ARKANSAS REGISTER

Transmittal Sheet

Use only for **FINAL** and **EMERGENCY RULES**

Secretary of State
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For Office Use Only:

Effective Date _____ Code Number _____

Name of Agency Department of Human Services

Department Division of Medical Services

Contact Cheryl Freeman E-mail cheryl.freeman@dhs.arkansas.gov Phone 501-537-1675

Statutory Authority for Promulgating Rules Arkansas Code Annotated 20-76-201

Rule Title: Prosthetics 2-16; Section V 7-16

Intended Effective Date (Check One)		Date
☐ Emergency (ACA 25-15-204)	Legal Notice Published	12/01/2016
☑ 10 Days After Filing (ACA 25-15-204)	Final Date for Public Comment	12/30/2016
☐ Other _____ (Must be more than 10 days after filing date.)	Reviewed by Legislative Council	06/16/2017
	Adopted by State Agency	05/01/2017

Electronic Copy of Rule e-mailed from: (Required under ACA 25-15-218)

Thomas Herndon — thomas.herndon@dhs.arkansas.gov

Contact Person — E-mail Address — Date

CERTIFICATION OF AUTHORIZED OFFICER

I Hereby Certify That The Attached Rules Were Adopted
In Compliance with the Arkansas Administrative Act. (ACA 25-15-201 et. seq.)

Dawn Stehle /TPH
Signature

(501) 683-4997 — dawn.stehle@dhs.arkansas.gov
Phone Number — E-mail Address

Director
Title

6/20/17
Date

Revised 7/2015 to reflect new legislation passed in the 2015 Regular Session (Act 1258). This act changed the effective date from 30 days to 10 days after filing the rule.

FINANCIAL IMPACT STATEMENT

PLEASE ANSWER ALL QUESTIONS COMPLETELY

DEPARTMENT Department of Human Services
DIVISION Division of Medical Services
PERSON COMPLETING THIS STATEMENT Brian Jones
TELEPHONE NO. 501-537-2064 **FAX NO.** 501-404-4619 **EMAIL:** brian.jones@dhs.arkansas.gov

To comply with Ark. Code Ann. § 25-15-204(e), please complete the following Financial Impact Statement and file two copies with the questionnaire and proposed rules.

SHORT TITLE OF THIS RULE **Prosthetics 2-16 and Section V 7-16**

1. Does this proposed, amended, or repealed rule have a financial impact? Yes ☐ No ☒

2. Is the rule based on the best reasonably obtainable scientific, technical, economic, or other evidence and information available concerning the need for, consequences of, and alternatives to the rule? Yes ☒ No ☐

3. In consideration of the alternatives to this rule, was this rule determined by the agency to be the least costly rule considered? Yes ☒ No ☐

   If an agency is proposing a more costly rule, please state the following:

   (a) How the additional benefits of the more costly rule justify its additional cost;

   (b) The reason for adoption of the more costly rule;

   (c) Whether the more costly rule is based on the interests of public health, safety, or welfare, and if so, please explain; and;

   (d) Whether the reason is within the scope of the agency's statutory authority; and if so, please explain.

4. If the purpose of this rule is to implement a federal rule or regulation, please state the following:

   (a) What is the cost to implement the federal rule or regulation?

Current Fiscal Year		**Next Fiscal Year**	
General Revenue		General Revenue	
Federal Funds		Federal Funds	
Cash Funds		Cash Funds	
Special Revenue		Special Revenue	
Other (Identify)		Other (Identify)	

Total _____ Total _____

(b) What is the additional cost of the state rule?

Current Fiscal Year		Next Fiscal Year	
General Revenue	$0	General Revenue	$0
Federal Funds	$0	Federal Funds	$0
Cash Funds		Cash Funds	
Special Revenue		Special Revenue	
Other (Identify)		Other (Identify)	
Total	$0	Total	$0

5. What is the total estimated cost by fiscal year to any private individual, entity and business subject to the proposed, amended, or repealed rule? Identify the entity(ies) subject to the proposed rule and explain how they are affected.

Current Fiscal Year
$ _____

Next Fiscal Year
$ _____

6. What is the total estimated cost by fiscal year to state, county, and municipal government to implement thi rule? Is this the cost of the program or grant? Please explain how the government is affected.

Current Fiscal Year
$ $0

Next Fiscal Year
$ $0

There is no budget impact as the changes are just policy changes which do not affect rates.

7. With respect to the agency's answers to Questions #5 and #6 above, is there a new or increased cost or obligation of at least one hundred thousand dollars ($100,000) per year to a private individual, private entity, private business, state government, county government, municipal government, or to two (2) or more of those entities combined?

Yes ☐ No ☒

If YES, the agency is required by Ark. Code Ann. § 25-15-204(e)(4) to file written findings at the time of filing the financial impact statement. The written findings shall be filed simultaneously with the financial impact statement and shall include, without limitation, the following:

(1) a statement of the rule's basis and purpose;

(2) the problem the agency seeks to address with the proposed rule, including a statement of whether a rule is required by statute;

(3) a description of the factual evidence that:

(a) justifies the agency's need for the proposed rule; and
(b) describes how the benefits of the rule meet the relevant statutory objectives and justify the rule's costs;

(4) a list of less costly alternatives to the proposed rule and the reasons why the alternatives do not adequately address the problem to be solved by the proposed rule;

(5) a list of alternatives to the proposed rule that were suggested as a result of public comment and the reasons why the alternatives do not adequately address the problem to be solved by the proposed rule;

(6) a statement of whether existing rules have created or contributed to the problem the agency seeks to address with the proposed rule and, if existing rules have created or contributed to the problem, an explanation of why amendment or repeal of the rule creating or contributing to the problem is not a sufficient response; and

(7) an agency plan for review of the rule no less than every ten (10) years to determine whether, based upon the evidence, there remains a need for the rule including, without limitation, whether:
(a) the rule is achieving the statutory objectives;
(b) the benefits of the rule continue to justify its costs; and
(c) the rule can be amended or repealed to reduce costs while continuing to achieve the statutory objectives.

ARKANSAS DEPARTMENT OF HUMAN SERVICES

Division of Medical Services
Program Development & Quality Assurance

P.O. Box 1437, Slot S295 · Little Rock, AR 72203-1437
501-320-6428 · Fax: 501-404-4619
TDD/TTY: 501-682-6789

TO: Arkansas Medicaid Health Care Providers -- Prosthetics

EFFECTIVE DATE: May 1, 2017

SUBJECT: Provider Manual Update Transmittal PROSTHET-2-16

REMOVE		INSERT	
Section	**Effective Date**	**Section**	**Effective Date**
242.191	5-31-15	242.191	5-1-17
242.192	12-1-12	242.192	5-1-17
—	—	242.194	5-1-17
—	—	242.195	5-1-17

Explanation of Updates

Section 242.191 has been updated to provide an overview on documentation required when submitting claims for wheelchairs and wheelchair seating systems for individuals ages two through adult. Included are instructions on completing the new form, Evaluation for Wheelchair and Wheelchair Seating (DMS-0843).

Section 242.192 has been updated to change some of the procedure code payment methods from ""Purchase" to "Manually Priced."

Section 242.194, Replacement, Growth and Modification of Specialized Wheelchairs and Wheelchair Seating Systems, has been added.

Section 242.195, Repairs of Specialized Wheelchairs and Wheelchair Seating Systems, has been added.

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 Hewlett Packard Enterprise 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 the Program Development and Quality Assurance Unit at (501) 320-6429.

Arkansas Medicaid provider manuals (including update transmittals), official notices, notices of rule making 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.

Dawn Stehle
Director

TOC required

242.191 Wheelchairs and Wheelchair Seating Systems for Individuals Ages Two Through Adult 5-1-17

Arkansas Medicaid covers wheelchairs and wheelchair seating systems for individuals ages two through adult.

For any item to be covered by Arkansas Medicaid, the beneficiary must be eligible for a defined Medicaid Aid Category. Coverage is subject to the requirement that the equipment must be medically necessary for the diagnosis or treatment of an illness or injury to improve the functioning of an affected body part, and must meet all other Medicaid statutory and regulatory requirements and established criteria.

The beneficiary's diagnosis must warrant the type of equipment being purchased. Items may not be covered in every instance.

Providers are cautioned that an approved prior authorization does not guarantee payment. Reimbursement is contingent upon eligibility of both the beneficiary and the provider at the time service is provided and submission of an accurate and complete request. The DME provider is responsible for verifying the eligibility of the beneficiary at the time service is provided.

Specialized wheelchairs and wheelchair seating systems must be ordered by a physician.

When a request is submitted for a power wheelchair, Power-Operated Vehicle (POV) or specialized manual wheelchair, the following Medicaid requirements must be met:

A. A Prescription & Prior Authorization Request for Medical Equipment form (DMS-679) must be completed and submitted. This form must not be altered by the provider. **View or print form DMS-679 and instructions for completion.**

B. The DMS-679 must be signed and dated by the beneficiary's PCP or the ordering physician. The signature must be original. Stamp signatures are not acceptable. Medicaid will accept electronic signatures provided the electronic signatures comply with Arkansas Code § 25-31-103 et seq.

C. Correct Medicaid procedure codes and modifiers must be utilized. Requested items will be denied if correct procedures codes and modifiers are not used.

D. All requests for prior authorization must be legible (felt pens must not be used).

E. Medicaid requires the submission of the original request.

F. Medical documentation from the beneficiary's PCP or ordering physician which included a detailed face-to-face medical examination must be submitted to establish medical necessity.

G. An Evaluation for Wheelchair and Wheelchair Seating form (DMS-0843) must be submitted. This evaluation will be completed in three parts:

1. Part A—to be completed by the DME provider.
2. Part B—to be completed by the assistive technology practitioner or can be completed by a physical therapist or occupational therapist or seating specialist for Group 1 (one) and Group 2 (two) power wheelchairs with no power options.
3. Part C—to be completed by the beneficiary's PCP or the ordering physician.
4. An Evaluation for Wheelchair and Wheelchair Seating form (DMS-0843) must be completed for all specialized wheelchairs except for rental wheelchairs. **View or print form DMS-0843 and instructions for completion.**

Wheelchairs and Wheelchair Seating Systems for Individuals Ages Two Through Adult (Section 242.191)

Procedure Code	M1	M2	Description	PA	Payment Method
E0700	NU EP	U1 U1	Safety equipment, e.g., belt, harness or vest	N****	Purchase
E0700	NU EP	U2 U2	⁂(Travel restraint auto safe harness, E-Z on vest, no known comparable product) Safety equipment, e.g., belt, harness or vest	N****	Purchase
E0950	NU EP		⁂(Tray for W/C) W/C accessory, tray, each	Y	Purchase
E0950	NU EP	U2 U2	⁂(ABS tray, 4-SM 5-LG) W/C accessory, tray, each	Y	Purchase
E0950	NU EP	U3 U3	⁂(W/C Tray, Custom) W/C accessory, tray, each	Y	Purchase
E0950	NU EP	U4 U4	⁂(Tray, customized) W/C accessory, tray, each	N	Purchase
E0950	NU EP	U5 U5	⁂(Clear upper Ex support system) W/C accessory, tray, each	Y	Purchase
E0950	NU EP	U6 U6	⁂(Lap Tray Switch Array) Wheelchair accessory, tray, each	Y	Purchase
E0950	NU EP	U7 U7	Wheelchair accessory, tray, each	Y	Purchase
E0950	NU EP UE	U7	⁂(Removable Hinged Overlay for Tray) W/C accessory, tray, each	Y****	Purchase
E0950	NU EP	U8 U8	⁂(Lap Tray for Switch Array) Wheelchair accessory, tray, each	Y	Purchase
E0951	NU EP		Heel loop/holder, with or without ankle strap, each	N****	Purchase
E0952	NU EP		Toe loop/holder, each	N****	Purchase
E0955	NU EP		Wheelchair accessory, headrest, cushioned, any type, including fixed mounting hardware, each	N	Purchase
E0956	NU EP		⁂(Trunk supports for any W/C, other than travel, with hardware) Wheelchair accessory, lateral trunk or hip support, any type, including fixed mounting hardware, each	N****	Purchase
E0956	NU EP	U1 U1	⁂(Lateral trunk supports, swing-away, each) Wheelchair accessory, lateral trunk or hip support, any type, including fixed mounting hardware, each	N****	Purchase

Wheelchairs and Wheelchair Seating Systems for Individuals Ages Two Through Adult (Section 242.191)

Procedure Code	M1	M2	Description	PA	Payment Method
E0970	NU EP		No. 2 footplates, except for elevating leg rest	N****	Purchase
E0971	NU EP		Anti-tipping device W/C	N****	Purchase
E0973	NU EP		W/C accessory, adjustable height, detachable armrest, complete assembly, each	N****	Purchase
E0973	NU EP	U1 U1	⁂(Height Adj. Arms, replacement) W/C accessory, adjustable height, detachable armrest, complete assembly, each	N****	Purchase
E0974	NU EP		Manual wheelchair accessory, anti-rollback device (⁂ grade aids), each	N****	Purchase
E0978	NU EP		Wheelchair accessory, positioning belt/safety belt/pelvic strap, each	N****	Purchase
E0978	NU EP	U1 U1	⁂(Belt, safety or chest, w/pad) Wheelchair accessory, positioning belt/safety belt/ pelvic strap, each	N**** N	Purchase
E0978	NU EP	U2 U2	Wheelchair accessory, positioning belt/safety belt/pelvic strap, each	N****	Purchase
E0980	NU EP		⁂(Chest panel, 21-SM 22-LG) Safety vest, wheelchair	N****	Purchase
E0980	NU EP	U1 U1	⁂(Shoulder retractors) Safety vest, W/C	N****	Purchase
E0981	NU EP		W/C accessory, seat upholstery, replacement only, each	N	Purchase
E0982	NU EP		W/C accessory, back upholstery, replacement only, each	N****	Purchase
E0982	NU EP	U1 U1	⁂(Standard back upholstery replacement) W/C accessory, back upholstery, replacement only, each	N****	Purchase
E0990	NU EP		⁂(Elevating foot, legrest) W/C accessory, elevating legrest, complete assembly, each	N****	Purchase
E0990	NU EP	U1 U1	⁂(Elevating legrest 90 Degree, 12" - 16" Width) W/C accessory, elevating legrest, complete assembly, each	N****	Purchase
E0992	NU EP		⁂ (Manual wheelchair accessory, solid seat)	N****	Purchase
E0992	NU EP	U1 U1	⁂Manual w/c accessory, solid seat insert (Large adjustable solid seat w/hardware)	N****	Purchase
E0992	NU EP	U2 U2	⁂(Foam and Plywood Flat Side Manual wheelchair accessory, solid seat)	N****	Purchase

Wheelchairs and Wheelchair Seating Systems for Individuals Ages Two Through Adult (Section 242.191)

Procedure Code	M1	M2	Description	PA	Payment Method
E1084*	NU EP		Hemi-W/C; detachable arms, desk or full-length, swing-away, detachable, elevating legrests	N****	Purchase
E1086*	NU EP		Hemi W/C; detachable arms, desk or full-length, swing-away, detachable footrests	N****	Purchase
E1086*	NU EP	U1 U1	Hemi W/C, detachable arms, desk or full-length, swing-away detachable footrests	Y	Purchase
E1088*	NU EP		High strength lightweight W/C; detachable arms, desk or full-length, swing-away, detachable, elevating legrests	Y♦	Purchase
E1090	NU EP		High-strength lightweight W/C; detachable arms, desk or full-length, swing-away, detachable footrests	N****	Purchase
E1092*	NU EP		Wide, heavy-duty W/C; detachable arms, desk or full-length, swing-away, detachable, elevating legrests	Y♦	Purchase
E1093*	NU EP		Wide, heavy-duty W/C; detachable arms, desk or full-length arms, swing-away, detachable footrests	Y♦	Purchase
E1110*	NU EP		Semi-reclining W/C; detachable arms, desk or full-length, elevating legrests	Y♦	Purchase
E1161	NU EP		Manual adult size W/C, includes tilt in space	Y♦	Purchase
E1170*	NU EP		Amputee W/C; fixed full-length arms, swing-away, detachable, elevating legrests	N****	Purchase
E1172*	NU EP		Amputee W/C; detachable arms, desk or full-length, without footrests or legrests	Y♦	Purchase
E1180*	NU EP		Amputee W/C; detachable arms, desk or full-length, swing-away, detachable footrests	Y♦	Purchase
E1200*	NU EP		Amputee W/C; fixed full-length arms, swing-away, detachable footrests	N****	Purchase
E1220*	NU EP		W/C, specially sized or constructed **(indicate brand name, model number, if any, and justification)**	Y	Manually Priced
E1225	NU EP		⁂(Folding Backrest, 8 Degree Bend, Low, 15" - 16") Manual W/C accessory, semi-reclining back, (recline greater than 15 degrees, but less than 80 degrees), each	N****	Purchase
E1228	NU EP		⁂(Folding Backrest, Tall, 19" - 20") Special back height for W/C	N****	Purchase

Wheelchairs and Wheelchair Seating Systems for Individuals Ages Two Through Adult (Section 242.191)

Procedure Code	M1	M2	Description	PA	Payment Method
E2201	NU EP		⁂(Seat Width 20") Manual w/c accessory, nonstandard seat frame width > than or equal to 20 inches and < 24 inches	N****	Purchase
E2201	NU EP	U1 U1	⁂(Frame Width 14"-15") Manual w/c accessory, nonstandard seat frame width > than or equal to 20 inches and < 24 inches	N****	Purchase
E2201	NU EP	U2 U2	⁂(Frame Width 19"-20") Manual w/c accessory, nonstandard seat frame width > than or equal to 20 inches and < 24 inches	N****	Purchase
E2201	NU EP	U3 U3	Manual w/c accessory, nonstandard seat frame width > than or equal to 20 inches and < 24 inches	N****	Manually Priced
E2203	NU EP		⁂(Seat Depth 15") Manual w/c accessory, nonstandard seat frame depth, 20 to less than 22 inches	N****	Purchase
E2203	NU EP	U1 U1	⁂(Seat Depth 17" - 18") Manual w/c accessory, nonstandard seat frame depth, 20 to less than 22 inches	N****	Purchase
E2203	NU EP	U2 U2	⁂(Frame, Long; 16", 17"3, 18", 19"3, 20" Depth) Manual w/c accessory, nonstandard seat frame depth, 20 to less than 22 inches	N****	Purchase
E2203	NU EP	U3 U3	⁂(Seat Depth 19" - 20") Manual w/c accessory, nonstandard seat frame depth, 20 to less than 22 inches	N****	Purchase
E2203	NU EP	U4 U4	Manual w/c accessory, nonstandard seat frame depth, 20 to less than 22 inches	N	Manually Priced
E2206	NU EP		Manual wheelchair accessory, wheel lock assembly, complete, each	N	Purchase
E2207	NU EP		Wheelchair accessory, crutch and cane holder, each	N****	Purchase
E2208	NU EP		Wheelchair accessory, cylinder tank carrier, each	N	Purchase
E2209	NU EP		Wheelchair accessory, arm trough, each	N	Purchase
E2210	NU EP		Wheelchair accessory, bearings, any type, replacement only, each	N	Purchase
E2211	NU EP		Manual wheelchair accessory, pneumatic propulsion tire, any size, each	N	Purchase
E2212	NU EP		Manual wheelchair accessory, tube for pneumatic propulsion tire, any size, each	N	Purchase

Wheelchairs and Wheelchair Seating Systems for Individuals Ages Two Through Adult (Section 242.191)

Procedure Code	M1	M2	Description	PA	Payment Method
E2311	NU EP		Power w/c accessory, electronic connection between wheelchair controller and two or more power seating system motors, including all related electronics, indicator feature, mechanical function selection switch, and fixed mounting hardware	Y	Purchase
E2322	NU EP		Power w/c accessory, hand control interface, multiple mechanical switches, nonproportional, including all related electronics, mechanical stop switch, and fixed mounting hardware	Y	Purchase
E2323	NU EP		Power w/c accessory, specialty joystick handle for hand control interface, prefabricated	Y	Purchase
E2324	NU EP		Power w/c accessory, chin cup for chin control interface	Y	Purchase
E2325	NU EP		Power w/c accessory, sip & puff interface nonproportional, including all related electronics, mechanical stop switch, and manual swing-away mounting hardware	Y	Purchase
E2326	NU EP		Power wheelchair accessory, breath tube kit for sip and puff interface ⁂ (replacement only)	Y	Purchase
E2327	NU EP		Power w/c accessory, head control interface, mechanical, proportional, including all related electronics, mechanical direction change switch, and fixed mounting hardware	Y	Purchase
E2359	NU EP		Power w/c accessory, group 34 sealed lead acid battery, each	N	Purchase
E2360	NU EP		Power w/c accessory, 22 NF non-sealed lead acid battery, each	N	Purchase
E2361	NU EP		Power w/c accessory, 22 NF sealed lead acid battery, each, (e.g., gel cell, absorbed glassmat)	N	Purchase
E2363	NU EP		Power w/c accessory, group 24 sealed lead acid battery, each (e.g., gel cell, absorbed glassmat)	N	Purchase
E2363	NU EP	U1 U1	Power w/c accessory, group 24 sealed lead acid battery, each (e.g., gel cell, absorbed glassmat)	N	Purchase
E2365	NU EP		⁂(U-1 gel cell battery, each) Power wheelchair accessory, U-1 sealed lead acid battery, each, (e.g., gel cell, absorbed glassmat)	N	Purchase

Wheelchairs and Wheelchair Seating Systems for Individuals Ages Two Through Adult (Section 242.191)

Procedure Code	M1	M2	Description	PA	Payment Method
E2383	NU EP		Power wheelchair accessory, insert for pneumatic drive wheel tire (removable), any type, any size, replacement only, each	Y	Purchase
E2384	NU EP		Power wheelchair accessory, pneumatic caster tire, any size, replacement only, each	Y	Purchase
E2385	NU EP		Power wheelchair accessory, tube for pneumatic caster tire, any size, replacement only, each	Y	Purchase
E2386	NU EP		Power wheelchair accessory, foam filled drive wheel tire, any size, replacement only, each	Y	Purchase
E2387	NU EP		Power wheelchair accessory, foam caster tire, any size, replacement only, each	Y	Purchase
E2601	NU EP UE		General use wheelchair seat cushion, width less than 22 in., any depth	N****	Purchase
E2602	NU EP UE		General use wheelchair seat cushion, width 22 in. or greater, any depth	N	Purchase
E2611	NU EP UE		General use wheelchair back cushion, width less than 22 in., any height, including any type mounting hardware	N	Purchase
E2612	NU EP UE		General use wheelchair back cushion, width 22 in. or greater, any height, including any type mounting hardware	N	Purchase
E2619	NU EP		Replacement cover for wheelchair seat cushion or back cushion, each	N	Purchase
E2622	NU EP UE		Skin protection wheelchair seat cushion, adjustable, width less than 22 inches, any depth	N	Purchase
E2623	NU EP UE		Skin protection wheelchair seat cushion, adjustable, width 22 inches or greater, any depth	N	Purchase
E2624	NU EP UE		Skin protection and positioning wheelchair seat cushion, adjustable width less than 22 inches, any depth	N	Purchase
E2625	NU EP UE		Skin protection and positioning wheelchair seat cushion, adjustable width 22 inches or greater, any depth	N	Purchase
E2626	NU EP		Wheelchair accessory, shoulder elbow, mobile arm support attached to wheelchair, balanced, adjustable	Y	Purchase

Wheelchairs and Wheelchair Seating Systems for Individuals Ages Two Through Adult (Section 242.191)

Procedure Code	M1	M2	Description	PA	Payment Method
K0011	NU EP	U1 U1	⁂(Motorized, power base or conventional frame w/c DA/swing-away footrests, programmable electronics and custom options) Standard-weight frame motorized/power, W/C with programmable control parameters for speed adjustment, tremor dampening, acceleration control and braking	Y♦	Purchase
K0012	NU EP		⁂(Motorized folding frame, DA, swing-away footrests) Lightweight portable motorized/power W/C	Y♦	Purchase
K0012	NU EP	U1 U1	⁂(Motorized folding frame, DA, swing-away ELR) Lightweight portable motorized/power W/C	Y♦	Purchase
K0014[1,2]	NU EP		Other motorized/power W/C base	Y♦	Purchase
K0014[1,2]	NU EP	U1 U1	⁂(Center Drive power base) Other motorized/ power W/C base	Y♦	Purchase
K0014[1,2]	NU EP	U3 U3	⁂ (Motorized, Power Base or conventional frame W/C DA/swing-away foot rests, programmable electronics and custom options) Other motorized/power W/C base	Y♦	Purchase
K0014[1,2]	NU EP	U4 U4	⁂ (Motorized, Power Base or conventional frame W/C DA/swing-away elevated foot rests, programmable electronics and custom options) Other motorized/power W/C base	Y♦	Purchase
K0017	NU EP		⁂(Receiver for height adjustable arms) Detachable, adjustable height armrest, base, each	N****	Purchase
K0017	NU EP	U1 U1	⁂(Dual post and adjustable height DA) Detachable, adjustable height armrest, base, each	N****	Purchase
K0019	NU EP		Arm pad, each	N	Purchase
K0020	NU EP		Fixed, adjustable height armrest, pair	N****	Purchase
K0038**	EP	U1	⁂(Knee strap) Leg strap, each	N	Purchase
K0038	NU EP		⁂(Single leg strap, each) Leg strap, each	N****	Purchase
K0038	NU EP	U2 U2	⁂(Foot straps, pair) Leg strap, each	N****	Purchase

Wheelchairs and Wheelchair Seating Systems for Individuals Ages Two Through Adult (Section 242.191)

Procedure Code	M1	M2	Description	PA	Payment Method
K0108	NU EP		⁂(W/C miscellaneous equipment; applicable pages from the manufacturer's catalog must be attached to the claim form.) Other accessories	N****	Manually Priced
K0739	NU EP	U1 U1	⁂(Labor only, Repair or non-routine service for durable medical equipment requiring the skill of a technician, labor component, per 15 minutes. A maximum of twenty units per date of service is allowable, 20 units = 5 hours of labor)	Y	Purchase
S1002	EP		⁂(Wheelchair, custom molded seating system only) Customized item, list in addition to code for basic item	N****	Manually Priced
S1002	NU EP	U1 U1	⁂(Foam-in-place seat, Pindot quick foam contour system) Customized item, list in addition to code for basic item	N****	Purchase

The following procedure codes may be billed only on paper.

Wheelchairs and Wheelchair Seating Systems for Individuals Ages Two Through Adult (Section 242.191)

No National Code	M1	M2	Local Code	Description	PA	Payment Method
Bill on paper	NU EP		Z1613	One-piece footboard (each)	N****	Purchase
Bill on paper	NU EP		Z1793	Custom foot platform	N****	Purchase
Bill on paper	EP		Z1824**	PC Car Seat/Snug Seat	Y	Purchase
Bill on paper	NU EP		Z2137	Adjustable Rem. Abductor w/hardware (ea)	N****	Purchase
Bill on paper	NU EP		Z2138	Adjustable Flip Down Abductor w/hardware (ea)	N****	Purchase
Bill on paper	NU EP		Z2139	Lateral Hip/Thigh support w/hardware (ea)	N****	Purchase
Bill on paper	NU EP		Z2140	Adductor - no hardware	N****	Purchase
Bill on paper	NU EP		Z2141	Abductor - no hardware	N****	Purchase

The following procedure codes may be billed only on paper.

Wheelchairs and Wheelchair Seating Systems for Individuals Ages Two Through Adult (Section 242.191)

No National Code	M1	M2	Local Code	Description	PA	Payment Method
Bill on paper	NU EP		Z2582	Quick Release Axle	N****	Purchase
Bill on paper	NU EP		Z2585	Growing Seat Pan	N****	Purchase
Bill on paper	NU EP		Z2586	Growing Back Upholstery	N****	Purchase
Bill on paper	NU EP		Z2588	Deep Contour Back 20" Width	N****	Purchase
Bill on paper	NU EP		Z2589	Adjustable Contour Lateral Pelvic Support	N****	Purchase
Bill on paper	NU EP		Z2592	Remote Joystick Module	N****	Purchase
Bill on paper	NU EP		Z2599	Transit Option	N****	Purchase
Bill on paper	NU EP		Z2604	Adjustable Back Upholstery	N****	Purchase
Bill on paper	NU EP		Z2616	Swing-away Mount (Joystick)	N****	Purchase

Required Documentation

Face-to-Face Examination

In order for Medicaid to provide reimbursement for a Power/motorized Wheelchair (PWC), Power Operated Vehicle (POV) (scooter) or specialized manual wheelchair, the following requirements must be met.

A. A face-to-face physician examination must be performed.

B. The physician must perform a medical examination for the specific purpose of assessing the beneficiary's mobility limitation and needs. The results of this exam must be recorded in the patient's medical record.

C. The prescription must be written only **after** the face-to-face physician examination and assessment of mobility limitations have occurred and the medical history and physical examination is completed.

D. The prescription and the medical records documenting the in-person visit and examination report must be sent to the equipment supplier within forty-five (45) days of completion of the examination.

E. The physician may refer the beneficiary to a licensed/certified professional, a Physical Therapist (PT) or Occupational Therapist (OT) to perform a wheelchair assessment.

If the beneficiary is referred to a physical/occupational therapist before the physician completes the face-to-face examination, the physician must review the physical/occupational therapist's written report and perform the final examination. The forty-five (45)-day period begins on the

E. Strollers and stroller-like chairs of any kind are not covered by Arkansas Medicaid. A stroller is a four-wheeled, often collapsible, chair-like carriage. They are helpful to caregivers and are typically used for transportation. Although stroller and stroller-like chairs may be used to transport individuals with medical conditions, such items do not serve a medical purpose. Strollers and stroller-like chairs have no positioning components for medical use, cannot be modified for growth and accommodate changes in medical or physical condition, and cannot be self-propelled by the individual.

F. Prior authorization is required even when insurance pays primary to Medicaid. Explanation of benefits (EOB) of the other insurance must be submitted with the request.

G. All wheelchair requests require a manufacturer's brand and the model name of the base.

H. In the event a wheelchair is stolen, damaged in the home, or by vehicle or fire, a police/fire report, copy of the home owners/auto insurance coverage and detailed documentation of events leading to the loss/damage are required.

I. Mobility bases for car seats are not covered by Medicaid.

J. Options, accessories, and replacement parts that are medically necessary for wheelchairs that do not have specific HCPCS codes should be coded K0108 (other accessories). The manufacturer's suggested retail price (MSRP) must be listed for each item coded K0108, and the MSRP quote to the DME provider must be included. The MSRP quote **must not be altered** by the DME provider. If the MSRP is altered in any way, the request will be denied.

K. In the event a beneficiary wishes to change services from one DME provider to another DME provider, an affidavit signed and dated by the beneficiary must be submitted with the request from the new DME provider.

L. The existence of a procedure code does not necessarily indicate coverage by Arkansas Medicaid.

M. The allowed amount of a POV includes all options and accessories that are provided at the time of initial issue. This includes but is not limited to batteries, battery chargers, seating systems, etc. All options and accessories provided at the initial issue of a Power-Operated Vehicle (POV) are included and should not be billed separately.

N. If coverage criteria is not met for a specific item requested, and Arkansas Medicaid determines that another item is more appropriate and meets medical necessity, that item will be authorized.

O. The wheelchair will significantly improve the beneficiary's ability to participate in Mobility Related Activities of Daily Living (MRADL) and the individual will use the wheelchair on a regular basis in the home.

P. The individual's home will provide adequate access between rooms, maneuvering space and surface for use of the requested wheelchair.

Non-Covered Items for Specialized Wheelchairs and Wheelchair Systems

A. Items that are deluxe in nature. Deluxe items are items of convenience that are not medically necessary. Deluxe items are often used for social purposes or convenience. Deluxe items include deluxe accessories which increase the cost of purchase or operation. Deluxe items and deluxe accessories are not covered by Arkansas Medicaid.

B. Items for use in hospitals, nursing home or other institutions.

C. Items for the beneficiary's comfort or the caregiver's convenience.

D. Two pieces of equipment that serve the same purpose.

Specialized Rehabilitative Equipment, All Ages (Section 242.192)

Procedure Code	M1	M2	Description	PA	Payment Method
E0149	NU EP		⁂(4 Wheel Reverse Walker) Walker, heavy-duty, wheeled, rigid or folding, any type	N	Purchase
E0163	EP NU	U1 U1	⁂(Potty Chair - Small) Commode chair, stationary, with fixed arms	Y	Purchase
E0168	EP		⁂(Rehab Shower/Commode Chair) Commode chair, extra wide and/or heavy-duty, stationary or mobile, with or without arms, any type, each	Y♦	Purchase
E0168	EP	UB	⁂(Adaptive Commode Chair) Commode chair, extra wide and/or heavy-duty, stationary or mobile, with or without arms, any type, each	N	Purchase
E0168	NU		⁂(Adaptive Commode Chair) Commode chair, extra wide and/or heavy-duty, stationary or mobile, with or without arms, any type, each	N	Purchase
E0168	NU	U1	⁂(Rehab Shower/Commode Chair) Commode chair, extra wide and/or heavy-duty, stationary or mobile, with or without arms, any type, each	Y♦	Purchase
E0241	NU EP		⁂(Bolt-on Sm. Grab Bar) Bathroom wall rail, each	N	Purchase
E0241	NU EP	U1 U1	⁂(Bolt-on Lg. Grab Bar) Bathroom wall rail, each	N	Purchase
E0241	NU EP	U2 U2	⁂(Bolt-on Med. Grab Bar) Bathroom wall rail, each	N	Purchase
E0245	NU EP		⁂(Adj. Bath Chair w/Back) Tub stool or bench	N	Purchase
E0245	NU EP	U2 U2	⁂(Padded Tub Transfer Bench) Tub stool or bench	N	Purchase
E0245	NU EP	U3 U3	⁂(30" Bath Chair) Tub stool or bench	N	Purchase
E0245	NU EP	U4 U4	⁂(38" Bath Chair) Tub stool or bench	N	Purchase
E0245	NU EP	U5 U5	⁂(47" Bath Chair) Tub stool or bench	N	Purchase
E0245	NU EP	U6 U6	⁂(56" Bath Chair) Tub stool or bench	N	Purchase
E0245	NU EP	UB UB	⁂(Non-padded tub transfer bench) Tub stool or bench	N	Purchase
E0246	NU EP		⁂(Clamp-on Tub Grab Bar) Transfer tub rail attachment	N	Purchase

Specialized Rehabilitative Equipment, All Ages (Section 242.192)

Procedure Code	M1	M2	Description	PA	Payment Method
E1035**	EP	U2	⁂(Carrie Seat - Jr.) Multi-positional patient transfer system, with integrated seat, operated by care giver	Y	Purchase
E1035	NU EP	U3 U3	⁂(Carrie Seat - Sm. Adult) Multi-positional patient transfer system, with integrated seat, operated by care giver	Y♦	Purchase
E8000	EP		⁂(14") Gait trainer, pediatric size, posterior support, includes all accessories and components	Y	Manually Priced
E8000	EP	U1	⁂(19") Gait trainer, pediatric size, posterior support, includes all accessories and components	Y	Manually Priced
E8000	EP	U2	⁂(Intermediate) Gait trainer, pediatric size, posterior support, includes all accessories and components	Y	Manually Priced
E8001	EP		⁂(14") Gait trainer, pediatric size, upright support, includes all accessories and components	Y	Manually Priced
E8001	EP	U1	⁂(19") Gait trainer, pediatric size, upright support, includes all accessories and components	Y	Manually Priced
E8001	EP	U2	⁂(Intermediate) Gait trainer, pediatric size, upright support, includes all accessories and components	Y	Manually Priced
E8002	EP		⁂(14") Gait trainer, pediatric size, anterior support, includes all accessories and components	Y	Manually Priced
E8002	EP	U1	⁂(19") Gait trainer, pediatric size, anterior support, includes all accessories and components	Y	Manually Priced
E8002	EP	U2	⁂(Intermediate) Gait trainer, pediatric size, anterior support, includes all accessories and components	Y	Manually Priced

The following list of codes may only be billed on paper.
Specialized Rehabilitative Equipment, All Ages (Section 242.192)

No National Code	M1	Local Code	Description	PA	Payment Method
Bill on paper	NU EP	Z1996	Sm. 51" Supine Stander	Y♦	Purchase
Bill on paper	NU EP	Z1997	Lg. 71" Supine Stander	Y♦	Purchase
Bill on paper	EP	Z1998**	27" Prone Stander	Y	Purchase

The following list of codes may only be billed on paper.
Specialized Rehabilitative Equipment, All Ages (Section 242.192)

No National Code	M1	Local Code	Description	PA	Payment Method
Bill on paper	EP	Z2021**	Mobile Floor Sitter Med/Lg.	N	Purchase
Bill on paper	EP	Z2038**	Therapy Ball - Sm.	N	Purchase
Bill on paper	EP	Z2039**	Therapy Ball - Med.	N	Purchase
Bill on paper	EP	Z2040**	Therapy Ball - Lg.	N	Purchase
Bill on paper	EP	Z2043**	Seat & Back Pad for Toddler Chairs	Y	Purchase
Bill on paper	EP	Z2044**	Tray for Toddler Chair	Y	Purchase
Bill on paper	EP	Z2045**	14" T&S High Back w/Support Activity Chair	Y	Purchase
Bill on paper	EP	Z2046**	16" T&S High Back w/Support Activity Chair	Y	Purchase
Bill on paper	NU EP	Z2047	Orthopedic Car Seat	Y	Purchase
Bill on paper	NU EP	Z2072	Lg. Wrap Around Bath Support	N	Purchase
Bill on paper	NU EP	Z2073	Sm. Wrap Around Back Support	N	Purchase
Bill on paper	NU EP	Z2074	Lg. Toilet Support w/Hi Back	N	Purchase
Bill on paper	NU EP	Z2075	Sm. Toilet Support w/Hi Back	N	Purchase
Bill on paper	NU EP	Z2077	Flexible Shower Hose	N	Purchase
Bill on paper	NU EP	Z2089	Toilet Seat Reducer Ring (Padded)	N	Purchase
Bill on paper	NU EP	Z2093	Adult Gait Trainer	Y♦	Purchase
Bill on paper	EP	Z2094**	Tyke Strider Walker w/2 Wheels	N	Purchase
Bill on paper	EP	Z2095**	Tweener Strider Walker w/2 Wheels	N	Purchase
Bill on paper	EP	Z2096**	Middle Strider Walker w/2 Wheels	N	Purchase
Bill on paper	NU EP	Z2097	Adult Strider Walker w/2 Wheels	N	Purchase

E. Requests for replacement where malicious damage, neglect or misuse of the equipment may have occurred may be investigated by Arkansas Medicaid. Requests may be denied if such circumstances are confirmed.

F. If a wheelchair is stolen or damaged by vehicle, fire or in the home, the beneficiary must provide the following with the request:

1. A police or fire report.
2. Copy of the homeowner's or auto insurance coverage.
3. Detailed documentation of events leading to the loss and damage.

If Arkansas Medicaid denies a repair or replacement in a case of malicious damage or misuse, payment of repairs is the responsibility of the beneficiary or caregiver.

242.195 Repairs of Specialized Wheelchairs and Wheelchair Systems 5-1-17

A. Arkansas Medicaid will cover repairs for wheelchairs and wheelchair seating.

B. Repair services must receive prior authorization from AFMC.

C. Detailed documentation from the technician that supports the equipment or services being requested must be submitted. Documentation must include the following:

1. Date and place of purchase of the current chair.
2. Brand and model name of the base.
3. Brand and model name of parts and accessories needed for repairs.

D. Correct procedure codes per the current Medicaid policy must be used.

E. Requests for repairs must be submitted on form DMS-679 (Prescription & Prior Authorization Request for Medical Equipment) and must be signed and dated by the beneficiary's PCP or ordering physician. **View or print form DMS-679 and instructions for completion.**

F. Repairs for previously authorized wheelchairs that the beneficiary has outgrown will not be covered if a new chair has been authorized.

G. In the event a request is submitted for repairs for a wheelchair authorized by another state agency, documentation or a delivery ticket showing that the wheelchair was authorized by another state agency must be submitted with the request.

H. Arkansas Medicaid will not cover repairs/damage due to the following:

1. Neglect.
2. Misuse.
3. Abuse.
4. Improper installation or repair by the DME provider.
5. Use of parts or changes by the DME provider or the beneficiary not authorized by Arkansas Medicaid.

I. When a request is submitted for a new wheelchair with a statement that the previous wheelchair cannot be repaired, documentation from the manufacturer of the previous chair stating the reason why the previous wheelchair cannot be repaired must be included.

J. If the previous wheelchair cannot be repaired, several color photographs taken at different angles must be included with the new request.

ARKANSAS DEPARTMENT OF HUMAN SERVICES

Division of Medical Services
Program Development & Quality Assurance

P.O. Box 1437, Slot S295 · Little Rock, AR 72203-1437
501-320-6428 · Fax: 501-404-4619
TDD/TTY: 501-682-6789

TO: Arkansas Medicaid Health Care Providers – All Providers

EFFECTIVE DATE: May 1, 2017

SUBJECT: Provider Manual Update Transmittal SecV-7-16

REMOVE		INSERT	
Section	**Effective Date**	**Section**	**Effective Date**
500.000	—	500.000	—
DMS-679	12/14	DMS-679	5-1-17
DMS-679A	12/14	—	—
—	—	DMS-0843	5-1-17

Explanation of Updates

Section 500.000 has been updated to remove the Prescription & Prior Authorization Request for Medical Equipment form (DMS-679A), revise the Medical Equipment Request for Prior Authorization and Prescription form (DMS-679) and add the Evaluation for Wheelchair and Wheelchair Seating form (DMS-0843).

Form DMS-679 is being updated to reflect the most current version of the form.

Form DMS-0843 is being added to all provider manuals.

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

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 Hewlett Packard Enterprise 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 the Program Development and Quality Assurance Unit at (501) 320-6429.

Arkansas Medicaid provider manuals (including update transmittals), official notices, notices of rule making 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.

Dawn Stehle
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-J430	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
Adjustment Request Form – Medicaid XIX – Pharmacy Program	DMS-802

Form Name	Form Link
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
Evaluation for Wheelchair and Wheelchair Seating	DMS-0843
Explanation of Check Refund	HP-CR-002
Gait Analysis Full Body	DMS-647
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 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
Procedure Code/NDC Detail Attachment Form	DMS-664
Provider Application	DMS-652

In order by form number:

AAS-9502
AAS-9506
AAS-9559
Address Change
Autodeposit
CMS-485
CSPC-EPSDT
DCO-645
DDS/FS#0001.a
DMS-0101
DMS-0688
DMS-0843
DMS-102
DMS-201
DMS-202
DMS-2606
DMS-2608
DMS-2609
DMS-2610
DMS-2615
DMS-2618
DMS-2633
DMS-2634
DMS-2647
DMS-2685
DMS-2687
DMS-2692
DMS-2698
DMS-2704
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-683
DMS-686
DMS-689
DMS-693
DMS-699
DMS-699A
DMS-7708
DMS-7736
DMS-7782
DMS-7783
DMS-801
DMS-802
DMS-831
DMS-840
DMS-841
DMS-844
DMS-845
DMS-846
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 Finance Administration, Sales and Tax Use Unit

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

Hewlett Packard Enterprise EDI Support Center (formerly AEVCS Help Desk)

Hewlett Packard Enterprise Inquiry Unit

Hewlett Packard Enterprise Manual Order

Hewlett Packard Enterprise Provider Assistance Center (PAC)

Hewlett Packard Enterprise 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

First Connections Infant & Toddler Program, Developmental Disabilities Services, Appeals

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

Health Care Declarations

Immunizations Registry Help Desk

Magellan Pharmacy Call Center

Medicaid ID Card Example

Medicaid Managed Care Services (MMCS)

Medicaid Reimbursement Unit Communications Hotline

Medicaid Tooth Numbering System

National Supplier Clearinghouse

Partners Provider Certification

Primary Care Physician (PCP) Enrollment Voice Response System

Provider Qualifications, Division of Behavioral Health Services

Select Optical

Standard Register

Table of Desirable Weights

U.S. Government Printing Office

ValueOptions

Vendor Performance Report

ARKANSAS DEPARTMENT OF HUMAN SERVICES
DIVISION OF MEDICAL SERVICES
PRESCRIPTION & PRIOR AUTHORIZATION REQUEST FOR MEDICAL EQUIPMENT

SECTION A - TO BE COMPLETED BY THE PROVIDER

☐ INITIAL ☐ RECERT ☐ MODIFICATION ☐ EXT OF BENEFITS	START DATE:
BENEFICIARY NAME: (LAST, FIRST, MI)	BENEFICIARY MEDICAID ID #:
BENEFICIARY MAILING ADDRESS:	DATE OF BIRTH: / SEX: ☐ MALE ☐ FEMALE
PROVIDER NAME:	PROVIDER MAILING ADDRESS:
PROVIDER IDENTIFICATION #/TAXONOMY CODE:	PROVIDER PHONE & CONTACT PERSON:
PRESCRIBING PHYSICIAN NAME:	PHYSICIAN PROVIDER IDENTIFICATION #/TAXONOMY CODE:

PROCEDURE CODE	MOD 1	MOD 2	TOS	DESCRIPTION OF ITEMS	UNITS	MSRP	POWER WHEELCHAIR GROUP (IF APPLICABLE)

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

DME PROVIDER SIGNATURE _____ DATE _____

SECTION B - TO BE COMPLETED BY THE PHYSICIAN

EST. LENGTH OF NEED: _____WKS _____ MONTHS _____LIFETIME	EPSDT REFERRAL: ☐ YES ☐ NO ☐ N/A	CURRENT HEIGHT: INCHES	CURRENT WEIGHT: LBS
DIAGNOSIS & ICD CODE:	DIAGNOSIS & ICD CODE:	DIAGNOSIS & ICD CODE:	DIAGNOSIS & ICD CODE:

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

It is my professional opinion that the equipment requested above is medically necessary:

PHYSICIAN NAME (PRINT) _____ PHYSICIAN MEDICAID ID NUMBER _____

PHYSICIAN SIGNATURE (NO STAMP) _____ DATE _____

IF (PCP) PRIMARY CARE PHYSICAN IS NOT THE PRESCRIBING PHYSICIAN, THEN PLEASE PROVIDE THE FOLLOWING INFORMATION:

PRIMARY CARE PHYSICIAN (PCP) NAME (PRINT) _____ PCP MEDICAID ID NUMBER _____

ARKANSAS DEPARTMENT OF HUMAN SERVICES
DIVISION OF MEDICAL SERVICES

EVALUATION FOR WHEELCHAIR AND WHEELCHAIR SEATING

PART A (MUST BE COMPLETED BY DME PROVIDER ONLY)

1. CLIENT INFORMATION:

Date:	Medicaid ID #:	Date of Birth:	
Client Name:	Sex: Male: ☐ Female: ☐	Current Height:	Current Weight:
Address:	City:	State:	Zip:

2. ACCESSIBILITY AND TRANSPORTATION:

Ramp to House:	Yes: ☐	No: ☐	School Bus:	Yes: ☐	No: ☐
Doorway Accessible:	Yes: ☐	No: ☐	Tie Down:	Yes: ☐	No: ☐
Bathroom Accessible:	Yes: ☐	No: ☐	Van Lift:	Yes: ☐	No: ☐
Equipment Fits in Trunk:	Yes: ☐	No: ☐			

If no ramp to house; describe access to house: _____

Type of vehicle: _____

Type of house:

Single-Family: ☐ Apartment: ☐ Multiplex: ☐ Mobile Home: ☐ Other: ☐

If Multi-Story, Will Client Be Required to Get Upstairs: Yes: ☐ No: ☐ N/A: ☐

If Yes, Explain: _____

_____

Is Client Enrolled in a School: Yes: ☐ No: ☐

If Yes, Name of School: _____

School Address: _____

Hours Per Day Client Spends in Wheelchair: _____

ARKANSAS DEPARTMENT OF HUMAN SERVICES
DIVISION OF MEDICAL SERVICES

EVALUATION FOR WHEELCHAIR AND WHEELCHAIR SEATING

PART B (MUST BE COMPLETED BY ATP ONLY)

PT/OT/SEATING SPECIALIST must **ONLY** complete **PART B** when requesting a Scooter, Group One or Group Two Power Wheelchairs with No Power Options

1. NEW WHEELCHAIR SPECIFICATIONS:

Power: ☐ **If Power Wheelchair, Group #:** _____ **Scooter:** ☐ **Manual:** ☐

Brand/Model Name: _____ **Manufacturer:** _____

Seat Width: _____ **Seat Depth:** _____

Seat To Floor Height: _____ **Front:** _____ **Rear:** _____

2. DRIVE CONTROLS:

Joystick:	**Yes:** ☐ **No:** ☐	**Standard Mount:**	**Swing-Away:**
Type of Joystick:	**Standard:**	**T-Bar:**	**Ball:**
Chin Control:	**Sip N' Puff:**	**Head Array:**	
Other:			
Justification:			

3. SEATING:

SEAT	BACK	LATERAL SUPPORT
Contour Seat:	**Contour:**	**Curved Pad:**
Custom Molded:	**Custom Molded:**	**Fixed:** **Left/Right**
Planar Seat:	**Folding:**	**Flat Pad:**
Size:	**Planar:**	**Swing-Away:**
Sling Seat:	**Sling Back:**	**Other:**
Solid Seat:	**Captain's Seat:**	**Justification:**
Captain's Seat:	**Other:**	
Other:	**Justification:**	
Justification:		

ARKANSAS DEPARTMENT OF HUMAN SERVICES
DIVISION OF MEDICAL SERVICES

EVALUATION FOR WHEELCHAIR AND WHEELCHAIR SEATING

PART B (MUST BE COMPLETED BY ATP ONLY)

5. ACCESSORIES:

ARMRESTS	FRONT RIGGING	REAR WHEELS
Adj. Height:	Angle Adjustable/High Mount:	Composite/Mag:
Arm Troughs:	Ankle Straps:	Flat Free Inserts:
Desk Length:	Articulating Leg-Rests: *(Circle Number)*	One Arm Drive:
Detachable:	60 70 75 80 85 90 Degrees	Right: Left:
Flip Back:	Detachable:	Hand-Rims *(Any Type)*:
Full Length:	Heel Loops:	Pneumatic Tires:
Padded Swing-Away:	Leg Straps:	Projection Hand-Rims:
Swing-Away:	One Piece/Platform:	Vertical/Oblique:
Other:	Shoe Holders Size:	Size:
	Swing-Away:	Spokes:
Justification:	Toe Straps:	Other:
	XLG Footplates:	
	Other:	Justification:
	Justification:	

Was Client Evaluated in a Power Wheelchair: Yes: ☐ No: ☐

If No, State Reasons Why:

If Yes, Does The Client Have The Fine Motor, Fine Sensory and Cognitive Abilities To Operate The Power Wheelchair Safely With Respect To Others? Yes: ☐ No: ☐

If No, Explain:

Additional Information:

ARKANSAS DEPARTMENT OF HUMAN SERVICES
DIVISION OF MEDICAL SERVICES

EVALUATION FOR WHEELCHAIR AND WHEELCHAIR SEATING

PART B (MUST BE COMPLETED BY ATP ONLY)

8. PHYSICAL THERAPY:

Physical Therapy: Yes: ☐ No: ☐

If Yes, Where and How Often:

Reason For Referral:

Client Lives: Alone: ☐ With Spouse: ☐ Parents: ☐ Foster Parents: ☐

Residential Facility: ☐ Other: ☐

If Residential Facility, Name of Facility:

Does Client Have Any of The Following: (*Check All That Apply*)

Walker: Cane: ☐ Crutches: ☐ Braces: ☐ Orthotics: ☐ Prosthesis ☐ Other: ☐ ☐

Describe How Any of The Above Are Used:

9. ENVIRONMENTAL EVALUATION:

Is Client Totally Chair Confined: Yes: ☐ No: ☐

Transfer Capabilities:

Is Client Ambulatory: Yes: ☐ No: ☐

If Yes, How Far Can Client Walk:

Please Specify Limitation:

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PART B (MUST BE COMPLETED BY ATP ONLY)

13. ORTHOPEDIC DEFORMITIES:

(Check all that apply)

- Scoliosis: ☐
- Kyphosis: ☐
- Trunk Rotation: ☐
- Pelvic Rotation: ☐
- Amputee (*Specify*): ☐
- Contractures: ☐
- Wind Swept: ☐
- Hip Dislocation: ☐
- Spasms: ☐
- Other: ☐

Description and Severity of Each:

TONE: *(Check all that apply)*

- Hypertonic: Yes: ☐ No: ☐
- Hypotonic: Yes: ☐ No: ☐
- Mixed: Yes: ☐ No: ☐
- Normal: Yes: ☐ No: ☐

WEAKNESS OF: *(Check All That Apply)*

- All Extremities: ☐
- Right Lower Extremity: ☐
- Left Lower Extremity: ☐
- Right Upper Extremity: ☐
- Left Upper Extremity: ☐

14. SPASTICITY OF: *(Check all that apply)*

- All Extremities: ☐ Detail of Spasticity:
- Right Lower Extremity: ☐ Detail of Spasticity:
- Left Lower Extremity: ☐ Detail of Spasticity:
- Right Upper Extremity: ☐ Detail of Spasticity:
- Left Upper Extremity: ☐ Detail of Spasticity:

Additional Details:

15. HEAD CONTROL: *(Check all that apply)*

- None: ☐
- Poor: ☐
- Fair: ☐
- Good: ☐

Provide Detail of Each:

TRUNK CONTROL: *(Check all that apply)*

- None: ☐
- Poor: ☐
- Fair: ☐
- Good: ☐

Provide Detail of Each:

PART B (MUST BE COMPLETED BY ATP ONLY)

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PART C (MUST BE COMPLETED BY PRESCRIBING PHYSICIAN ONLY)

1. **DIAGNOSIS: CURRENT**

MEDICATIONS:

1. _____ _____
2. _____ _____
3. _____ _____
4. _____ _____
5. _____ _____

2. **INJURY:**

Date of Injury: _____ **Level of Injury:** _____

Future Surgery Planned: Yes ☐ No ☐ **If Yes, Explain:** _____

3. **MEDICAL EQUIPMENT:**

Apnea Monitor: ☐ **Oxygen:** ☐ **Communication Device:** ☐
Ventilator: ☐ **Other:** ☐

4. **ADDITIONAL INFORMATION:** _____

Seizures: **Are They Controlled?** **If Yes, How Long?** _____

_____ _____
Prescribing Physician Name *(Please Print)* **Physician's Provider Number**

_____ _____
Prescribing Physician Signature *(No Stamp Please)* **Date of Evaluation**