and Prior Authorization Process For Intervention/Treatment

Health Care Declarations

ICD-9-CM, CPT, and HCPCS Reference Book Ordering

Immunizations Registry Help Desk

Medicaid ID Card Example

Medicaid Managed Care Services (MMCS)

Medicaid Reimbursement Unit Communications Hotline

Medicaid Tooth Numbering System

National Supplier Clearinghouse

Primary Care Physician (PCP) Enrollment Voice Response System

Provider Qualifications, Division of Behavioral Health Services

QSource of Arkansas

Select Optical

Standard Register

Table of Desirable Weights

ValueOptions

U.S. Government Printing Office

Vendor Performance Report

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 – All Providers**

DATE: **July 1, 2012**

SUBJECT: **Provider Manual Update Transmittal SecV-1-12**

REMOVE		**INSERT**	
Section	**Date**	**Section**	**Date**
500.000	—	500.000	—
DMS-646	3/00	—	—
DMS-648	3/00	DMS-648	7/12
DMS-650	3/00	DMS-650	7/12

Explanation of Updates

This transmittal and the enclosed forms are for informational purposes only. **Please do not complete the enclosed forms.**

Section 500.000 is updated to indicate that Form DMS-646 (Evaluation Form Lower Limb) has been discontinued. It is also updated to indicate that Form DMS-648 has been renamed to Upper-Limb Prosthetic Evaluation and Form DMS-650 has been renamed to Lower-Limb Prosthetic Evaluation.

Form DMS-646 (Evaluation Form Lower Limb) has been discontinued. Providers should use Form DMS-650 (Lower-Limb Prosthetic Evaluation) instead.

Form DMS-648 has been renamed to Upper-Limb Prosthetic Evaluation and includes updated fields.

Form DMS-650 has been renamed to Lower-Limb Prosthetic Evaluation and includes updated fields.

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.

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

If you need this material in an alternative format, such as large print, please contact our Americans with Disabilities Act Coordinator at 501-682-0593 (Local); 1-800-482-5850, extension 2-0593 (Toll-Free) or to obtain access to these numbers through voice relay, 1-800-877-8973 (TTY Hearing Impaired).

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.

Andrew Allison, PhD
Director

ARKANSAS MEDICAID

UPPER-LIMB PROSTHETIC EVALUATION FORM

INSTRUCTIONS: Carefully complete this entire form to the best of your professional knowledge leaving no portions blank. Mark inappropriate areas N/A (not applicable).

Name_____ Age_____ Sex_____ Date_____

Date of Amputation_____ _____Right _____Left _____Bilateral

Level of Amputation:

_____ Partial Hand _____ Elbow Disarticulation

_____ Wrist Disarticulation _____ Transhumeral

_____ Transradial _____ Shoulder Disarticulation

Dates of revision amputation surgery_____

Has patient worn a prosthesis before _____Yes _____No

Age of current prosthesis_____

Evaluation of fit and function of current prosthesis:

_____

_____

_____

Name _____

Medical necessity for new prosthesis:

_____
_____
_____

Recommendations for new prosthesis:

Socket type _____

Suspension of prosthesis _____

Type of wrist joint _____

Type of elbow joint _____

Type of terminal device_____

L-Codes and description of new prosthesis:

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Name and Credentials of Prosthetist _____

Name _____

Attestation of Referring Physician:

I have reviewed all portions of this Upper-Limb Evaluation Form prepared for my patient, _____, and I agree with the treatment plan and accept this as a prescription for a medically necessary prosthesis.

_____MD _____Address

_____MD (Print Name) _____

Date_____ _____Phone#

ARKANSAS MEDICAID

LOWER-LIMB PROSTHETIC EVALUATION FORM

INSTRUCTIONS: Carefully complete this entire form to the best of your professional knowledge leaving no portions blank. Mark inappropriate areas N/A (not applicable).

Name _____ Age_____ Sex_____ Date_____

Date of Amputation_____ _____Right _____Left _____Bilateral

Level of Amputation:

_____ Partial Foot _____ Knee Disarticulation

_____ Symes _____ Transfemoral

_____ Transtibial _____ Hip Disarticulation

Dates of revision amputation surgery_____

Has patient worn a prosthesis before _____Yes _____No

Age of current prosthesis_____

Evaluation of fit and function of current prosthesis:

_____

_____

_____

Name _____

Medical necessity for prosthetic services requested: (Replacement socket, new prosthesis, etc.)

_____
_____
_____

Recommendations for new prosthesis:

Socket type _____

Suspension of prosthesis _____

Type of knee joint _____

Type of ankle / foot _____

L-Codes and description of new prosthesis:

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Name _____

Current Medicare Functional Level of Patient's Activity (K-Levels)

_____ K-0 Patient does not have the ability to ambulate or transfer safely with or without assistance and a prosthesis does not enhance their quality of life or mobility.

_____ K-1 Patient has the ability or potential to use a prosthesis for transfers or ambulation on level surfaces at a fixed cadence. Typical of a limited or unlimited household ambulatory.

_____ K-2 Patient has the ability or potential for ambulation with the ability to traverse low level environmental barriers such as curbs, stairs or uneven surfaces. Typical of the limited community ambulatory.

_____ K-3 Patient has the ability or potential for ambulation with variable cadence. Typical of the community ambulatory who has the ability to traverse most environmental barriers and may have vocational, therapeutic or exercise activity that demands prosthetic utilization beyond simple locomotion.

_____ K-4 Patient has the ability or potential for prosthetic ambulation that exceeds basic ambulation skills exhibiting high impact, stress or energy levels. Typical of the prosthetic demands of a child, active adult or athlete.

Name and Credentials of Prosthetist _____

Attestation of Referring Physician:

I have reviewed all portions of this Lower-Limb Evaluation Form prepared for my patient, _____, and I agree with the treatment plan and accept this as a prescription for a medically necessary prosthesis.

_____MD _____Address

_____MD (Print Name) _____

Date_____ _____Phone#