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 1-18 & Section V 2-18

Intended Effective Date (Check One)		Date
☐ Emergency (ACA 25-15-204)	Legal Notice Published	6/15/2018
☐ 10 Days After Filing (ACA 25-15-204)	Final Date for Public Comment	7/14/2018
☑ Other 9/01/2018 (Must be more than 10 days after filing date.)	Reviewed by Legislative Council	8/17/2018
	Adopted by State Agency	9/1/2018

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

Thomas Herndon	thomas.herndon@dhs.arkansas.gov	8/20/2018
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.)

Signature

(501) 371-2165 tami.harlan@dhs.arkansas.gov
Phone Number E-mail Address

Interim Director of Medical Services
Title

8/20/2018
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.

ARKANSAS DEPARTMENT OF HUMAN SERVICES

Division of Medical Services
Office of Policy Coordination & Promulgation

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: September 1, 2018

SUBJECT: Provider Manual Update Transmittal SecV-2-18

REMOVE		INSERT	
Section	**Effective Date**	**Section**	**Effective Date**
DMS-602	12/14	DMS-602	9/18
DMS-679	12/14	DMS-679	9/18
DMS-679A	12/14	DMS-679A	9/18
DMS-0843	5/17	DMS-0843	9/18

Explanation of Updates

Forms DMS-602, DMS-679, DMS-679A and DMS-0843 have been updated to add Advanced Practice Registered Nurse to the signature line.

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

This update transmittal memorandum indicates which sections of your provider manual have been revised. Electronic versions of provider manuals available from the Arkansas Medicaid website have changes incorporated. See Section I for instructions on updating a paper copy of the manual.

If you have questions regarding this transmittal, please contact the 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 Office of Policy Coordination and Promulgation 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: https://medicaid.mmis.arkansas.gov/Provider/Docs/Docs.aspx.

Thank you for your participation in the Arkansas Medicaid Program.

Tami Harlan, Interim Director

ARKANSAS DEPARTMENT OF HUMAN SERVICES

Division of Medical Services
Office of Policy Coordination & Promulgation

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: September 1, 2018

SUBJECT: Provider Manual Update Transmittal PROSTHET-1-18

REMOVE		INSERT	
Section	**Effective Date**	**Section**	**Effective Date**
203.100	11-1-09	203.100	9-1-18
211.100	4-1-09	211.100	9-1-18
211.200	4-1-09	211.200	9-1-18
211.300	4-6-15	211.300	9-1-18
211.400	4-1-09	211.400	9-1-18
211.500	8-1-05	211.500	9-1-18
211.600	8-1-05	211.600	9-1-18
221.100	4-1-09	221.100	9-1-18
242.191	11-1-17	242.191	9-1-18
242.194	5-1-17	242.194	9-1-18
242.310	12-15-14	242.310	9-1-18

Explanation of Updates

Section 203.100 is updated to include advanced practice registered nurse (APRN) to the documentation case files.

Section 211.100 is updated to add APRN to condition for provision of services.

Section 211.200 is updated to add APRN to physician's role in the prosthetics program.

Section 211.300 is updated to add APRN to prosthetics service provision.

Section 221.400 is updated to add APRN to prescription and referral renewal.

Section 211.500 is updated to add APRN to service initiation delays.

Section 211.600 is updated to add APRN to the termination of services documentation notices.

Section 221.100 is updated to add APRN to prior authorization form.

Section 242.191 is updated to add APRN to DMS-679 signature instructions.

Section 242.194 is updated to add APRN to the documentation requirement for wheelchair replacement.

Section 242.310 is updated to add APRN to the CMS-1500 claim form instructions.

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Thank you for your participation in the Arkansas Medicaid Program.

Tami Harlan
Interim Director

TOC not required

203.100 Documentation in Beneficiary's Case Files 9-1-18

The provider must develop and maintain sufficient written documentation to support each service for which billing is made. All entries in a beneficiary's file must be signed and dated by the individual who provided the service, along with the individual's title. The documentation must be kept in the beneficiary's case file.

Documentation should consist of, at a minimum, material that includes:

A. An audit trail between the prosthetics provider, the beneficiary, the beneficiary's primary care physician and advanced practice registered nurse and the Division of Medical Services.

B. When applicable, documentation including the request for and approval of prior authorization and/or the request for and approval of extension of benefits for services provided.

C. Prescriptions for prosthetics services, signed and dated by the beneficiary's primary care physician or advanced practice registered nurse within the scope of practice.

D. The prosthetics provider's signed and dated:

1. Certification that used equipment is reconditioned, is in good working order and has no defects in workmanship or material
2. The beneficiary's consent to receive services
3. Notification of termination of prosthetics services
4. Documentation to reflect that necessary training and orientation has been provided to the beneficiary and any other applicable persons
5. Any additional or special documentation, requested in writing, that is needed to provide fair and impartial review of individual cases, requested in writing.

211.100 Condition for Provision of Services 9-1-18

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

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

B. The individual must be an Arkansas Medicaid beneficiary.

C. Services must be medically necessary and prescribed by the beneficiary's primary care physician (PCP) or Advanced Practice Registered Nurses (APRN) unless the beneficiary is exempt from PCP requirements. A PCP referral is required. **See Section I**.

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

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

F. When applicable, form DMS-679A, titled *Prescription & Prior Authorization Request for Medical Equipment Excluding Wheelchairs & Wheelchair Components*, must be utilized when requesting prior authorization for some medical supplies (i.e.: compression burn garments), orthotics appliances, prosthetic devices and durable medical equipment, excluding wheelchairs, wheelchair seating systems or wheelchair repairs, when these

items are prescribed for eligible Medicaid beneficiaries. **View or print form DMS-679A and instructions for completion.**

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

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

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

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

211.200 Physician's Role in the Prosthetics Program 9-1-18

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

211.300 Prosthetics Service Provision 9-1-18

At least once every 6 months, the prosthetics provider must receive a prescription for prosthetics services from either the beneficiary's primary care physician or advanced practice registered nurse within the scope of practice and, when applicable:

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

B. Prepare a Prescription & Prior Authorization Request for Medical Equipment Excluding Wheelchairs & Wheelchair Components for some medical supplies (i.e.: compression burn garments), orthotic appliances, prosthetic devices and durable medical equipment for beneficiaries 21 years of age or older and for specified services for beneficiaries under age 21. **View or print form DMS-679A and instructions for completion.**

C. Send the prepared request for prior authorization to either the beneficiary's primary care physician or advanced practice registered nurse within the scope of practice for prescriptions

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

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

As necessary, the provider must:

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

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

C. Repair equipment within 3 working days of notification,

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

E. Provide necessary documentation.

211.400 Prescription and Referral Renewal 9-1-18

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

211.500 Service Initiation Delays 9-1-18

If all prescribed prosthetics services are not begun by the prosthetics provider within 30 working days of the prescription date, the prosthetics provider must notify the beneficiary and either the beneficiary's primary care physician or advanced practice registered nurse within the scope of practice in writing and explain the delay. The provider must retain documentation justifying the service delay.

211.600 Termination of Services 9-1-18

If prosthetics services are terminated, the provider must notify either the beneficiary's primary care physician or advanced practice registered nurse within the scope of practice and the beneficiary (if not deceased) in writing, within 10 working days of the termination, documenting the effective date of and reasons for the termination.

221.100 Request for Prior Authorization 9-1-18

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

A. The *Medical Equipment Request for Prior Authorization and Prescription Form* (Form DMS-679) will be used when requesting prior authorization for wheelchairs, wheelchair seating systems and wheelchair repairs. The primary care physician or advanced practice

registered nurse within the scope of practice must sign the DMS-679. The primary care physician's or advanced practice registered nurse's signature must be an original, not a stamp.

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

B. The Arkansas Foundation for Medical Care, Inc., (AFMC) reviews requests for prior authorization for some medical supplies (i.e., compression burn garments), orthotic appliances, prosthetic devices and durable medical equipment, excluding wheelchairs, wheelchair seating systems and wheelchair repairs. Form DMS-679A, titled *Prescription and Prior Authorization Request for Medicaid Equipment Excluding Wheelchairs & Wheelchair Components* must be completed for use with those items of durable medical equipment, excluding wheelchairs, wheelchair seating systems and wheelchair repairs.

242.191 Specialized Wheelchairs and Wheelchair Seating Systems for Individuals Age Two Through Adult 9-1-18

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.

For those services that are not included in the Arkansas Medicaid State Plan, (e.g., highly technological wheelchairs and rehab equipment), the PCP must complete form DMS-693, titled Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Prescription/Referral for Medically Necessary Services/Items Not Specifically Included in the Medicaid State Plan. **View or print form DMS-679 and instructions for completion.**

NOTE: If the service or item(s) are specifically included in the Arkansas Medicaid State Plan, the completion of form DMS-693 is not required.

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, APRN 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, APRN 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, APRN 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.**

H. A manufacturer's order form documenting the suggested retail price for the brand and model wheelchair and accessories and a manufacturer's quote must be submitted with the DMS 679.

I. A DMS-693, Early and Periodic Screening, Diagnosis and Treatment (EPSDT) form, must be submitted for all pediatric wheelchairs and include detailed PCP or APRN medical documentation that clearly demonstrates medical necessity and clearly identifies the medical condition and the specific equipment that will meet the beneficiary's medical needs. Form DMS-693 and the supporting documentation must be submitted as an attachment to the request for prior authorization. It will then be reviewed for medical necessity. **View or print form DMS-693.**

J. If requirements A through I are not completed correctly, the request could be denied.

K. Arkansas Medicaid requires a Durable Medical Equipment (DME) provider to employ a RESNA (Rehabilitation Engineering and Assistive Technology Society of North America) certified ATP (Assistive Technology Practitioner) who specializes in wheelchair seating. The ATP will provide direct in-person recommendations for evaluation of the beneficiary's wheelchair selection, and is employed by the supplier. This applies for specialized manual wheelchair and power wheelchair in the category of Group 2 (single power option) and above.

The ATP's involvement in the wheelchair selection must be documented. Documentation of the ATP's involvement does not qualify as a face-to-face examination and may not be cosigned by a physician.

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

Modifiers in this section are indicated by the headings M1 and M2. Prior authorization requirements are shown under the heading PA. If prior authorization is needed, that information is indicated with a "Y" in the column; if not, an "N" is shown.

Other coding information found in the chart:

[1] **The purchase of this component for beneficiaries age 21 and older is limited to one per five-year period.**

[2] The purchase of this wheelchair component for beneficiaries under age 21 is limited to one per two-year period.

* The purchase of wheelchairs for beneficiaries age 21 and older is limited to one per five-year period.

** Bill only for beneficiaries under age 21.

This procedure code is payable for beneficiaries ages 2 through 20. Prior authorization is required through Utilization Review.

**** Items listed require prior authorization (PA) when used in combination with other items listed and the total combined value exceeds the $1,000.00 Medicaid maximum allowable reimbursement limit.

♦ Prior authorization is not required when other insurance pays at least 50% of the Medicaid maximum allowable reimbursement amount.

Note: W/C or w/c indicates wheelchair.

⁂(...) This symbol, along with text in parentheses, indicates the Arkansas Medicaid description of the product. When using a procedure code with this symbol, the product must meet the indicated Arkansas Medicaid description.

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

National 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 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

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

National Procedure Code	M1	M2	Description	PA	Payment Method
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
E0956	NU EP	U2 U2	⁂(Med. Chest Panel Support) Wheelchair accessory, lateral trunk or hip support, any type, including fixed mounting hardware, each	N****	Purchase
E0956	NU EP	U3 U3	⁂(Chest/Thoracic Supports) Wheelchair accessory, lateral trunk or hip support, any type, including fixed mounting hardware, each	N****	Purchase
E0957	NU EP		Wheelchair accessory, medial thigh support, (⁂-flip-up) any type, including fixed mounting hardware, each	N	Purchase
E0958	NU EP		Manual W/C accessory, one-arm drive attachment, each	N****	Purchase
E0959	NU EP		⁂(Amputee adapters for conventional chair, ea.) Manual W/C accessory, adapter for amputee, each	N****	Purchase
E0959	NU EP		⁂(Amputee axle plate for high performance manual W/C, ea.) Manual wheelchair accessory, adapter for amputee, each	N****	Purchase
E0959	NU EP	U1 U1	Manual W/C accessory, adapter for amputee, each	N	Purchase
E0960	NU EP		W/C accessory, shoulder harness/straps or chest strap including any type mounting hardware	N	Purchase
E0961	NU EP		Manual W/C accessory, wheel lock brake extension (handle), each	N****	Purchase

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

National Procedure Code	M1	M2	Description	PA	Payment Method
E0966	NU EP		Manual wheelchair accessory, headrest extension, each	N****	Purchase
E0967	NU EP		⁂(Hand rim, any type) Manual W/C accessory, hand rim w/projections, any type, replacement only, each	N****	Purchase
E0967	NU EP	U1 U1	⁂(Hand rim, any type) Manual W/C accessory, hand rim w/projections, any type, replacement only, each	N****	Purchase
E0967	NU EP	U2 U2	⁂(Hand rim, any type) Manual W/C accessory, hand rim w/projections, any type, replacement only, each	N****	Purchase
E0967	NU EP	U3 U3	⁂(Hand rim, any type) Manual W/C accessory, hand rim w/projections, any type, replacement only, each	N****	Purchase
E0967	NU EP	U4 U4	⁂(Hand rim, any type) Manual W/C accessory, hand rim w/projections, any type, replacement only, each	N****	Purchase
E0970	NU EP		No. 2 footplates, except for elevating legrest	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

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

National Procedure Code	M1	M2	Description	PA	Payment Method
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, leg rest) W/C accessory, elevating leg rest, complete assembly, each	N****	Purchase
E0990	NU EP	U1 U1	⁂(Elevating Leg Rest 90 Degree, 12" - 16" Width) W/C accessory, elevating leg rest, 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
E0992	NU EP	U3 U3	⁂(Foam & Plywood Seat, MPI Like Manual wheelchair accessory, solid seat)	N****	Purchase
E0992	NU EP	U4 U4	⁂(Adjustable solid standard seat with hardware Manual wheelchair accessory, solid seat)	N****	Purchase
E0994	NU EP		Armrest, each	N****	Purchase
E1002	NU EP		W/C accessory power seating system, tilt only	Y♦	Purchase
E1004	NU EP		W/C accessory, power seating system, recline only, with mechanical shear reduction	Y♦	Purchase
E1006	NU EP		W/C accessory, power seating system, combination tilt and recline, w/o shear reduction	Y	Purchase
E1007	NU EP		Wheelchair accessory, power seating system, combination tilt and recline, with mechanical shear reduction	Y	Purchase
E1010	NU EP		W/C accessory, addition to power seating system, power leg elevation system, including leg rest, each	Y	Purchase
E1020	NU EP		⁂(Adjustable Contour Lateral Thigh Support) Residual limb support system for W/C	N****	Purchase

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

National Procedure Code	M1	M2	Description	PA	Payment Method
E1028	NU EP		Wheelchair accessory, manual swingaway, retractable or removable mounting hardware for joystick, other control interface or positioning accessory	N	Purchase
E1029	NU EP		⁂(Ventilator Tray With Battery Tray) Wheelchair accessory, ventilator tray, fixed	Y	Purchase
E1030	NU EP		Wheelchair accessory, ventilator tray, gimbaled	Y	Purchase
E1050*	NU EP		Full reclining W/C, fixed full-length arms, swing-away, detachable elevating legrests	N****	Purchase
E1060*	NU EP		Full reclining W/C, detachable arms, desk or full-length, swing-away detachable, elevating legrests	Y♦	Purchase
E1070#	EP		⁂(A maximum use of three months only) Fully-reclining wheelchair, detachable arms, (desk or full-length) swing-away, detachable footrest/elevated legrest	Y	Rental only
E1084*	NU EP		Hemi-W/C; detachable arms, desk or full-length, swing-away, detachable, elevating leg rests	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 legrest	Y♦	Purchase
E1161	NU EP		Manual adult size W/C, includes tilt in space	Y♦	Purchase

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

National Procedure Code	M1	M2	Description	PA	Payment Method
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
E1228	NU EP		⁂(Folding Straight Backrest, Low, (15" - 16") Special back height for W/C	N****	Purchase
E1228	NU EP		⁂(Folding Straight Backrest, Tall, 19" - 20") Special back height for W/C	N****	Purchase
E1228	NU EP	U1 U1	⁂(High back contour seat) Special back height for W/C	N****	Purchase
E1228	NU EP	U2 U2	⁂(Positioning tall back) Special back height for W/C	N****	Purchase
E1230*	NU EP		Power operated vehicle (three- or four-wheel nonhighway), specify brand name and model number	Y♦	Purchase
E1230	EP NU	U1 U1	Power operated vehicle (three- or four-wheel nonhighway), specify brand name and model number	Y♦	Purchase
E1232*	EP		W/C, pediatric size, tilt-in-space, folding, adjustable, with seating system	Y♦	Purchase
E1233*	EP		W/C, pediatric size, tilt-in-space, rigid, adjustable, without seating system	Y♦	Purchase
E1234*	EP		W/C, pediatric size, tilt-in-space, folding, adjustable, without seating system	Y♦	Purchase
E1235*	NU EP		Wheelchair, pediatric size, rigid, adjustable, with seating system	Y♦	Purchase

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

National Procedure Code	M1	M2	Description	PA	Payment Method
E1235[2]	EP	U1	⁂(Rigid W/C Frame) W/C, pediatric size, rigid, adjustable with seating system	Y	Purchase
E1236	EP		Wheelchair, pediatric size, folding, adjustable, with seating system	Y	Purchase
E1237*	EP		W/C, pediatric size, rigid, adjustable, without seating system	Y♦	Purchase
E1238*	EP		W/C, pediatric size, folding, adjustable, without seating system	Y♦	Purchase
E1240*	NU EP		Lightweight W/C; detachable arms, desk or full-length, swing-away, detachable, elevating legrest	Y♦	Purchase
E1260*	NU EP		Lightweight W/C; detachable arms, desk or full-length, swing-away, detachable footrests	N****	Purchase
E1280*	NU EP		Heavy-duty W/C; detachable arms, desk or full-length, elevating legrests	Y♦	Purchase
E1290*	NU EP		Heavy-duty W/C; detachable arms, swing-away, detachable footrests	Y♦	Purchase
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

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

National Procedure Code	M1	M2	Description	PA	Payment Method
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
E2213	NU EP		Manual wheelchair accessory, insert for pneumatic propulsion tire (removable), any type, any size, each	N	Purchase
E2214	NU EP		Manual wheelchair accessory, pneumatic caster tire, any size, each	N	Purchase
E2215	NU EP		Manual wheelchair accessory, tube for pneumatic caster tire, any size, each	N	Purchase
E2220	NU EP		Manual wheelchair accessory, solid (rubber/plastic) propulsion tire, any size, each	N	Purchase
E2221	NU EP		Manual wheelchair accessory, solid (rubber/plastic) caster tire (removable), any size, each	N	Purchase
E2226	NU EP		Manual wheelchair accessory, caster fork, any size, replacement only, each	N	Purchase
E2231	NU EP		Manual wheelchair accessory, solid seat support base (replaces sling seat), includes any type mounting hardware	Y	Purchase
E2291	EP		Back, planar, for pediatric-size wheelchair, including fixed attaching hardware	N	Manually Priced

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

National Procedure Code	M1	M2	Description	PA	Payment Method
E2292	EP		Seat, planar, for pediatric-size wheelchair, including fixed attaching hardware	N	Manually Priced
E2293	EP		Back, contoured, for pediatric-size wheelchair, including fixed attaching hardware	N	Manually Priced
E2294	EP		Seat, contoured, for pediatric-size wheelchair, including fixed attaching hardware	N	Manually Priced
E2295	EP		Manual wheelchair accessory, for pediatric size wheelchair, dynamic seating frame, allows coordinated movement of multiple positioning features	Y	Manually Priced
E2310	NU EP		Power w/c accessory, electronic connection between wheelchair controller and one power seating system motor, including all related electronics, indicator feature, mechanical function selection switch, and fixed mounting hardware	Y	Purchase
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 swingaway mounting hardware	Y	Purchase
E2326	NU EP		Power wheelchair accessory, breath tube kit for sip and puff interface ⁂ (replacement only)	Y	Purchase

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

National Procedure Code	M1	M2	Description	PA	Payment Method
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
E2365	NU EP	U1 U1	Power w/c accessory, U-1 sealed lead acid battery, each, gel cell	N	Purchase
E2366	NU EP		⁂(24-Volt Battery Charger - Standard, Replacement) Power w/c accessory, battery charger, single mode, for use with only one battery type, sealed or non-sealed, each	N	Purchase
E2367	NU EP		⁂(24-Volt Battery Charger - Dual Mode, Replacement) Power w/c accessory, battery charger, dual mode, sealed or non-sealed, each	N	Purchase
E2368	NU EP		Power wheelchair component, motor, replacement only	N	Purchase
E2369	NU EP		Power wheelchair component, gear box, replacement only	N	Purchase
E2370	NU EP		Power wheelchair component, motor and gear box combination, replacement only	Y	Purchase
E2372	NU EP		Power wheelchair accessory, group 27 non-sealed lead acid battery, each	Y	Purchase

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

National Procedure Code	M1	M2	Description	PA	Payment Method
E2373	NU EP		Power wheelchair accessory, hand or chin control interface, mini-proportional, compact, or short throw remote joystick or touchpad, proportional, including all related electronics and fixing mounting hardware.	Y	Purchase
E2375	NU EP		Power wheelchair accessory, nonexpandable controller, including all related electronics and mounting hardware, replacement only	Y	Purchase
E2376	NU EP		Power wheelchair accessory, expandable controller, including all related electronics and mounting hardware, replacement only	Y	Purchase
E2377	NU EP		Power wheelchair accessory, expandable controller, including all related electronics and mounting hardware, upgrade provided at initial issue	Y	Purchase
E2378	NU EP		Power wheelchair component, actuator, replacement only	Y	Purchase
E2381	NU EP		Power wheelchair accessory, pneumatic drive wheel tire, any size, replacement only, each	Y	Purchase
E2382	NU EP		Power wheelchair accessory, tube for pneumatic drive wheel tire, any size, replacement only, each	Y	Purchase
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

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

National Procedure Code	M1	M2	Description	PA	Payment Method
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
E2627	NU EP		Wheelchair accessory, shoulder elbow, mobile arm support attached to wheelchair, balanced, adjustable Rancho type	Y	Purchase
E2628	NU EP		Wheelchair accessory, shoulder elbow, mobile arm support attached to wheelchair, balanced, reclining	Y	Purchase
E2629	NU EP		Wheelchair accessory, shoulder elbow, mobile arm support attached to wheelchair, balanced, friction arm support (friction dampening to proximal and distal joints)	Y	Purchase
E2630	NU EP		Wheelchair accessory, shoulder elbow, mobile arm support, monosuspension arm and hand support, overhead elbow forearm hand sling support, yoke type suspension support	Y	Purchase

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

National Procedure Code	M1	M2	Description	PA	Payment Method
E2631	NU EP		Wheelchair accessory, addition to mobile arm support, elevating proximal arm	Y	Purchase
E2632	NU EP		Wheelchair accessory, addition to mobile arm support, offset or lateral rocker arm with elastic balance control	Y	Purchase
E2633	NU EP		Wheelchair accessory, addition to mobile arm support, supinator	Y	Purchase
K0004	NU EP		High-strength lightweight wheelchair	Y****	Purchase
K0005*	NU EP		⁂(High-performance manual W/C-adult) Ultralightweight W/C	Y♦	Purchase
K0005*	NU EP	U1 U1	⁂(High-performance manual W/C with growth adjustability-child) Ultralightweight W/C	Y♦	Purchase
K0010	NU EP		⁂(Motorized, standard frame, DA, swing away footrests) Standard weight frame motorized/power W/C	Y♦	Purchase
K0010	NU EP	U1 U1	⁂(Motorized, standard frame, DA, swing away ELR) Standard weight frame motorized/power W/C	Y♦	Purchase
K0011	NU EP		⁂(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
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

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

National Procedure Code	M1	M2	Description	PA	Payment Method
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
K0039	NU EP		Leg strap, H style, each	N****	Purchase
K0040	NU EP		Adjustable angle footplate, each	N****	Purchase
K0043	NU EP		⁂(SWFR, replacement) Footrest, lower extension tube, each	N	Purchase
K0044	NU EP		⁂(SWFR Hanger bracket, replacement) Footrest, upper hanger bracket, each	N****	Purchase
K0045	NU EP		⁂(Padded custom foot box) Footrest, complete assembly	N****	Purchase
K0047	NU EP		Elevating legrest, upper hanger bracket, each	N****	Purchase

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

National Procedure Code	M1	M2	Description	PA	Payment Method
K0056	NU EP		Seat height less than 17 inches or equal to or greater than 21 inches for a high-strength, lightweight, or ultralightweight W/C	N****	Manually Priced
K0056	NU EP	U1 U1	⁂(Seat height 19.5"5) Seat height less than 17 inches or equal to or greater than 21 inches for a high strength, lightweight or ultralightweight W/C	N****	Purchase
K0065	NU EP		Spoke protectors, each	N****	Purchase
K0070	NU EP		⁂(Wheel assembly, complete with pneumatic tires, 20"/22"/24"/26"/ea. replacement) Rear wheel assembly, complete with pneumatic tire, spokes or molded, each	N****	Purchase
K0071	NU EP	U1 U1	⁂(Wheel assembly with pneumatic tires, 22", pair, rear wheels) Front caster assembly, complete, with pneumatic tire, each	N****	Purchase
K0071	NU EP		⁂(Polyurethane casters, 5", pair, front casters) Front caster assembly, complete, with pneumatic tire, each	N****	Purchase
K0072	NU EP		⁂(Polyurethane casters, 5", pair, front casters) Front caster assembly, complete, with semipneumatic tire, each	N****	Purchase
K0073	NU EP		Caster pin lock, each	N****	Purchase
K0077	NU EP		Front caster assembly, complete, with solid tire, each	N	Purchase
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 only be billed on paper.

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

National Procedure Code	M1	M2	Description	PA	Payment Method	Deleted Local Code
E0190	EP	U3	⁂(Adductor - no hardware)	N****	Purchase	Z2140
E0190	NU	U3	⁂(Adductor - no hardware)	N****	Purchase	Z2140
E0190	EP	U4	⁂(Abductor - no hardware)	N****	Purchase	Z2141
E0190	NU	U4	⁂(Abductor - no hardware)	N****	Purchase	Z2141
E0190	EP	U5	⁂(Hip guides - no hardware)	N	Purchase	Z2142
E0190	NU	U5	⁂(Hip guides - no hardware)	N	Purchase	Z2142
E0190	EP	U6	⁂(Laterals - no hardware)	N****	Purchase	Z2145
E0190	NU	U6	⁂(Laterals - no hardware)	N****	Purchase	Z2145
E0191	EP	U1	⁂(Elbow Block w/Bracket)	N****	Purchase	Z2203
E0191	NU	U1	⁂(Elbow Block w/Bracket)	N****	Purchase	Z2203
E0700	EP	U3	PC Car Seat/Snug Seat	Y	Purchase	Z1824**
E0951 E0952	EP		Heel loop/holder, any type, with or without ankle strap, (ea) Shoe Holders S/M/L/XL	N****	Purchase	Z2183
E0951 E0952	NU		Heel loop/holder, any type, with or without ankle strap, (ea) Shoe Holders S/M/L/XL	N****	Purchase	Z2183
E0955	EP		Sub Occipital Three Piece Head Set w/REM Hardware	N****	Purchase	Z2188
E0955	NU		Sub Occipital Three Piece Head Set w/REM Hardware	N****	Purchase	Z2188
E0956	EP	U4	⁂(Lateral Hip/Thigh support w/hardware (ea))	N****	Purchase	Z2139
E0956	NU	U4	⁂(Lateral Hip/Thigh support w/hardware (ea))	N****	Purchase	Z2139
E0956	EP	U5	⁂(Rigid Side Guard)	N****	Purchase	Z2186
E0956	NU	U5	⁂(Rigid Side Guard)	N****	Purchase	Z2186
E0956	EP	U6	⁂(Fabric Side Guard)	N****	Purchase	Z2187
E0956	NU	U6	⁂(Fabric Side Guard)	N****	Purchase	Z2187
E0957	EP	U1	⁂(Adjustable Rem. Abductor w/hardware (ea))	N****	Purchase	Z2137
E0957	NU	U1	⁂(Adjustable Rem. Abductor w/hardware (ea))	N****	Purchase	Z2137
E0957	EP	U2	⁂(Adjustable Flip Down Abductor w/hardware (ea))	N****	Purchase	Z2138

The following procedure codes may only be billed on paper.

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

National Procedure Code	M1	M2	Description	PA	Payment Method	Deleted Local Code
E0957	NU	U2	⁂(Adjustable Flip Down Abductor w/hardware (ea))	N****	Purchase	Z2138
E0970	EP		SWFR Composite Foot Plate (Replacement)	N****	Purchase	Z2181
E0970	NU		SWFR Composite Foot Plate (Replacement)	N****	Purchase	Z2181
E0978	EP	U3	⁂(Forehead Strap System)	N****	Purchase	Z2189
E0978	NU	U3	⁂(Forehead Strap System)	N****	Purchase	Z2189
E1011	EP		Rigid Wheelchair Growth Kit Modification to pediatric size wheelchair, width adjustment package (not to be dispensed with initial chair)	N	Purchase	Z2185
E1011	NU		Rigid Wheelchair Growth Kit Modification to pediatric size wheelchair, width adjustment package (not to be dispensed with initial chair)	N	Purchase	Z2185
E1020	EP	U1	⁂(Adjustable Contour Lateral Pelvic Support)	N****	Purchase	Z2589
E1020	NU	U1	⁂(Adjustable Contour Lateral Pelvic Support)	N****	Purchase	Z2589
E1028	EP		Wheelchair accessory, manual swing away, retractable or removable mounting hardware for joystick, other control interface or positioning accessory, Swing Away Mount (Joystick)	N****	Purchase	Z2616
E1028	NU		Wheelchair accessory, manual swing away, retractable or removable mounting hardware for joystick, other control interface or positioning accessory, Swing Away Mount (Joystick)	N****	Purchase	Z2616
E2201	EP	U3	X-Tube Assembly Folding W/C (Replacement)	N****	Purchase	Z2184
E2201	EP		Manual W/C Accessory, Non-standard Seat Frame Width, > or equal to 20" & <24"	N****	Purchase	Z2184

The following procedure codes may only be billed on paper.

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

National Procedure Code	M1	M2	Description	PA	Payment Method	Deleted Local Code
E2201	NU		Manual W/C Accessory, Non-standard Seat Frame Width, > or equal to 20" & <24"	N****	Purchase	Z2184
E2201	EP	U1	Manual W/C Accessory, Non-standard Seat Frame Width, > or equal to 24" & <27"	N****	Purchase	Z2184
E2201	NU	U1	Manual W/C Accessory, Non-standard Seat Frame Width, > or equal to 24" & <27"	N****	Purchase	Z2184
E2201	EP	U2	Manual W/C Accessory, Non-standard Seat Frame Width, > or equal to 24" & <27"	N****	Purchase	Z2184
E2201	NU	U1	Manual W/C Accessory, Non-standard Seat Frame Depth, 22" to 25"	N****	Purchase	Z2184
E2203	EP		Manual W/C Accessory, Non-standard Seat Frame Depth 20" to <22"	N****	Purchase	Z2184
E2203	EP	U1	Manual W/C Accessory, Non-standard Seat Frame Depth, 22" to 25"	N****	Purchase	Z2184
E2203	NU		Manual W/C Accessory, Non-standard Seat Frame Depth, > or equal to 20" & 24"	N****	Purchase	Z2184
E2210	NU EP		Power W/C Sleeve Top or Bottom Stem Bearing (Replacement)	N****	Purchase	Z2175
E2210	NU		Power W/C Sleeve Top or Bottom Stem Bearing (Replacement)	N****	Purchase	Z2175
E2231	NU EP	U1	⁂(Growing Seat Pan)	N****	Purchase	Z2585
E2231	NU	U1	⁂(Growing Seat Pan)	N****	Purchase	Z2585
E2373	NU EP	U1	⁂(Remote Joystick Module)	N****	Purchase	Z2592
E2373	NU	U1	⁂(Remote Joystick Module)	N****	Purchase	Z2592
E2611 E2612	NU EP		General use wheelchair back cushion, width less than 22 inches, any height, including any type mounting hardware, Growing Back Upholstery	N****	Purchase	Z2586

The following procedure codes may only be billed on paper.

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

National Procedure Code	M1	M2	Description	PA	Payment Method	Deleted Local Code
E2611 E2612	NU		General use wheelchair back cushion, width less than 22 inches, any height, including any type mounting hardware, Growing Back Upholstery	N****	Purchase	Z2586
E2611	NU EP	U1	⁂(Adjustable Back Upholstery)	N****	Purchase	Z2604
E2611	NU	U1	⁂(Adjustable Back Upholstery)	N****	Purchase	Z2604
E2612	EP		General use wheelchair back cushion, width 22 inches or greater, any height, including any type mounting hardware	N****	Purchase	Z2586
E2612	NU		General use wheelchair back cushion, width 22 inches or greater, any height, including any type mounting hardware	N****	Purchase	Z2586
E2619	NU EP		Air Exchange Seat Cover for Cushions (Replacement)	N	Purchase	Z2158
E2619	NU		Air Exchange Seat Cover for Cushions (Replacement)	N	Purchase	Z2158
E2620	NU EP	U1	⁂(Deep Contour Back 20" Width)	N****	Purchase	Z2588
E2620	NU	U1	⁂(Deep Contour Back 20" Width)	N****	Purchase	Z2588
E2622	NU EP	U1	Fluid Flo-lite pad (Replacement)	N	Purchase	Z2159
E2622	NU	U1	Fluid Flo-lite pad (Replacement)	N	Purchase	Z2159
K0045	NU EP		One-piece footboard (each)	N****	Purchase	Z1613
K0045	NU		One-piece footboard (each)	N****	Purchase	Z1613
K0045	NU EP	U2	Custom foot platform	N****	Purchase	Z1793
K0045	NU	U2	Custom foot platform	N****	Purchase	Z1793
K0108	NU EP	U1	⁂(Swing Away Adj. Stroller Handles)	N****	Purchase	Z2196
K0108	NU	U1	⁂(Swing Away Adj. Stroller Handles)	N****	Purchase	Z2196
K0108	NU EP	U2	⁂(Quick Release Axle)	N****	Purchase	Z2582
K0108	NU	U2	⁂(Quick Release Axle)	N****	Purchase	Z2582

The following procedure codes may only be billed on paper.

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

National Procedure Code	M1	M2	Description	PA	Payment Method	Deleted Local Code
K0108	NU EP	U3	⁂(Transit Option)	N****	Purchase	Z2599
K0108	NU	U3	⁂(Transit Option)	N****	Purchase	Z2599

242.194 Replacement, Growth and Modification of Specialized Wheelchairs and Wheelchair Seating Systems 9-1-18

Arkansas Medicaid will cover replacement equipment as needed due to growth, normal wear and tear, theft, irreparable damage or loss not covered by insurance.

The following requirements must be met:

A. Detailed documentation from the beneficiary's PCP or ordering physician /APRN describing the significant changes in the beneficiary's condition that require growth/modification or replacement must be submitted.

B. The request must be submitted on form DMS-679 (Prescription & Prior Authorization Request for Medical Equipment). **View or print form DMS-679 and instructions for completion.**

C. An Evaluation for Wheelchair and Wheelchair Seating form (DMS-0843) must be submitted. The evaluation must be signed and dated by the beneficiary's PCP/APRN or ordering physician. The signature must be an original signature. A stamped signature will not be accepted by Arkansas Medicaid. An electronic signature will be accepted. **View or print form DMS-0843.**

D. A manufacturer's suggested retail price list and a manufacturer's quote must be submitted. A quote created by the DME provider will not be accepted.

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.

242.310 Completion of CMS-1500 Claim Form 9-1-18

Field Name and Number	Instructions for Completion

Field Name and Number		Instructions for Completion
1.	(type of coverage)	Not required.
1a.	INSURED'S I.D. NUMBER (For Program in Item 1)	Beneficiary's or participant's 10-digit Medicaid or ARKids First-A or ARKids First-B identification number.
2.	PATIENT'S NAME (Last Name, First Name, Middle Initial)	Beneficiary's or participant's last name and first name.
3.	PATIENT'S BIRTH DATE	Beneficiary's or participant's date of birth as given on the individual's Medicaid or ARKids First-A or ARKids First-B identification card. Format: MM/DD/YY.
	SEX	Check M for male or F for female.
4.	INSURED'S NAME (Last Name, First Name, Middle Initial)	Required if insurance affects this claim. Insured's last name, first name, and middle initial.
5.	PATIENT'S ADDRESS (No. Street)	Optional. Beneficiary's or participant's complete mailing address (street address or post office box).
	CITY	Name of the city in which the beneficiary or participant resides.
	STATE	Two-letter postal code for the state in which the beneficiary or participant resides.
	ZIP CODE	Five-digit zip code; nine digits for post office box.
	TELEPHONE (Include Area Code)	The beneficiary's or participant's telephone number or the number of a reliable message/contact/ emergency telephone.
6.	PATIENT RELATIONSHIP TO INSURED	If insurance affects this claim, check the box indicating the patient's relationship to the insured.
7.	INSURED'S ADDRESS (No., Street)	Required if insured's address is different from the patient's address.
	CITY	
	STATE	
	ZIP CODE	
	TELEPHONE (Include Area Code)	
8.	RESERVED	Reserved for NUCC use.
9.	OTHER INSURED'S NAME (Last name, First Name, Middle Initial)	If patient has other insurance coverage as indicated in Field 11d, the other insured's last name, first name, and middle initial.
a.	OTHER INSURED'S POLICY OR GROUP NUMBER	Policy and/or group number of the insured individual.
b.	RESERVED	Reserved for NUCC use.
	SEX	Not required.
c.	RESERVED	Reserved for NUCC use.

Field Name and Number	Instructions for Completion
d. INSURANCE PLAN NAME OR PROGRAM NAME	Name of the insurance company.
10. IS PATIENT'S CONDITION RELATED TO:	
a. EMPLOYMENT? (Current or Previous)	Check YES or NO.
b. AUTO ACCIDENT?	Required when an auto accident is related to the services. Check YES or NO.
PLACE (State)	If 10b is YES, the two-letter postal abbreviation for the state in which the automobile accident took place.
c. OTHER ACCIDENT?	Required when an accident other than automobile is related to the services. Check YES or NO.
d. CLAIM CODES	The "Claim Codes" identify additional information about the beneficiary's condition or the claim. When applicable, use the Claim code to report appropriate claim codes as designated by the NUCC. When required to provide the subset of Condition codes, enter the condition codes in this field. The subset of approved Condition Codes is found at **www.nucc.org** under Code Sets.
11. INSURED'S POLICY GROUP OR FECA NUMBER	Not required when Medicaid is the only payer.
a. INSURED'S DATE OF BIRTH	Not required.
SEX	Not required.
b. OTHER CLAIM ID NUMBER	Not required.
c. INSURANCE PLAN NAME OR PROGRAM NAME	Not required.
d. IS THERE ANOTHER HEALTH BENEFIT PLAN?	When private or other insurance may or will cover any of the services, check YES and complete items 9, 9a and 9d. Only one box can be marked.
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE	Enter "Signature on File," "SOF" or legal signature.
13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE	Enter "Signature on File," "SOF" or legal signature.

Field Name and Number	Instructions for Completion
14. DATE OF CURRENT: ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)	Required when services furnished are related to an accident, whether the accident is recent or in the past. Date of the accident. Enter the qualifier to the right of the vertical dotted line. Use Qualifier 431 Onset of Current Symptoms or Illness; 484 Last Menstrual Period.
15. OTHER DATE	Enter another date related to the beneficiary's condition or treatment. Enter the qualifier between the left-hand set of vertical, dotted lines. The "Other Date" identifies additional date information about the beneficiary's condition or treatment. Use qualifiers: 454 Initial Treatment 304 Latest Visit or Consultation 453 Acute Manifestation of a Chronic Condition 439 Accident 455 Last X-Ray 471 Prescription 090 Report Start (Assumed Care Date) 091 Report End (Relinquished Care Date) 444 First Visit or Consultation
16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION	Not required.
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	Primary Care Physician (PCP)/Advanced Practice Registered Nurse (APRN) referral is not required for prosthetics. If services are the result of a Child Health Services (EPSDT) screening/ referral, enter the referral source, including name and title.
17a. (blank)	Not required.
17b. NPI	Enter NPI of the referring physician.
18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES	When the serving/billing provider's services charged on this claim are related to a beneficiary's or participant's inpatient hospitalization, enter the individual's admission and discharge dates. Format: MM/DD/YY.
19. ADDITIONAL CLAIM INFORMATION	Identifies additional information about the beneficiary's condition or the claim. Enter the appropriate qualifiers describing the identifier. See **www.nucc.org** for qualifiers.
20. OUTSIDE LAB?	Not required.
$ CHARGES	Not required.

Field Name and Number	Instructions for Completion
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY	Enter the applicable ICD indicator to identify which version of ICD codes is being reported. Use "9" for ICD-9-CM. Use "0" for ICD-10-CM. Enter the indicator between the vertical, dotted lines in the upper right-hand portion of the field. Diagnosis code for the primary medical condition for which services are being billed. Use the appropriate International Classification of Diseases (ICD). List no more than 12 diagnosis codes. Relate lines A-L to the lines of service in 24E by the letter of the line. Use the highest level of specificity.
22. RESUBMISSION CODE	Reserved for future use.
ORIGINAL REF. NO.	Any data or other information listed in this field does not/will not adjust, void or otherwise modify any previous payment or denial of a claim. Claim payment adjustments, voids and refunds must follow previously established processes in policy.
23. PRIOR AUTHORIZATION NUMBER	The prior authorization or benefit extension control number if applicable.
24A. DATE(S) OF SERVICE	The "from" and "to" dates of service for each billed service. Format: MM/DD/YY. 1. On a single claim detail (one charge on one line), bill only for services provided within a single calendar month. 2. Providers may bill on the same claim detail for two or more sequential dates of service within the same calendar month when the provider furnished equal amounts of the service on each day of the date sequence.
B. PLACE OF SERVICE	Two-digit national standard place of service code. See Section 242.200 for codes.
C. EMG	Enter "Y" for "Yes" or leave blank if "No." EMG identifies if the service was an emergency.
D. PROCEDURES, SERVICES, OR SUPPLIES	
CPT/HCPCS	Enter the correct CPT or HCPCS procedure code from Sections 242.100 through 242.195.
MODIFIER	Modifier(s) if applicable.

Field Name and Number	Instructions for Completion
E. DIAGNOSIS POINTER	Enter the diagnosis code reference letter (pointer) as shown in Item Number 21 to relate to the date of service and the procedures performed to the primary diagnosis. When multiple services are performed, the primary reference letter for each service should be listed first; other applicable services should follow. The reference letter(s) should be A-L or multiple letters as applicable. The "Diagnosis Pointer" is the line letter from Item Number 21 that relates to the reason the service(s) was performed.
F. $ CHARGES	The full charge for the service(s) totaled in the detail. This charge must be the usual charge to any client, patient, or other beneficiary of the provider's services.
G. DAYS OR UNITS	The units (in whole numbers) of service(s) provided during the period indicated in Field 24A of the detail.
H. EPSDT/Family Plan	Enter E if the services resulted from a Child Health Services (EPSDT) screening/referral.
I. ID QUAL	Not required.
J. RENDERING PROVIDER ID #	Enter the 9-digit Arkansas Medicaid provider ID number of the individual who furnished the services billed for in the detail or
NPI	Enter NPI of the individual who furnished the services billed for in the detail.
25. FEDERAL TAX I.D. NUMBER	Not required. This information is carried in the provider's Medicaid file. If it changes, please contact Provider Enrollment.
26. PATIENT'S ACCOUNT N O.	Optional entry that may be used for accounting purposes; use up to 16 numeric or alphabetic characters. This number appears on the Remittance Advice as "MRN."
27. ACCEPT ASSIGNMENT?	Not required. Assignment is automatically accepted by the provider when billing Medicaid.
28. TOTAL CHARGE	Total of Column 24F—the sum all charges on the claim.
29. AMOUNT PAID	Enter the total of payments previously received on this claim. Do not include amounts previously paid by Medicaid. *Do **not** include in this total the automatically deducted Medicaid or ARKids First-B co-payments.
30. RESERVED	Reserved for NUCC use.
31. SIGNATURE OF PHYSICIAN/ADVANCED PRACTICE REGISTERED NURSE OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS	The provider or designated authorized individual must sign and date the claim certifying that the services were personally rendered by the provider or under the provider's direction. "Provider's signature" is defined as the provider's actual signature, a rubber stamp of the provider's signature, an automated signature, a typewritten signature, or the signature of an individual authorized by the provider rendering the service. The name of a clinic or group is not acceptable.

Field Name and Number	Instructions for Completion
32. SERVICE FACILITY LOCATION INFORMATION	If other than home or office, enter the name and street, city, state, and zip code of the facility where services were performed.
a. (blank)	Not required.
b. (blank)	Not required.
33. BILLING PROVIDER INFO & PH #	Billing provider's name and complete address. Telephone number is requested but not required.
a.(blank)	Enter NPI of the billing provider or
b.(blank)	Enter the 9-digit Arkansas Medicaid provider ID number of the billing provider.

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 A (MUST BE COMPLETED BY DME PROVIDER ONLY)

3. CURRENT WHEELCHAIR AND SEATING SYSTEMS:

Has a Wheelchair: Yes: ☐ No: ☐ **Serial Number:** _____

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

Power: ☐ **Scooter:** ☐ **Manual:** ☐ **Standard:** ☐ **Folding:** ☐ **Rigid:** ☐

Date of Purchase: _____ **Previous DME Provider:** _____

4. PRESENT SEATING SYSTEMS:

Type of Seat: _____ **Type of Back:** _____

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

Can the Current Wheelchair Be Grown/Modified/Repaired to Meet the Client's Need: Yes: ☐ No: ☐

If No, Explain: _____

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
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EVALUATION FOR WHEELCHAIR AND WHEELCHAIR SEATING

PART B (MUST BE COMPLETED BY ATP ONLY)

4. BASIC MEASURING AND FITTING:

Independence in a wheelchair and seating device can be either enhanced or inhibited as a result of accurate or inaccurate measurements. Make sure there are complete anatomic and equipment measurements.

ACTUAL USER MEASUREMENTS

A: _____

B (R): _____

B (L): _____

C (R): _____

C (L): _____

D1: _____

D2: _____

E (R): _____

E (L): _____

F: _____

G: _____

H: _____

I (R): _____

I (L): _____

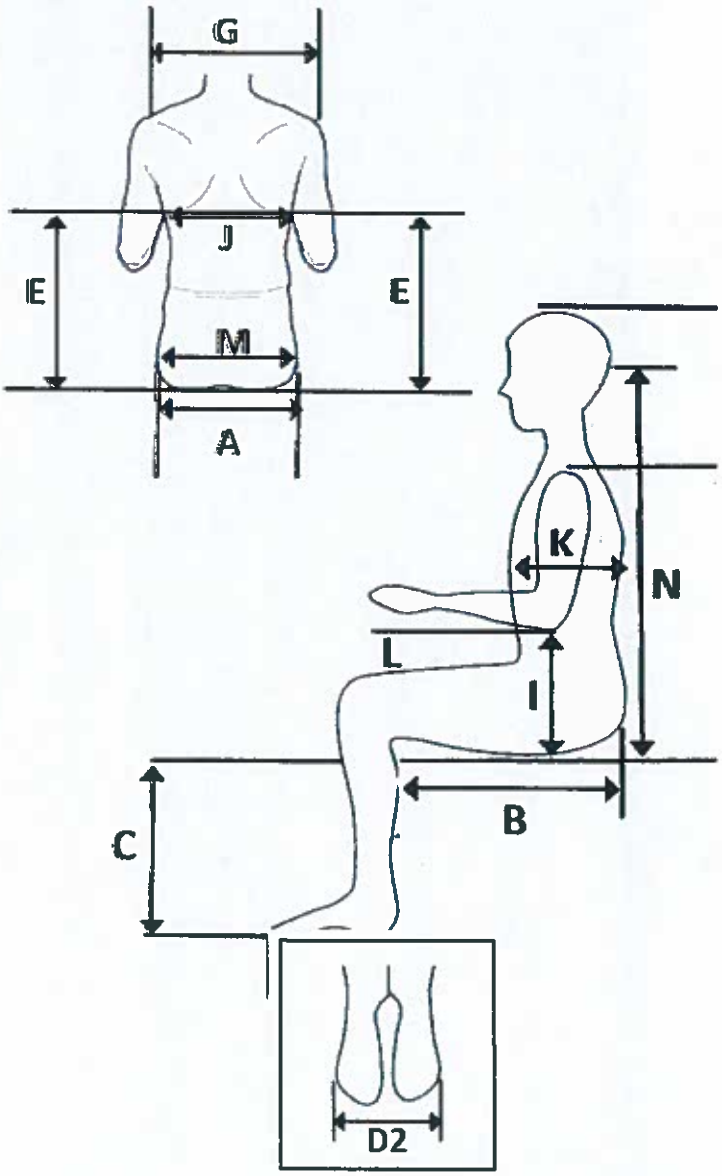
J: _____

K: _____

L: _____

M: _____

N: _____



Overall Width of Body (When Scoliosis Present)
Overall Depth of Body (When Kyphosis Present)

ARKANSAS DEPARTMENT OF HUMAN SERVICES
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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:

EVALUATION FOR WHEELCHAIR AND WHEELCHAIR SEATING

PART B (MUST BE COMPLETED BY ATP ONLY)

6. ACCESSORIES: *(Continued)*

CASTORS:	ACCESSORIES:	SEATBELTS:
Flat-Free Inserts:	Anti-Tip Tubes:	Airplane Styles:
Pneumatic Tires:	Batteries:	Auto Styles:
Solid Tires:	Tray:	Padded:
Justification:	Type:	Velcro:
	Wheel-Lock Extensions:	Other:
	Other:	
		Justification:
	Justification:	

7. POSITIONING COMPONENTS:

Abductors: Flip Down: ☐ Removable: ☐ Fixed: ☐ Custom: ☐ Size: Detachable: ☐

Thigh Support: Left: ☐ Right: ☐ Bilateral: ☐ Fixed: ☐ Detachable: ☐

Hip Guide: Left: ☐ Right: ☐ Bilateral: ☐ Fixed: ☐ Detachable: ☐

Head/Neck Support: Type:

Vest: Chest Harness: Straps: Padded: Non-Padded:

Size: Small: Medium: Large: Extra-Large:

Anterior Trunk Support: Type: Size:

Size:

Tilt Or Recline Requirements and Justification:

ARKANSAS DEPARTMENT OF HUMAN SERVICES
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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:

EVALUATION FOR WHEELCHAIR AND WHEELCHAIR SEATING

PART B (MUST BE COMPLETED BY ATP ONLY)

10. ENVIRONMENTAL EVALUATION: *(Continued)*

a. **Is Client Able To Adequately Self-Propel in a Standard/Manual Wheelchair:** Yes: ☐ No: ☐

b. **Lightweight Wheelchair:** Yes: ☐ No: ☐

c. **Ultra-Lightweight Wheelchair:** Yes: ☐ No: ☐

d. **Any Difficulty Wheeling Over Carpet Or Grass:** Yes: ☐ No: ☐

If Yes, Explain:

e. **Type of Terrain Encountered Daily:**

11. MEDICAL NECESSITY CONSIDERATION: (Check all that apply)

a. Independent:	☐	Pressure Relief:	☐
b. Progressive Condition:	☐	Endurance:	☐
c. Comfort:	☐	Growth:	☐
d. Supported Position:	☐	Other:	☐

12. PRECAUTIONS:

Skin Breakdown: Yes: ☐ No: ☐ High Risk: ☐ Moderate Risk: ☐ Low Risk: ☐

If Yes, Describe:

Sensation: Absent: ☐ Impaired: ☐ Both: ☐

Location of Sensation:

EVALUATION FOR WHEELCHAIR AND WHEELCHAIR SEATING

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:

ARKANSAS DEPARTMENT OF HUMAN SERVICES
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EVALUATION FOR WHEELCHAIR AND WHEELCHAIR SEATING

16. CONTRACTURES: *(Check all that apply)*

Ankles:	Yes:	No:
Hips:	Yes:	No:
Knees:	Yes:	No:
Feet:	Yes:	No:
Shoulders:	Yes:	No:
Elbows:	Yes:	No:
Hands:	Yes:	No:
Wrists:	Yes:	No:

OTHER: *(Check all that apply)*

Edemas:	Yes:	No:
Incontinent:	Yes:	No:
Poor Skin Integrity:	Yes:	No:
History of Decubitus:	Yes:	No:
Unable To Position:	Yes:	No:
Seizures:	Yes:	No:
Vision:	Normal:	Impaired:
Hearing:	Normal:	Impaired:

17. ADDITIONAL INFORMATION:

Will Client Self-Propel Manual Wheelchair Or Will Family Member Or Caregiver Push Client:

Name of ATP *(Please Print)*

Name of PT/OT/Seating Specialist

RESNA Certified: Yes ☐ No ☐

RESNA Certification Number: _____

Signature of PT/OT/Seating Specialist

Signature of ATP

Date

ARKANSAS DEPARTMENT OF HUMAN SERVICES
DIVISION OF MEDICAL SERVICES

EVALUATION FOR WHEELCHAIR AND WHEELCHAIR SEATING

PART C (MUST BE COMPLETED BY PRESCRIBING PHYSICIAN/ADVANCED PRACTICE REGISTERED NURSE ONLY)

MEDICATIONS:	DIAGNOSIS: CURRENT
1.	
2.	
3.	
4.	
5.	

1. INJURY:

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

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

2. MEDICAL EQUIPMENT:

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

Ventilator: ☐ **Other:** ☐

3. ADDITIONAL INFORMATION:

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

Prescribing Physician/Advanced Practice Registered Nurse Name *(Please Print)*	**Physician/Advanced Practice Registered Nurse's Provider Number**
Prescribing Physician/Advanced Practice Registered Nurse Signature *(No Stamp Please)*	**Date of Evaluation**

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/ADVANCED PRACTICE REGISTERED NURSE 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/ADVANCE PRACTICE REGISTERED NURSE (APRN)

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/APRN NAME (PRINT) _____ PHYSICIAN/APRN MEDICAID ID NUMBER _____

PHYSICIAN/APRN SIGNATURE (NO STAMP) _____ DATE _____

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

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

Instructions for Completion of Prior Authorization Request for Medical Equipment Form

SECTION A - TO BE COMPLETED BY THE PROVIDER

REVIEW TYPE:	Indicate the type of prior authorization request: initial, recertification, modification to a current authorization, or extension of benefits.
DATE(S) OF SERVICE REQUESTED:	Enter the requested date(s) of service.
PATIENT INFORMATION:	Enter the beneficiary's full name (Last, First, MI), ten-digit (10-digit) Medicaid ID number, mailing address, date of birth (MM/DD/YYYY), and sex (male or female).
PROVIDER INFORMATION:	Enter the provider name, address, provider identification number and taxonomy code, telephone number, and contact person.
PHYSICIAN INFORMATION:	Enter the prescribing physician/advanced practice registered nurse's name, provider identification number, and taxonomy code.
PROCEDURE CODES:	List all procedure codes (including any modifier or type of service if applicable) for items ordered that require authorization. (Procedure codes that do not require authorization should not be listed.) Enter the number of units requested and a narrative description for each item ordered.
PERSON SUBMITTING REQUEST:	The person submitting the request must sign and date, verifying the attestation in this section.

SECTION B - TO BE COMPLETED BY THE PHYSICIAN/APRN

EST. LENGTH OF NEED:	Enter the estimated length of need (the length of time the physician expects the patient to require use of the ordered item) by filling in the appropriate number of weeks or months or indicate permanent if the physician expects that the patient will require the item for the duration of his/her life.
EPSDT REFERRAL:	If applicable, indicate if the request is made as the result of an EPSDT referral.
HEIGHT & WEIGHT:	Enter the beneficiary's current height measured in inches and weight measured in pounds.
DIAGNOSIS & ICD CODES:	In the first space, list the diagnosis & ICD code that represents the primary reason for ordering this item. List any additional diagnosis & ICD codes that would further describe the medical need for the item (up to 4 codes).
QUESTION SECTION:	Answer the question by checking the appropriate "YES" or "NO" box.
PRESCRIBING PHYSICIAN/ADVANCED PRACTICE REGISTERED NURSE:	The prescribing physician/advanced practice registered nurse within scope of practice must sign/date in the space indicated. Signature and date stamps are not acceptable.
MEDICAL NECESSITY:	Documentation supporting medical necessity of the requested items must be submitted.

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/ADVANCED PRACTICE REGISTERED NURSE 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/ADVANCE PRACTICE REGISTERED NURSE (APRN)

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/APRN NAME (PRINT)

_____ PHYSICIAN/APRN MEDICAID ID NUMBER

_____ PHYSICIAN/APRN SIGNATURE (NO STAMP)

_____ DATE

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

_____ PRIMARY CARE PHYSICIAN (PCP) NAME (PRINT)

_____ PCP MEDICAID ID NUMBER

Instructions for Completion of Prior Authorization Request for Medical Equipment Form

SECTION A - TO BE COMPLETED BY THE PROVIDER

REVIEW TYPE:	Indicate the type of prior authorization request: initial, recertification, modification to a current authorization, or extension of benefits.
DATE(S) OF SERVICE REQUESTED:	Enter the requested date(s) of service.
PATIENT INFORMATION:	Enter the beneficiary's full name (Last, First, MI), ten-digit (10-digit) Medicaid ID number, mailing address, date of birth (MM/DD/YYYY), and sex (male or female).
PROVIDER INFORMATION:	Enter the provider name, address, provider identification number and taxonomy code, telephone number, and contact person.
PHYSICIAN INFORMATION:	Enter the prescribing physician/advanced practice registered nurse's name, provider identification number, and taxonomy code.
PROCEDURE CODES:	List all procedure codes (including any modifier or type of service if applicable) for items ordered that require authorization. (Procedure codes that do not require authorization should not be listed.) Enter the number of units requested and a narrative description for each item ordered.
PERSON SUBMITTING REQUEST:	The person submitting the request must sign and date, verifying the attestation in this section.

SECTION B - TO BE COMPLETED BY THE PHYSICIAN/APRN

EST. LENGTH OF NEED:	Enter the estimated length of need (the length of time the physician expects the patient to require use of the ordered item) by filling in the appropriate number of weeks or months or indicate permanent if the physician expects that the patient will require the item for the duration of his/her life.
EPSDT REFERRAL:	If applicable, indicate if the request is made as the result of an EPSDT referral.
HEIGHT & WEIGHT:	Enter the beneficiary's current height measured in inches and weight measured in pounds.
DIAGNOSIS & ICD CODES:	In the first space, list the diagnosis & ICD code that represents the primary reason for ordering this item. List any additional diagnosis & ICD codes that would further describe the medical need for the item (up to 4 codes).
QUESTION SECTION:	Answer the question by checking the appropriate "YES" or "NO" box.
PRESCRIBING PHYSICIAN/ADVANCED PRACTICE REGISTERED NURSE:	The prescribing physician/advanced practice registered nurse within scope of practice must sign/date in the space indicated. Signature and date stamps are not acceptable.
MEDICAL NECESSITY:	Documentation supporting medical necessity of the requested items must be submitted.

ARKANSAS DEPARTMENT OF HUMAN SERVICES
DIVISION OF MEDICAL SERVICES
REQUEST FOR EXTENSION OF BENEFITS FOR MEDICAL SUPPLIES
FOR MEDICAID BENEFICIARIES UNDER AGE 21

For Office Use Only (1)
Control Number _____

Section A.

Patient's Last Name (2)	First Name (3)	MI (4)	Sex (5) M F	Patient's Medicaid ID No. (6)
Caregiver's Name (7)	Residence (8)		Date of Birth (9)	Social Security Number of Beneficiary (10)

Section B.

HCPCS Code (11)	Requested Units Per Month (12)	Description of Items Requested (13)	Units Approved (14)

Justification for extended benefits and dates of service. (15)

Attach medical records substantiating medical necessity. (16) Diagnosis Code (17) _____ Additional Diagnosis Code (18) _____

Name and address of provider requesting extension of benefits: (19) _____

Provider's Identification Number/Taxonomy code: (20) _____

Provider's Signature: (21) _____ Date (22) _____

Section C.

_____ _____
Signature of Prescribing Physician/Advanced Practice Registered Nurse (23) Date (24)

_____
Prescribing Physician/Advanced Practice Registered Nurse's ID Number/Taxonomy Code (25)

Provider will be notified of approval or denial within 30 working days.

Retain a copy for your file.

Forward the original to:

Division of Medical Services
Utilization Review Section
P.O. Box 1437, Slot S413
Little Rock, AR 72203

DMS-602 (Rev. 09-01-18)

Completion of Request for Extension of Benefits for Medical Supplies for Medicaid Beneficiaries Under Age 21 – Form DMS-602

Utilization Review (UR) staff to complete all "For Office Use Only Sections."

Item 1 - Control Number - TO BE COMPLETED BY UR. This number must be entered on the claim submitted for payment.

Section A - To be completed by provider requesting extension

Item 2 - Beneficiary's Last Name: Enter the beneficiary's last name.
Item 3 - First Name: Enter the beneficiary's first name.
Item 4 - Middle Initial: Enter the beneficiary's middle initial.
Item 5 - Sex: Check (M) for Male – (F) for Female.
Item 6 - Beneficiary's Medicaid ID Number: Enter the beneficiary's ten (10) digit ID number.
Item 7 - Caregiver's Name: Enter the beneficiary's Primary Caregiver's last name, first name and middle initial.
Item 8 - Residence: Enter the beneficiary's residential address. Include the nine (9) digit zip code.
Item 9 - Date of Birth: Enter the beneficiary's month, day and year of birth (MM/DD/CCYY).
Item 10 - Social Security Number: Enter the social security number of the beneficiary.

Section B - To be completed by provider requesting extension

Item 11 - HCPCS Code: Refer to the billing section of the Prosthetics Provider Manual for appropriate code.
Item 12 - Requested Units Per Month: Give the total units requested for month.
Item 13 - Description of Items Requested: Description of items as listed in billing section of the Home Health or Prosthetics Provider Manual.
Item 14 - Units Approved by UR: FOR UR USE ONLY - UR will enter units approved.
Item 15 - Justification for Extended Benefits and Dates of Service: Brief summary of why extension needed and dates of need.
Item 16 - Attach medical records substantiating medical necessity: Brief medical summary from physician substantiating medical necessity.
Item 17 - Diagnosis Code: Enter beneficiary's primary ICD diagnosis code.
Item 18 - Additional Diagnosis Code: Enter beneficiary's secondary ICD diagnosis code if applicable.
Item 19 - Name and Address of Provider Requesting Extension of Benefits: Enter name and address of Medicaid provider requesting the extension of benefits for medical supplies.
Item 20 - Provider's Identification Number/Taxonomy Code: Enter the provider identification number and taxonomy code of the provider requesting the extension of benefits for medical supplies.
Item 21 - Provider's Signature: Enter signature of provider's authorized representative requesting extension of benefits for medical supplies.
Item 22 - Date: Enter the date of signature by the provider.

Section C - To be completed by provider requesting extension

Item 23 - Signature of Prescribing Physician/Advanced Practice Registered Nurse (APRN): To be completed by Prescribing Physician/APRN reviewing the request for extension of benefits.
Item 24 - Date: Enter date signed.
Item 25 - Physician/APRN's ID Number/Taxonomy Code: To be completed by prescribing Physician.

Division of Medical Services

PRESCRIPTION & PRIOR AUTHORIZATION REQUEST FOR MEDICAL EQUIPMENT

EXCLUDING Wheelchairs & Wheelchair Components

SECTION A - TO BE COMPLETED BY THE PROVIDER

☐ INITIAL ☐ RECERT ☐ MODIFICATION ☐ EXT OF BENEFITS	START DATE:
PROVIDER NAME:	PROVIDER MAILING ADDRESS:
PROVIDER IDENTIFICATION #/TAXONOMY CODE:	PROVIDER PHONE & CONTACT PERSON:

BENEFICIARY NAME: (LAST, FIRST, MI)	BENEFICIARY MEDICAID ID #:	
BENEFICIARY MAILING ADDRESS:	DATE of BIRTH:	SEX: ☐ MALE ☐ FEMALE

PRESCRIBING PHYSICIAN/ADVANCED PRACTICE REGISTERED NURSE (APRN):	PROVIDER IDENTIFICATION #/TAXONOMY CODE:

PROCEDURE CODE	MOD 1	MOD 2	TOS	DESCRIPTION OF ITEMS REQUESTED	UNITS REQUESTED

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

PROVIDER SIGNATURE _____ DATE _____

SECTION B - TO BE COMPLETED BY THE PHYSICIAN/APRN

EST. LENGTH OF NEED: _____WKS _____ MONTHS _____PERM	EPSDT REFERRAL: ☐ YES ☐ NO ☐ N/A	CURRENT HEIGHT: INCHES	CURRENT WEIGHT: LBS

DIAGNOSIS & ICD CODE:	DIAGNOSIS & ICD CODE:	DIAGNOSIS & ICD CODE:

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

MEDICAL NECESSITY FOR REQUESTED SERVICES:

PHYSICIAN/ADVANCED PRACTICE REGISTERED NURSE SIGNATURE _____ DATE _____

****A prescription for the requested items MUST be documented above or a separate prescription MUST be submitted. If the above documentation is insufficient to justify the requested items, a letter of medical necessity from either the prescribing physician or advanced practice registered nurse WILL be required.**

Please retain a copy of this form in your files.

Send completed form to:

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

PO Box 180001

Fort Smith, AR 72918-0001

Instructions for Completion of Prior Authorization Request for Medical Equipment Form

SECTION A - TO BE COMPLETED BY THE PROVIDER

REVIEW TYPE:	Indicate the type of prior authorization request: initial, recertification, modification to a current authorization, or extension of benefits.
DATE(S) OF SERVICE REQUESTED:	Enter the requested date(s) of service.
PROVIDER INFORMATION:	Enter the provider name, address, provider identification number and taxonomy code, telephone number, and contact person.
PATIENT INFORMATION:	Enter the beneficiary's full name (Last, First, MI), ten-(10) digit Medicaid ID number, mailing address, date of birth (MM/DD/YYYY), and sex (male or female).
PHYSICIAN/APRN INFORMATION:	Enter the prescribing physician/advanced practice registered nurse's name, provider identification number, and taxonomy code.
PROCEDURE CODES:	List all procedure codes (including any modifier or type of service if applicable) for items ordered that require authorization. (Procedure codes that do not require authorization should not be listed.) Enter the number of units requested and a narrative description for each item ordered.
PERSON SUBMITTING REQUEST:	The person submitting the request must sign and date, verifying the attestation in this section.

SECTION B - TO BE COMPLETED BY THE PHYSICIAN/APRN

EST. LENGTH OF NEED:	Enter the estimated length of need (the length of time the physician/APRN expects the patient to require use of the ordered item) by filling in the appropriate number of weeks or months or indicate permanent if the physician/APRN expects that the patient will require the item for the duration of his/her life.
EPSDT REFERRAL:	If applicable, indicate if the request is being made as the result of an EPSDT referral.
HEIGHT & WEIGHT:	Enter the beneficiary's current height measured in inches and weight measured in pounds.
DIAGNOSIS & ICD CODES:	In the first space, list the diagnosis & ICD code that represents the primary reason for ordering this item. List any additional diagnosis & ICD codes that would further describe the medical need for the item (up to 3 codes).
QUESTION SECTION:	Answer the question by checking the appropriate "YES" or "NO" box.
MEDICAL NECESSITY:	The physician/APRN within scope of practice must document medical necessity for the requested services and sign/date in the space indicated. Signature and date stamps are not acceptable.
****PRESCRIPTION:**	A written prescription MUST be submitted with all requests. This can be documented on the request form or a separate prescription may be attached.
****LETTER OF MEDICAL NECESSITY:**	If the information provided on the request form is insufficient to justify the requested items, a letter of medical necessity from the prescribing physician/APRN WILL be required.