|  |  |
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| section ii - CHILD HEALTH MANAGEMENT SERVICESContents |  |

[200.000 CHILD HEALTH MANAGEMENT SERVICES program GENERAL INFORMATION](#_Toc497490770)

[201.000 Arkansas Medicaid Participation Requirements for Child Health Management Services (CHMS) Providers](#_Toc497490771)

[201.100 CHMS Certification Requirement Reviews: Arkansas Department of Health , Office of Quality Assurance and Arkansas Foundation for Medical Care, Inc.](#_Toc497490772)

[201.110 CHMS Corrective Action Plan (CAP)](#_Toc497490773)

[201.120 Certification Appeal Process](#_Toc497490774)

[201.200 CHMS Licensing Requirement Reviews and Appeal Process: Division of Child Care and Early Childhood Education, Child Care Licensing Unit](#_Toc497490775)

[202.000 Arkansas Medicaid Participation Requirements for Providers of Comprehensive Health Assessments for Foster Children](#_Toc497490776)

[203.000 Documentation Required of All Medicaid Providers](#_Toc497490777)

[203.100 Required CHMS Medical/Clinical Records](#_Toc497490778)

[203.200 Electronic Signatures](#_Toc497490779)

[204.000 The Child Health Management Services (CHMS) Provider’s Role in the Child Health Services (EPSDT) Program](#_Toc497490780)

[205.000 Referral to First Connections Program Pursuant to Part C of the Individuals with Disabilities Education Act (IDEA)](#_Toc497490781)

[206.000 Election to Provide Special Education Services in Accordance with Part B of the Individuals with Disabilities Education Act (IDEA)](#_Toc497490782)

[210.000 PROGRAM COVERAGE](#_Toc497490783)

[211.000 Introduction](#_Toc497490784)

[212.000 Scope](#_Toc497490785)

[212.100 Child Health Management Services](#_Toc497490786)

[212.200 CHMS Service Delivery Professionals](#_Toc497490787)

[212.300 Supervising Physician Requirements and Duties](#_Toc497490788)

[212.400 Other Personnel Requirements and Duties](#_Toc497490789)

[213.000 Definitions](#_Toc497490790)

[213.100 Definitions of Service Components](#_Toc497490791)

[213.200 Definitions of Staff](#_Toc497490792)

[214.000 Staff Records/Credentialing](#_Toc497490793)

[214.100 Record Requirements for Full-time Employees](#_Toc497490794)

[214.200 Record Requirements for Part-time Employees](#_Toc497490795)

[215.000 General Standards](#_Toc497490796)

[216.000 Service Settings](#_Toc497490797)

[216.100 Physical Facility Requirements](#_Toc497490798)

[217.000 Establishing Need for CHMS Services](#_Toc497490799)

[217.100 Definition of Developmental Diagnosis](#_Toc497490800)

[217.200 Cognition Testing](#_Toc497490801)

[218.000 Groupings of Services](#_Toc497490802)

[218.200 Individual Treatment Planning](#_Toc497490803)

[218.300 Day Treatment Services](#_Toc497490804)

[218.400 Transition/Follow-Up](#_Toc497490805)

[219.000 Evaluation of Clinical Care/Internal Quality Assurance](#_Toc497490806)

[219.100 Individual Case Review](#_Toc497490807)

[219.200 Clinical Care Evaluation](#_Toc497490808)

[220.000 Benefit Limits](#_Toc497490809)

[221.000 Referral Process for Non-Child Health Management Services](#_Toc497490810)

[222.000 Inspection of Care](#_Toc497490811)

[240.000 PRIOR AUTHORIZATION FOR Child health management SERVICES](#_Toc497490812)

[241.000 Intake Process](#_Toc497490813)

[242.000 Prior Authorization Request to Determine and Verify the Patient’s Need for Child Health Management Services](#_Toc497490814)

[243.000 Mechanisms for Record Transfer and Reporting](#_Toc497490815)

[244.000 Flow Chart of Intake and Prior Authorization Process for Intervention/Treatment](#_Toc497490816)

[245.000 Guidelines for Retrospective Review of Occupational, Physical and Speech Therapy Services](#_Toc497490817)

[245.100 Occupational and Physical Therapy Guidelines](#_Toc497490818)

[245.110 Accepted Tests for Occupational Therapy](#_Toc497490819)

[245.120 Accepted Tests for Physical Therapy](#_Toc497490820)

[245.200 Speech-Language Therapy Guidelines](#_Toc497490821)

[245.210 Accepted Tests for Speech-Language Therapy](#_Toc497490822)

[245.220 Intelligence Quotient (IQ) Testing](#_Toc497490823)

[245.300 Recoupment Process](#_Toc497490824)

[246.000 Appeal Process for Medicaid Beneficiaries](#_Toc497490825)

[250.000 REIMBURSEMENT](#_Toc497490826)

[251.000 Method of Reimbursement](#_Toc497490827)

[251.010 Fee Schedules](#_Toc497490828)

[252.000 Rate Appeal Process](#_Toc497490829)

[260.000 BILLING PROCEDURES](#_Toc497490830)

[261.000 Introduction to Billing](#_Toc497490831)

[262.000 CMS-1500 Billing Procedures](#_Toc497490832)

[262.100 Child Health Management Services Procedure Codes](#_Toc497490833)

[262.110 Diagnosis and Evaluation Procedure Codes](#_Toc497490834)

[262.120 Treatment Procedure Codes](#_Toc497490835)

[262.130 CHMS Procedure Codes – Foster Care Program](#_Toc497490836)

[262.200 National Place of Service (POS) Codes](#_Toc497490837)

[262.300 Billing Instructions – Paper Only](#_Toc497490838)

[262.310 Completion of CMS-1500 Claim Form](#_Toc497490839)

[262.400 Special Billing Procedures](#_Toc497490840)

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| 200.000 CHILD HEALTH MANAGEMENT SERVICES program GENERAL INFORMATION |  |
| 201.000 Arkansas Medicaid Participation Requirements for Child Health Management Services (CHMS) Providers | 10-1-17 |

Child Health Management Services (CHMS) providers must meet the Provider Participation and enrollment requirements contained within Section 140.000 of this manual as well as the following criteria to be eligible to participate in the Arkansas Medicaid Program:

A. CHMS must be provided by an organization that is certified by the Arkansas Medicaid Quality Improvement Organization (QIO) to be in full compliance with one of the two conditions described below:

1. An academic medical center program specializing in Developmental Pediatrics that is administratively staffed and operated by an academic medical center and under the direction of a boarded or board-eligible developmental pediatrician. An academic medical center consists of a medical school and its primary teaching hospitals and clinical programs. In order to be eligible for CHMS reimbursement, the academic medical center must:

a. Be located in the state of Arkansas;

b. Provide multi-disciplinary diagnostic, evaluation and treatment services to children throughout Arkansas;

c. Serve as a large multi-referral program as well as a referral source for other non-academic CHMS providers with the state and

d. Be staffed to provide training of pediatric residents and other professionals in the multi-disciplinary diagnostics, evaluation and treatment of children with special health care needs.

 For an academic medical center CHMS program, services may be provided at different sites operated by the academic medical center as long as the CHMS program falls under one administrative structure within the academic medical center.

**OR**

2. A program housed under one roof and one administrative structure.

B. An organization seeking to provide CHMS must complete a certification and licensure process for each CHMS service delivery site. A certification or a license is not transferable from one holder to another or from one location to another.

 A request for certification/licensure must be directed in writing to each of the following organizations:

1. The Arkansas Department of Health (certification). [View or print the Department of Health contact information.](../../Links/ADH.doc)

2. The Arkansas Medicaid Quality Improvement Organization (certification). [View or print QIO contact information](../../Links/AFMC.doc).

3. The Arkansas Department of Human Services, Division of Child Care and Early Childhood Education, Child Care Licensing Unit (licensure). [View or print the Arkansas Department of Human Services, Division of Child Care and Early Childhood Education, Child Care Licensing Unit contact information.](../../Links/DCCECELicUnit.doc)

C. The provider application and Medicaid contract must have accompanying copies of:

1. Current certification from the Department of Health

2. Current certification from the QIO and

3. Verification of current Child Care Center licensure from the Division of Child Care and Early Childhood Education.

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| 201.100 CHMS Certification Requirement Reviews: Arkansas Department of Health , Office of Quality Assurance and Arkansas Foundation for Medical Care, Inc. | 10-1-17 |

The Department of Health or its designees shall conduct an annual CHMS Certification Review to substantiate continued compliance with these regulations and standards.

A formal report, listing any cited deficiencies, shall be forwarded by the reviewer to the CHMS clinic within fifteen (15) working days of the certification review.

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| 201.110 CHMS Corrective Action Plan (CAP) | 8-1-05 |

The CHMS clinic shall have thirty (30) calendar days from the receipt date of the report to develop and submit a written corrective action plan to remedy the deficiencies noted in the certification review report. The clinic may formally request an extension of up to thirty (30) days by submitting sufficient written justification to the Department of Health and Human Services or its designee, as appropriate, within the first thirty (30) day time frame.

Within five (5) working days of receipt of the plan the reviewing entity shall inform the CHMS clinic in writing of any recommended modification to the corrective action plan. The notification shall include a time frame for the CHMS clinic to respond to a request for CAP modification.

Failure to file a corrective action plan and/or subsequent revisions to the plan within the required time frames shall result in the CHMS clinic being placed in a non-certified status. Written notice of non-certification will be forwarded to the CHMS clinic and the Arkansas Medicaid Provider Enrollment Unit. **Enrollment in the Arkansas Medicaid Child Health Management Program is contingent upon the CHMS clinic’s certification status.** Clinics holding a non-certification status are not eligible to receive reimbursement from the Arkansas Medicaid Program. A clinic’s non-certification status will remain in effect until the clinic is found to be in compliance with the certification requirements.

The Director of the Division of Medical Services will be apprised of the site visit results. The Director must approve or disapprove recommendations for renewal or non-renewal of certification.

All certification review reports, corrective action plans and progress reports will be filed with and maintained by the Department of Health and Human Services or its designees.

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| 201.120 Certification Appeal Process | 10-13-03 |

The CHMS clinic may appeal any cited deficiency or assigned timetable for corrective action resulting from a CHMS certification review.

The Division of Medical Services shall be responsible for the appeals process for CHMS clinics.

The clinic must submit a written request for appeal to the Division of Medical Services Director within thirty (30) days of receiving the formal written report of deficiencies. [View or print the Division of Medical Services Director contact information.](../../Links/DMSDirector.doc) The clinic must specify which deficiencies and/or time frames are being appealed and clearly demonstrate why the cited deficiencies are incorrect or the assigned time frames for correction are unreasonable.

Within ten (10) working days of receipt of the appeal request, a three (3) person committee will be appointed by the Division of Medical Services to review the site report, documentation supporting the certification reviewer’s recommendations and the appeal information submitted by the CHMS clinic. The committee may request additional documentation if necessary.

The committee will submit a written report of its finding to the Division of Medical Services Director, within ten (10) working days from the date the appeal request is received.

The final decision of the appeal rests with the Director. The CHMS clinic will be notified in writing of the Director’s decision within five (5) working days of the receipt of the committee’s report.

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| 201.200 CHMS Licensing Requirement Reviews and Appeal Process: Division of Child Care and Early Childhood Education, Child Care Licensing Unit | 8-1-05 |

The “Child Care Facility Licensing Act” Ark. Code Annotated §20-78-201-220, as amended, authorizes the Department of Health and Human Services, Division of Child Care and Early Childhood Education to establish rules and regulations governing the granting, denial, suspension and revocation of the licenses for child care facilities and their operation in Arkansas. Section 102, **Licensing Procedures**, of the *Minimum Licensing Requirements for Child Care Center*s manual, outlines the process for licensure and for maintaining licensed status. The process for licensing reviews, deficiency reports, corrective action plans and hearings and appeals administered by the Division of Child Care and Early Childhood Education shall be followed.

**Enrollment in the Arkansas Medicaid CHMS Program is contingent upon the CHMS clinic’s licensure status.**

The Director of the Division of Medical Services will be apprised of the site visit results. All certification review reports, corrective action plans and progress reports will be filed with and maintained by the Department of Health and Human Services, Division of Child Care and Early Childhood Education.

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| 202.000 Arkansas Medicaid Participation Requirements for Providers of Comprehensive Health Assessments for Foster Children | 8-1-05 |

Providers of comprehensive health assessments for foster children must meet the following criteria in order to be eligible to participate in the Arkansas Medicaid Program:

A. An organization seeking to provide comprehensive health assessments for foster children must be certified by the Division of Children and Family Services (DCFS). The request for certification should be directed in writing to the Department of Health and Human Services, Division of Children and Family Services, Contracts Management Unit. [View or print the Contracts Management Unit contact information.](../../Links/DCFSContractsMgt.doc)

B. A provider of comprehensive health assessments for foster children must complete and submit to the Medicaid Provider Enrollment Unit a provider application (form DMS-652), a Medicaid contract (form DMS-653) and a Request for Taxpayer Identification Number and Certification (Form W-9). A copy of the certification as a provider of comprehensive health assessments for foster children must accompany the application and contract. [View or print a provider application (DMS-652), a Medicaid contract (DMS-653) and a Request for Taxpayer Identification Number and Certification (Form W-9).](../../Forms/ApplicationPacket.doc)

The Arkansas Medicaid Program must approve the provider application and the Medicaid contract.

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| 203.000 Documentation Required of All Medicaid Providers | 10-15-09 |

Documentation and provider participation requirements are detailed within Section 140.000, Provider Participation, of this manual.

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| 203.100 Required CHMS Medical/Clinical Records | 10-1-17 |

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

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

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

C. For CHMS Diagnosis/Evaluation Services:

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

1. Identifying data and demographic information

2. Consent for service and release of information forms required by law or local policy

3. Referral source(s) as documented by a PCP referral

4. Reason(s) for referral as documented on the PCP referral

5. Results of the annual developmental screen performed by the Department of Human Services’ Third Party Vendor, or an approved medical diagnosis exemption of the developmental screen, in accordance with the Provider Manual Governing Independent Assessments and Developmental Screens that shows diagnostic/evaluation services are needed.

 If the physician or CHMS provider believes that the child has a significant developmental diagnosis, disability, or delay such that he or she does not need a developmental screen, the physician or CHMS provider may send relevant documentation for review by the Third Party Vendor’s clinician. The Third Party Vendor’s Clinician will determine the necessity of a developmental screen.

6. Content and results of all diagnostic work-ups and/or problem assessments, including the source documents, e.g., social history, test protocols, mental status examination, history of complaints, etc.

7. Treatment plan signed by a CHMS clinic physician

8. Medication record of all prescribed and/or administered medications

9. Progress notes and/or other documentation of:

a. Treatment received

b. Referral for treatment

c. Changes in the patient’s situation or condition

d. Significant events in the patient’s life relevant to treatment

e. Response to treatment

10. Submittal of prior authorization request (including intervention/treatment needed) to CHMS prior authorization contractor when appropriate.

D. For CHMS Day Treatment Services:

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

1. Documentation of completion of intake process.

2. Documentation of interdisciplinary evaluation to address presenting diagnosis and establish base line of functioning and subsequent submission of prior authorization request.

3. Physician’s prescription, form DMS-201, signed treatment plan and 6 month records review completed and signed by a CHMS physician.

4. PCP initial referral and 6 month pediatric day treatment referral.

5. Daily treatment records documenting services provided, relation of service to treatment plan and level of completion of treatment goal. Services must be provided in accordance with the treatment plan, with clear documentation of the services rendered.

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

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

6. Weekly progress notes that document the progress toward the goals and objectives lined out in the treatment plan.

7. Revisions of treatment plan including treatment goals will be documented at a minimum of each six months, or more often if warranted by the patient’s progress or lack of progress.

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| 203.200 Electronic Signatures | 10-8-10 |

Medicaid will accept electronic signatures provided the electronic signatures comply with Arkansas Code § 25-31-103 et seq.

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

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

The Arkansas Medical Assistance Program operates under a primary care case management (PCCM) system. A primary care physician (PCP) referral is required for all services not performed by the PCP, including an EPSDT Screen. A CHMS provider who is also a Child Health Services provider may perform an EPSDT Screen, with a PCP referral. The screen must be allowable within the periodicity schedule. However, if the EPSDT Screen is medically necessary but non-allowable due to the periodicity schedule it still may be performed with a PCP referral.

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

CHMS providers interested in enrolling in the Child Health Services (EPSDT) Program should contact the Central Child Health Services Office. [View or print the Central Child Health Services Office contact information.](../../Links/CentralCHS.doc)

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

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| 205.000 Referral to First Connections Program Pursuant to Part C of the Individuals with Disabilities Education Act (IDEA) | 10-1-17 |

DDS is the lead agency responsible for the general administration and supervision of the programs and activities utilized to carry out the provisions of Part C of the IDEA. First Connections is the DDS program in Arkansas that administers, monitors, and carries out all Part C of IDEA activities and responsibilities for the state. The First Connections program ensures that appropriate early intervention services are available to all infants and toddlers from birth to thirty-six (36) months of age (and their families) that are suspected of having a developmental delay.

Each CHMS must, within two (2) working days of receipt of referral of an infant or toddler thirty-six (36) months of age or younger, present the family with DDS-approved information about the Part C program, First Connections, so that the parent/guardian can make an informed choice regarding early intervention options. Each CHMS must maintain appropriate documentation of parent choice in the child record.

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| 206.000 Election to Provide Special Education Services in Accordance with Part B of the Individuals with Disabilities Education Act (IDEA) | 10-1-17 |

Local Education Agencies (LEA) have the responsibility to ensure that children, ages three (3) until entry into kindergarten, who have or are suspected of having a disability under Part B of IDEA (Part B), receive a Free Appropriate Public Education. The Arkansas Department of Education provides each CHMS with the option of participating in Part B as a LEA. Participation as a LEA requires a CHMS to provide special education and related services in accordance with Part B (Special Education Services) to all children with disabilities it is serving aged three (3) until entry into Kindergarten. A participating CHMS is also eligible to receive a portion of the federal grant funds made available to LEAs under Part B in any given fiscal year.

Each CHMS must therefore make an affirmative election to either provide or not provide Special Education Services to all children with disabilities it is serving aged three (3) until entry into kindergarten as follows:

A. Opt-in: A CHMS that elects to provide Special Education Services to all children with disabilities it is serving aged three (3) until entry into Kindergarten must follow Arkansas Department of Education Procedural Requirements and Program Standards for Special Education and comply with Part B at all times. Failure by a CHMS to provide all required Special Education Services in compliance with the above will result in a loss of Part B funds.

B. Opt-out: A CHMS that elects not to provide Special Education Services to all children with disabilities it is serving aged three (3) until entry into kindergarten must perform the following:

1. Prior to delivering any services to a child age three (3) or older who has or is suspected of having a disability under Part B, the CHMS must complete a Special Education Referral Form (or any successor form), and submit it to the appropriate LEA. The CHMS will be responsible for maintaining documentation evidencing that a timely and properly completed referral was provided to the appropriate LEA.

2. The CHMS must complete a Special Education Referral Form (or any successor form), and submit it to the appropriate LEA at least ninety (90) days prior to the third (3rd) birthday of any child who has or may have a disability under Part B that is being served by the CHMS. The CHMS will be responsible for maintaining documentation evidencing that a timely and properly completed referral was provided to the appropriate LEA.

3. For any child who has a disability under Part B served by the CHMS that will be entering kindergarten in a calendar year, the CHMS must complete a referral form and submit it to the LEA where the child will attend kindergarten by February 1 of that year. The CHMS will be responsible for maintaining documentation evidencing that a timely and properly completed referral was provided to the appropriate LEA.

A CHMS may change its election at any time; however, a decision to change will only be effective as of July 1st. A CHMS must inform DDS of its intent to change its election no later than March 1st for its election to be effective as of July 1st of the same calendar year. Any decision to change an election received by DDS after March 1st will not be effective until July 1st of the next calendar year. Any time a CHMS elects to cease providing Special Education Services, the CHMS must complete a Special Education Referral Form (or any successor form) for each child age three (3) or older it is currently serving, and submit each one to the appropriate LEA.

[View or print the Arkansas Department of Education Special Education contact information.](../../Links/ADESpecialEd.doc)

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| 210.000 PROGRAM COVERAGE |  |
| 211.000 Introduction | 10-1-17 |

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

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| 212.000 Scope | 1-1-07 |

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

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

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

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| 212.100 Child Health Management Services | 10-1-17 |

Services are limited to the following components:

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| Audiology | Neuropsychology | Psychological |
| Behavior | Nutrition | Social work |
| Day Treatment Services | Occupational/Physical Therapy | Speech/Language Pathology |
| Medical (to include nursing) | Psychiatry | Therapy |

Services are outpatient only and are available to eligible Medicaid patients under age 21. The CHMS provider will provide services in one or more of the above components. The CHMS provider will bill only for those services that are medically necessary. Prior authorization is required to admit a child into Child Health Management Services. See Section 240.000 of this manual for prior authorization procedures.

All services provided to a child must be included in an individual treatment plan signed by the CHMS pediatrician and include follow-up to ensure treatment has been done. (See Section 218.200.)

The CHMS clinic must establish a patient referral system within the clinic, to hospitals and other health care providers. (See Section 221.000).

Beneficiaries that are enrolled in a program that is dually certified as a DDTCS and CHMS cannot be billed under both programs during the same enrollment period. An enrollment period is defined as the twelve (12) months of allowed billing after the developmental screen is administered and a prescription is written for CHMS or DDTCS services for the beneficiary.

Beneficiaries that continue to qualify for either DDTCS or CHMS during the enrollment period can transfer to another CHMS or DDTCS program based on parent choice. These beneficiaries do not have to undergo another developmental screen.

Beneficiaries that graduate or no longer qualify for DDTCS or CHMS before the end of the enrollment period must be referred to the third party vendor for a developmental screen and obtain a new prescription before they can be reenrolled in a DDTCS or CHMS program.

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| 212.200 CHMS Service Delivery Professionals | 8-15-08 |

CHMS service delivery professionals must include the following:

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| Audiologist | Neuropsychologist | Psychological Examiner |
| Child and Adolescent Psychiatrist | Nutritionist | Registered Nurse |
| Developmental Pediatrician | Occupational Therapist | Social Worker |
| Early Childhood Developmental Specialist | Pediatric Psychologist | Speech/Language Pathologist |
| Licensed Counselor | Physical Therapist |  |

Services of a pediatric registered nurse practitioner and a licensed practical nurse are not required but may be used for activities within the scope of practice under state license. All personnel shall be licensed or certified to perform the services they render when such services require licensure or certification under the laws of the State of Arkansas.

The CHMS clinic shall develop written policies and job descriptions which clearly document the authority, responsibility and function of each staff member.

Effective for dates of service on and after October 1, 2008, when a CHMS clinic files a claim with Arkansas Medicaid, the clinic staff member who actually performed the service on behalf of the clinic must be identified on the claim as the performing provider. CHMS staff members who are eligible to enroll in the Arkansas Medicaid program have the option of either enrolling or requesting a Practitioner Identification Number ([View or print form DMS-7708](../../Forms/DMS-7708.doc)) so that they can be identified on claims. For example, an LCSW may choose to enroll in the Licensed Mental Health Practitioners program or choose to obtain a Practitioner Identification Number.

This action is taken in compliance with the federal Improper Payments Information Act of 2002 (IPIA), Public Law 107-300 and the resulting Payment Error Rate Measurement (PERM) program initiated by the Centers for Medicare and Medicaid Services (CMS).

Certain types of practitioners who perform services on behalf of a CHMS clinic are not allowed to enroll in the Arkansas Medicaid program. These practitioners must request a Practitioner Identification Number so that they can be identified on claims:

* Nutritionists
* Early Childhood Developmental Specialists
* Registered Nurses
* Licensed Practical Nurses

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| 212.300 Supervising Physician Requirements and Duties | 1-1-07 |

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

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

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

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

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| 212.400 Other Personnel Requirements and Duties | 10-13-03 |

A physician or registered nurse must be present in the CHMS clinic at any time specialized medical services occur. Medications must be administered only by licensed medical personnel.

Nursing services shall be provided only by licensed registered nurses; with the exception of nursing services that may be furnished by a certified physician’s assistant under the supervision, control and responsibility of a licensed physician. Other CHMS personnel may provide care required in the course of a day long program that would be performed by the parent if the child were home.

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| 213.000 Definitions | 10-1-17 |

A. CHMS Clinic

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

B. Clinic Services

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

1. Provided to outpatients;

2. Furnished at the clinic by or under the direction of a physician and

3. Provided at the clinic by a facility that is not a part of a hospital but is organized and operated to provide medical care (42 Code of Federal Regulations 440.90.)

C. Department

 The Arkansas Department of Human Services and its designated representatives.

D. Provider Organization

 The entity responsible for the operation of a CHMS clinic.

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| 213.100 Definitions of Service Components | 10-1-17 |

A. Audiology

 Assessment of hearing problems or other chronic ear problems.

B. Behavior

 Provision of counseling and therapy for behavior related problems identified by psychological, social and developmental medical evaluations.

C. Day Treatment Services

 Assessment, treatment planning and provision of an integrated developmentally based program of services to strengthen and enhance appropriate developmental outcomes.

D. Medical

 A complete medical evaluation that will identify developmental problems and/or coexisting medical problems and provide a plan of treatment or referral for the remediation or management of medical problems.

E. Neuropsychology

 Psychological testing in such areas as intelligence, achievement, emotional/behavioral, academic and social development; assessment of visual motor integration skills and adaptive behavior; assessment of psychomotor speed and strength, memory executive functioning including attention, problem solving and mental flexibility, verbal fluency and word finding.

F. Nutrition

 Assessment of a child’s nutritional deficiencies or special needs to include a plan of treatment to prevent, improve or resolve a developmental or other medical condition.

G. Occupational/Physical Therapy

 Evaluation, therapy and programming recommendations for motor dysfunction patients; coordination with medical and speech pathology assessments to maximize muscle function and coordination.

H. Psychiatry

 Psychiatric evaluation that will identify psychological and/or behavioral problems and provide a plan of treatment or referral to appropriate treatment. Provision of counseling and therapy may be included.

I. Psychology

 Psychological testing/assessment in such areas as development, intelligence, achievement, emotional, behavioral, academic and social development and assessment of visual motor integration skills and adaptive behavior.

J. Social Work

 Assessment of social/emotional risks or problems through the gathering of information from patient, family and others related to the treatment planning of the patient. A social history is used to describe all pertinent facts including assessment of family dynamics and need for intervention by CHMS staff.

K. Speech and Language Pathology

 Assessment of language development, oral-motor functions, articulation problems, strengths and weaknesses in auditory processing capabilities and the provision of therapy for problems identified.

L. Therapy

 Provision of counseling and therapy for problems identified by psychological, social and medical evaluations.

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| 213.200 Definitions of Staff | 10-1-17 |

A. Early Childhood Development Specialist (ECDS)

 This professional must possess at a minimum a Bachelor’s Degree plus one of the following:

1. Current Arkansas state certification in Early Childhood Special Education

**or**

2. A current Child Development Associate Certificate

**or**

3. 12 hours of completed college courses in one of the following areas—early childhood, child development, special education/elementary education or child and family studies and documented experience in working with children with special needs.

There must be one (1) ECDS for every fifty (50) beneficiaries enrolled at a CHMS site.

B. Licensed Practical Nurse

 Licensed in the State of Arkansas as a practical nurse.

C. Neuropsychologist

 Licensed in the State of Arkansas as a Psychologist (Ph.D. or PsyD) and has completed postdoctoral training in neuropsychology (including neurophysiology, clinical neuropsychology and neuropsychological assessment).

D. Nutritionist/Dietitian

 Dietitian licensed or registered by the State of Arkansas who has special training in the nutritional needs of children.

E. Pediatric Nurse Practitioner

 Licensed in the State of Arkansas as a registered nurse practitioner or advanced practice nurse with documented expertise in pediatrics.

F. Physician

 Licensed in the State of Arkansas to practice surgery and/or medicine and has documentable skills in the required CHMS specified subspecialty area.

G. Psychiatrist

 Licensed in the State of Arkansas and completed an accepted residency in child and adolescent psychiatry.

H. Psychological Examiner

 Licensed in the State of Arkansas as a psychological examiner.

I. Psychologist

 Licensed in the State of Arkansas to provide evaluation, screening and therapeutic services.

J. Registered Nurse

 Licensed in the State of Arkansas as a registered nurse.

K. Social Worker

 Licensed in the State of Arkansas as an LSW, LCSW holding, at a minimum, a B.A. in Social Work or a Master’s Degree in Social Work.

L. Related Professionals

 Speech therapist, physical therapist, licensed counselor and occupational therapist, etc. shall be considered as professional clinical personnel provided that they meet the requirements for registration or licensing in their respective professions within the State of Arkansas.

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| 214.000 Staff Records/Credentialing | 10-13-03 |

The CHMS clinic must maintain accurate and complete records for all employees and other health professionals who provide services at the clinic.

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| 214.100 Record Requirements for Full-time Employees | 10-13-03 |

Records for full-time employees shall, at a minimum, contain:

A. An initial resume and any other background information needed to justify the initial and/or continuing employment of an individual;

B. For an individual whose position requires licensure, documentation that the individual has or has applied for, within the time period and under the conditions prescribed by the appropriate licensing board, a current valid license;

C. Documentation verifying academic records and references required by the job description and

D. Current information relevant to work performance.

E. For those individuals who have direct patient contact, criteria set forth in Section 107 of Arkansas Minimum Licensing Requirements for Child Care Centers manual must be followed. Child abuse registry and criminal records checks must be obtained in a timely fashion and eligibility for hire restrictions as listed in 107.3 of Arkansas Minimum Licensing Requirements for Child Care Centers manual will be used.

R. Also, documentation of completion of continuing education hours (as required by specific licensing standards) that relate to the responsibilities and functions of the individuals’ position shall be maintained.

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| 214.200 Record Requirements for Part-time Employees | 10-13-03 |

Records for part-time employees must, at a minimum, contain:

A. An initial resume;

B. Verification of references and

C. A current valid license or application for licensure, if appropriate.

D. For those individuals who have direct patient contact, criteria set forth in Section 107 of Arkansas Minimum Licensing Requirements for Child Care Centers must be followed. Child abuse registry and criminal records checks must be obtained in a timely fashion and eligibility for hire restrictions as listed in 107.3 will be used.

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| 215.000 General Standards | 10-1-17 |

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

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

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

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

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

 Specifically, in the classroom setting, the following staff-to-beneficiary ratios\*\* must be observed:

1. For children 0-3 years: one (1) staff for every four (4) beneficiaries

2. For children 3-6 years: one (1) staff for every seven (7) beneficiaries

3. For children six (6) and up: one (1) staff for every then (10) beneficiaries.

\*\*These ratios will become effective on July 1, 2018.

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

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

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

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

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

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

K. Patient Rights

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

1. Non-discrimination in treatment as provided in Title VI of the Civil Rights Act of 1964; as amended; Section 504 of the Rehabilitation Act of 1973, as amended and the Americans with Disabilities Act of 1990;

2. Assignment to treatment solely on the basis of clinical need;

3. Maintenance of the confidentiality of clinical information;

4. Receipt of treatment in an atmosphere that enhances the dignity, self-respect and individuality of each patient;

5. Provisions to safeguard against hazardous treatment and against any risk entailed as a result of informed consent participation in research conducted in the CHMS clinic;

6. Maintenance of the right to communicate with family, friends, legal representatives and significant others and

7. Assurances that these rights are communicated to the patient prior to receipt of services.

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| 216.000 Service Settings | 10-13-03 |

Child Health Management Services are typically provided in either of two settings. The first is a multi-disciplinary clinical setting, where diagnostic services and/or treatment for individual children/families are provided. The second is a pediatric day program/intervention setting where many children are treated on a daily basis. Diagnostic services, though infrequently provided in this setting, will be provided as needed to serve the purpose of the developmental treatment planning for the children attending the center.

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| 216.100 Physical Facility Requirements | 10-13-03 |

The CHMS clinic administration shall be responsible for providing physical facilities that, at a minimum:

A. Are structurally sound and meet all applicable federal, state and local regulations for adequacy of construction, safety, sanitation and health;

B. Are conducive to effective patient care and comply with the appropriate state and local building fire safety and zoning codes;

C. Have separate areas that are functionally appropriate for providing patient privacy;

D. Meet the requirements of the service element involved for space and accessories, e.g., storage space, electrical outlets, etc.;

E. Are in compliance with Section 504 of the Rehabilitation Act of 1973, as amended and the Americans with Disabilities Act of 1990 with consideration for safety and age appropriateness for patients;

F. Are easily accessible for patients and staff and

G. Meet the same facility guidelines required for licensed childcare centers, in CHMS facilities where daily treatment programs are provided for pre-school children.

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| 217.000 Establishing Need for CHMS Services | 10-1-17 |

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

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

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

Child Health Management Services are delivered to those children with the most significant medical and/or developmental diagnoses and those presenting with multiple/complex conditions. These children may require one of the following services:

A. Frequent nursing services

B. Close physician monitoring (availability for consultation in addition to frequent face-to-face contact)

C. Special nutritional services requiring consultation with parents and staff and/or possible special menu planning and adapted feeding regimen

D. Constant coordination of care (in communication with the PCP) within the interdisciplinary team to maximize provision of individual services and appropriate therapy services

E. Additional family contact for education and support

F. Therapy services from more than one discipline (occupational, physical, speech)

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| 217.100 Definition of Developmental Diagnosis | 10-1-17 |

A. A developmental disability:

1. Is attributable to intellectual disability, cerebral palsy, spina bifida, Down syndrome, epilepsy or autism spectrum disorder.

a. Intellectual Disability – As established by scores of intelligence which fall two or more standard deviations below the mean of a standardized test of intelligence administered by a legally qualified professional; Infants/Preschool, 0-5 years - developmental scales, administered by qualified personnel authorized in the manual accompanying the instrument used, which indicate impairment of general functioning similar to that of developmentally disabled persons;

b. Cerebral Palsy – As established by the results of a medical examination provided by a licensed physician;

c. Spina Bifida – As established by the results of a medical examination provided by a licensed physician.

d. Down Syndrome – As established by the diagnosis of a licensed physician.

e. Epilepsy – As established by the results of a neurological and/or licensed physician;

f. Autism Spectrum Disorder – As established by the results of a team evaluation including at least a licensed physician and a licensed psychologist and a licensed Speech Pathologist;

 NOTE: Each of these six conditions is sufficient for determination of eligibility independent of each other. This means that a person who is intellectually disabled does not have to have a diagnosis of autism spectrum disorder, epilepsy, spina bifida, down syndrome, or cerebral palsy. Conversely, a person who has autism spectrum disorder, cerebral palsy, epilepsy, spina bifida, or Down syndrome does not have to have an intellectual disability to receive services.

2. Is attributable to any other condition of a person found to be closely related to intellectual disability because it results in impairment of general intellectual functioning or adaptive behavior similar to those of persons with intellectual disability or requires treatment and services similar to those required for such persons. This determination must be based on the results of a team evaluation including at least a licensed Physician and a licensed Psychologist.

a. In the case of individuals being evaluated for service, eligibility determination shall be based upon establishment of intelligence scores which fall two or more standard deviations below the mean of a standardized test of intelligence OR, is attributable to any other condition found to be closely related to an intellectual disability because it results in impairment of general intellectual functioning or adaptive behavior similar to those of persons with an intellectual disability, or requires treatment and services similar to those required for such persons.

b. Persons age 5 and over will be eligible for services if their I.Q. scores fall two or more standard deviations below the mean of a standardized test.

c. For persons ages 3 to 5, eligibility is based on an assessment that reflects functioning on a level two or more standard deviations from the mean in two or more areas as determined by a standardized test.

d. For infants and toddlers 0-36 months, eligibility for DDS Services will be indicated by a 25% delay in two or more areas based on an assessment instrument which yields scores in months. The areas to be assessed include: cognition; communication; social/emotion; motor; and adaptive.

3. Is attributable to dyslexia resulting from intellectual disability, cerebral palsy, epilepsy spina bifida, Down syndrome or autism spectrum disorder as established by the results of a team evaluation including at least a licensed Physician and a licensed Psychologist.

 NOTE: In the case of individuals being evaluated for service, eligibility shall be based upon their condition closely related to an intellectual disability by virtue of their adaptive behavior functioning.

B. The disability has continued or is expected to continue indefinitely.

C. The disability constitutes a substantial handicap to the beneficiary’s ability to function without appropriate support services.

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| 217.200 Cognition Testing | 10-1-17 |

Patients referred for developmental concerns are eligible for CHMS if they qualify on two or more developmental evaluations administered by appropriate CHMS professionals:

A. For ages 0-36 months:

1. A developmental evaluation that reflects a score of 25% or greater delay in at least two of the five domains (motor, social, cognitive, self-help/adaptive, or communication); or

2. A psychological evaluation that reflects a score of 75 or less; and

3. A physical therapy, occupational therapy or speech therapy evaluation that meets qualifying scores as set out in § 245.100 of this Manual.

B. For ages 3-5:

1. A developmental evaluation that reflects a score of at least two (2) standard deviations below the mean in at least two of the five domains (motor, social, cognitive, self-help/adaptive, or communication); or

2. A psychological evaluation that reflects a score of 70 or less; and

3. A physical therapy, occupational therapy, or speech therapy evaluation that meets qualifying scores as set out in § 245.100 of this Manual. .

The developmental evaluation must be comprehensive and include a norm referenced (standardized) evaluation and a criterion referenced evaluation. For all evaluations, the evaluator must document that the test protocols for each instrument were followed and that the evaluator met the qualifications to administer the instrument.

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| 218.000 Groupings of Services | 10-13-03 |

The following is a discussion of methods of care delivery characterized by a particular grouping of services and the general referral, approval and service route involved with each care method.

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| 218.200 Individual Treatment Planning | 10-1-17 |

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

A DMS-640 form is required for a PCP, or attending physician if the beneficiary is exempt from PCP managed care program requirements, referral and a separate DMS-640 form is required for a prescription for occupational, physical and speech therapy services. The PCP or attending physician must use form DMS-640 when making referrals and prescribing occupational, physical or speech therapy services. [View or print form DMS-640.](../../Forms/DMS-640.doc) A copy of the prescription must be maintained in the child’s CHMS record; the PCP or attending physician retains the original prescription. If occupational, physical and speech therapy sessions are missed; make-up therapy services must not exceed the prescribed number of minutes per week without an additional PCP/attending physician prescription on form DMS-640.

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

For those children receiving day treatment services on a daily or weekly basis, the individualized treatment plan will be written for a period of 12 months and will be updated as needed.

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

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| 218.300 Day Treatment Services | 10-1-17 |

Intervention/Treatment Services are defined as assessment and provision of an integrated developmentally based program of services (such as therapy treatment) to strengthen and enhance appropriate developmental outcomes. This treatment service is typically provided multiple times per week based on the orders/treatment plan signed by the CHMS physician.

Therapy Treatment Services may include psychotherapy, speech/language therapy, occupational therapy, physical therapy, behavioral therapy, family counseling, individual and group counseling, pediatric medical treatment and diagnostic services, nutrition and cognitive services. These treatment services are available for children from birth to age 21 and are provided based on the physician’s prescription, which authorizes the amount of day treatment needed.

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| 218.400 Transition/Follow-Up | 2-1-10 |

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

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

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

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| 219.000 Evaluation of Clinical Care/Internal Quality Assurance | 10-13-03 |

The CHMS clinic must maintain and document an ongoing evaluation of the quality of care given to each patient. This shall be done through Individual Case Review and Clinical Evaluation studies.

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| 219.100 Individual Case Review | 10-13-03 |

Each case shall be reviewed periodically by the relevant CHMS staff physician, evaluation team and/or relevant others in order to monitor the course of treatment, assess the quality of care provided and make any necessary changes in the individualized treatment plan. Each case shall be reviewed within two (2) weeks of the patient’s initial visit and at least every ninety (90) days during the course of treatment, unless otherwise specified and justified in the patient’s individualized treatment plan.

Each case review must be documented and include a description of the review results.

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| 219.200 Clinical Care Evaluation | 10-13-03 |

The CHMS clinic must annually conduct and document analysis and evaluation of patient care occurring within the clinic.

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| 220.000 Benefit Limits |  |
| 221.000 Referral Process for Non-Child Health Management Services | 10-13-03 |

In certain circumstances it may be determined that the patient is in need of services that are not available through the CHMS clinic. In those situations the CHMS clinic may make referrals for other services.

The CHMS clinic must establish policies and procedures for making referrals and for the follow-up of these referrals. These policies shall provide for:

A. Consultation with PCP;

B. Appropriate transfer of relevant information;

C. Joint discussion of the role of the referral in the overall treatment process;

D. Preparation of the patient for referral and

E. Follow-up reports subsequent to the referral.

These policies and procedures must be reviewed annually, signed and dated by appropriate clinical staff.

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| 222.000 Inspection of Care | 10-1-17 |

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

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

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

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

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

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

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

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| 240.000 PRIOR AUTHORIZATION FOR Child health management SERVICES |  |
| 241.000 Intake Process | 10-1-17 |

A. A prescription from the primary care physician (PCP) must be received by the CHMS clinic for a beneficiary to receive CHMS services.

B. The CHMS clinic must conduct an intake and assessment once the prescription is received.

The steps in the intake process are as follows:

1. The intake process begins with the family or referral source to identify the needs of the patient.

2. The CHMS clinic will schedule an appointment with the child’s family for the intake assessment.

3. The CHMS professional staff will assess the need of the patient for the services available. History and concerns of the family will be collected and the intake process will be completed.

4. If no concerns are found, the family will be provided other service information.

5. When developmental or medical concerns are found, a CHMS pediatrician visit will be scheduled.

6. After the visit is completed and the developmental screen results, as well as all other evaluation results are reviewed, admission for treatment services will be prescribed or not prescribed by the CHMS physician.

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| 242.000 Prior Authorization Request to Determine and Verify the Patient’s Need for Child Health Management Services | 10-1-17 |

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

A. When a recommendation is made for day treatment services, the CHMS Request for Prior AuthorizationformDMS-102must be completed by the CHMS clinic and submitted via mail, electronically, or by fax to the QIO. Fax transmission will be limited to 25 pages. For those clinics wishing to utilize electronic submission, contact the QIO and request specifics. [View or print CHMS Request for Prior Authorization form DMS-102 and instructions for completion](../../Forms/DMS-102.doc).[View or print QIO contact information](../../Links/AFMC.doc)**.**

 The request must include a report of the findings from the developmental screen, the diagnostic evaluation and a current plan for treatment. Review for medical necessity will be performed on the information sent by the provider. This information must substantiate the need for the child to receive services in a multidisciplinary CHMS clinic, including that the child meets the eligibility criteria laid out in Section 217.000.

B. Prior Authorization Review Process

1. Prior authorization requests are initially screened by a CHMS review coordinator (a registered nurse). When complete documents are received, a prior authorization review of the requested services is performed. If the CHMS review coordinator cannot approve all of the services requested, the review is sent to a pediatric physician advisor for determination.

2. When the request is approved, a prior authorization number is issued along with a preliminary length of service, procedure codes and units approved. Approval notifications are mailed to the CHMS provider and the Medicaid beneficiary.

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

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

E. The prior authorization/reconsideration process will be completed within thirty (30) working days of receipt of all required documentation. Intervention/Treatment Services may begin prior to the receipt of prior authorization only at the financial risk of the CHMS organization.

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

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

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| 243.000 Mechanisms for Record Transfer and Reporting | 10-13-03 |

All prior authorization requests will be shared via mail, fax or electronic submission.

All reports, records and documents will be available to Medicaid and other authorized entities concerning the prior authorization requests, approvals/denials, appeal process, patient information, etc., upon request with advance notice of 5 working days. Periodic set reports can be established and provided.

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| 244.000 Flow Chart of Intake and Prior Authorization Process for Intervention/Treatment | 2-1-10 |

[View or print Flow Chart of Intake and Prior Authorization Process for Intervention/Treatment](../../Links/CHMSFlowChart.doc)**.**

[View or print AFMC CHMS Request for Prior Authorization Form and instructions for completion](../../Forms/DMS-102.doc)**.**

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| 245.000 Guidelines for Retrospective Review of Occupational, Physical and Speech Therapy Services | 10-1-17 |

Arkansas Medicaid conducts retrospective review of the first 90 minutes per week of occupational, physical and speech therapy services. The purpose of retrospective review is to promote effective, efficient and economical delivery of health care services.

The Quality Improvement Organization (QIO), under contract to the Arkansas Medicaid Program, performs retrospective reviews of medical records to determine if services delivered and reimbursed by Medicaid meet medical necessity requirements. [View or print QIO contact information](../../Links/AFMCretroPA.doc).

For the provider’s information specific guidelines have been developed for occupational, physical and speech therapy retrospective reviews. These guidelines may be found in Sections 245.100 through 245.220.

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| 245.100 Occupational and Physical Therapy Guidelines  | 10-1-17 |

A. Medical Necessity

 Occupational and physical therapy services must be medically necessary to the treatment of the individual’s illness or injury. A diagnosis alone is not sufficient documentation to support the medical necessity of therapy. To be considered medically necessary, the following conditions must be met:

1. The service must be considered under accepted standards of practice to be a specific and effective treatment for the patient’s condition.

2. The service must be of such a level of complexity or the patient’s condition must be such that the services required can be safely and effectively performed only by or under the supervision of a qualified physical or occupational therapist.

3. There must be reasonable expectation that therapy will result in a meaningful improvement or a reasonable expectation that therapy will prevent a worsening of the condition. (See the medical necessity definition in the Glossary of this manual.)

B. Evaluation and Report Components

 To establish medical necessity, a comprehensive assessment in the suspected area of deficit must be performed. A comprehensive assessment must include:

1. Date of evaluation.

2. Child’s name and date of birth.

3. Diagnosis specific to therapy.

4. Background information including pertinent medical history; and, if the child is 12 months of age or younger, gestational age. The child should be tested in the child’s dominant language; if not, an explanation must be provided in the evaluation.

NOTE: To calculate a child’s gestational age, subtract the number of weeks born before 40 weeks of gestation from the chronological age. Therefore, a 7-month-old, former 28 week gestational age infant has a corrected age of 4 months according to the following equation:

 7 months - [(40 weeks) - 28 weeks) / 4 weeks]

 7 months - [(12) / 4 weeks]

 7 months - [3]

 4 months

5. Standardized test results, including all subtest scores, if applicable. Test results must be reported as standard scores, Z scores, T scores or percentiles. Age-equivalent scores and percentage of delay cannot be used to qualify for services,

6. If applicable, test results should be adjusted for prematurity (less than 37 weeks gestation) if the child is 12 months of age or younger, and this should be noted in the evaluation.

7. Objective information describing the child’s gross/fine motor abilities/deficits, e.g., range of motion measurements, manual muscle testing, muscle tone or a narrative description of the child’s functional mobility skills (strengths and weaknesses).

8. An interpretation of the results of the evaluation, including recommendations for therapy/minutes per week.

9. A description of functional strengths and limitations, a suggested treatment plan and potential goals that address each identified problem.

10. Signature and credentials of the therapist performing the evaluation.

C. Interpretation and Eligibility: Ages Birth to 21

1. Tests used must be norm-referenced, standardized and specific to the therapy provided.

2. Tests must be age appropriate for the child being tested.

3. All subtests, components and scores must be reported for all tests used for eligibility purposes.

4. Eligibility for therapy will be based upon a score of -1.50 standard deviations (SD) below the mean or greater in at least one subtest area or composite score on a norm-referenced, standardized test. When a -1.5 SD or greater is not indicated by the test, a criterion-referenced test along with informed clinical opinion must be included to support the medical necessity of services.

5. If the child cannot be tested with a norm-referenced, standardized test, criterion-based testing or a functional description of the child’s gross/fine motor deficits may be used. Documentation of the reason why a standardized test could not be used must be included in the evaluation.

6. The *Mental Measurement Yearbook (MMY)* is the standard reference to determine reliability and validity. Refer to ”Accepted Tests” sections for a list of standardized tests accepted by the Arkansas Medicaid program for retrospective review.

7. Range of Motion: A limitation of greater than ten degrees and/or documentation of how deficit limits function.

8. Muscle Tone: Modified Ashworth Scale.

9. Manual Muscle Test: A deficit is a muscle strength grade of fair (3/5) or below that impedes functional skills. With increased muscle tone, as in cerebral palsy, testing is unreliable.

10. Transfer Skills: Documented as the amount of assistance required to perform transfer, e.g., maximum, moderate, minimal assistance. A deficit is defined as the inability to perform a transfer safely and independently.

11. Children (birth to age 21) receiving services outside of the public schools must be evaluated annually.

12. Children (birth to age 2) in the Child Health Management Services (CHMS) program must be evaluated every 6 months.

13. Children (age three to 21) receiving services within public schools, as a part of an Individual Program Plan (IPP) or an Individual Education Plan (IEP), must have a full evaluation every three years; however, an annual update of progress is required.

D. Frequency, Intensity and Duration of Physical and/or Occupational Therapy Services

 The frequency, intensity and duration of therapy services should always be medically necessary and realistic for the age of the child and the severity of the deficit or disorder. Therapy is indicated if improvement will occur as a direct result of these services and if there is a potential for improvement in the form of functional gain.

1. Monitoring: May be used to ensure that the child is maintaining a desired skill level or to assess the effectiveness and fit of equipment such as orthotics and other durable medical equipment. Monitoring frequency should be based on a time interval that is reasonable for the complexity of the problem being addressed.

2. Maintenance Therapy: Services that are performed primarily to maintain range of motion or to provide positioning services for the patient do not qualify for physical or occupational therapy services. These services can be provided to the child as part of a home program that can be implemented by the child’s caregivers and do not necessarily require the skilled services of a physical or occupational therapist to be performed safely and effectively.

3. Duration of Services: Therapy services should be provided as long as reasonable progress is made toward established goals. If reasonable functional progress cannot be expected with continued therapy, then services should be discontinued and monitoring or establishment of a home program should be implemented.

E. Progress Notes

1. Child’s name.

2. Date of service.

3. Time in and time out of each therapy session.

4. Objectives addressed (should coincide with the plan of care).

5. A description of specific therapy services provided daily and the activities rendered during each therapy session, along with a form measurement.

6. Progress notes must be legible.

7. Therapists must sign each date of entry with a full signature and credentials.

8. Graduate students must have the supervising physical therapist or occupational therapist co-sign progress notes.

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| 245.110 Accepted Tests for Occupational Therapy | 3-15-12 |

To view the current list of Accepted Tests for Occupational Therapy, refer to Section 214.310 of the Occupational, Physical, Speech Therapy Services manual.

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| 245.120 Accepted Tests for Physical Therapy | 3-15-12 |

To view the current list of Accepted Tests for Physical Therapy, refer to Section 214.320 of the Occupational, Physical, Speech Therapy Services manual.

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| 245.200 Speech-Language Therapy Guidelines | 10-1-17 |

A. Medical Necessity

Speech-language therapy services must be medically necessary to the treatment of the individual’s illness or injury. A diagnosis alone is not sufficient documentation to support the medical necessity of therapy. To be considered medically necessary, the following conditions must be met:

1. The services must be considered under accepted standards of practice to be a specific and effective treatment for the patient’s condition.

2. The services must be of such a level of complexity, or the patient’s condition must be such, that the services required can be safely and effectively performed only by or under the supervision of a qualified speech and language pathologist.

3. There must be reasonable expectation that therapy will result in meaningful improvement or a reasonable expectation that therapy will prevent a worsening of the condition. (See the medical necessity definition in the Glossary of this manual.)

1. Types of Communication Disorders

1. Language Disorders — Impaired comprehension and/or use of spoken, written and/or other symbol systems. This disorder may involve the following components: forms of language (phonology, morphology, syntax), content and meaning of language (semantics, prosody), function of language (pragmatics) and/or the perception/processing of language. Language disorders may involve one, all or a combination of the above components.

2. Speech Production Disorders — Impairment of the articulation of speech sounds, voice and/or fluency. Speech Production disorders may involve one, all or combination of these components of the speech production system.

 An articulation disorder may manifest as an individual sound deficiency, i.e., traditional articulation disorder, incomplete or deviant use of the phonological system, i.e. phonological disorder or poor coordination of the oral-motor mechanism for purposes of speech production, i.e. verbal and/or oral apraxia, dysarthria.

3. Oral Motor/Swallowing/Feeding Disorders — Impairment of the muscles, structures and/or functions of the mouth (physiological or sensory-based) involved with the entire act of deglutition from placement and manipulation of food in the mouth through the oral and pharyngeal phases of the swallow. These disorders may or may not result in deficits to speech production.

C. Evaluation and Report Components

1. STANDARDIZED SCORING KEY:

 Mild: Scores between 84-78; -1.0 standard deviation

 Moderate: Scores between 77-71; -1.5 standard deviations

 Severe: Scores between 70-64; -2.0 standard deviations

 Profound: Scores of 63 or lower; -2.0+ standard deviations

2. LANGUAGE: To establish medical necessity, results from a comprehensive assessment in the suspected area of deficit must be reported. (Refer to Section 245.200, part D, paragraphs 9-12 for required frequency of re-evaluations.) A comprehensive assessment for Language disorder must include:

a. Date of evaluation.

b. Child’s name and date of birth.

c. Diagnosis specific to therapy.

d. Background information including pertinent medical history; and, if the child is 12 months of age or younger, gestational age. The child should be tested in his or her dominant language; if not, an explanation must be provided in the evaluation.

NOTE: To calculate a child’s gestational age, subtract the number of weeks born before 40 weeks of gestation from the chronological age. Therefore, a 7-month-old, former 28 week gestational age infant has a corrected age of 4 months according to the following equation:

 7 months - [(40 weeks) - 28 weeks) / 4 weeks]

 7 months - [(12) / 4 weeks]

 7 months - [3]

 4 months

e. Results from an assessment specific to the suspected type of language disorder, including all relevant scores, quotients and/or indexes, if applicable. A comprehensive measure of language must be included for initial evaluations. Use of one-word vocabulary tests alone will not be accepted. (To view a current list of Accepted Tests for Speech-Language Therapy, refer to Section 214.410 of the Occupational, Physical, Speech Therapy Services Manual.)

f. If applicable, test results should be adjusted for prematurity (less than 37 weeks gestation) if the child is 12 months of age or younger, and this should be noted in the evaluation.

g. Oral-peripheral speech mechanism examination, which includes a description of the structure and function of the orofacial structures.

h. Formal or informal assessment of hearing, articulation, voice and fluency skills.

i. An interpretation of the results of the evaluation including recommendations for frequency and intensity of treatment.

j. A description of functional strengths and limitations, a suggested treatment plan and potential goals that address each identified problem.

k. Signature and credentials of the therapist performing the evaluation.

3. SPEECH PRODUCTION (Articulation, Phonological, Apraxia): To establish medical necessity, results from a comprehensive assessment in the suspected area of deficit must be reported. (Refer to Section 245.200, part D, paragraphs 9-12 for required frequency of re-evaluations.) A comprehensive assessment for Speech Production (Articulation, Phonological, Apraxia) disorder must include:

a. Date of evaluation.

b. Child’s name and date of birth.

c. Diagnosis specific to therapy.

d. Background information including pertinent medical history; and, if the child is 12 months of age or younger, gestational age. The child should be tested in his or her dominant language; if not, an explanation must be provided in the evaluation.

NOTE: To calculate a child’s gestational age, subtract the number of weeks born before 40 weeks of gestation from the chronological age. Therefore, a 7-month-old, former 28 week gestational age infant has a corrected age of 4 months according to the following equation:

 7 months - [(40 weeks) - 28 weeks) / 4 weeks]

 7 months - [(12) / 4 weeks]

 7 months - [3]

 4 months

e. Results from an assessment specific to the suspected type of speech production disorder, including all relevant scores, quotients and/or indexes, if applicable. All errors specific to the type of speech production disorder must be reported (e.g., positions, processes, motor patterns). (To view a current list of Accepted Tests for Speech-Language Therapy, refer to Section 214.410 of the Occupational, Physical, Speech Therapy Services Manual.)

f. If applicable, test results should be adjusted for prematurity (less than 37 weeks gestation) if the child is 12 months of age or younger, and this should be noted in the evaluation.

g. Oral-peripheral speech mechanism examination, which includes a description of the structure and function of orofacial structures.

h. Formal screening of language skills. Examples include, but are not limited to, the Fluharty-2, KLST-2, CELF-4 Screen or TTFC.

i. Formal or informal assessment of hearing, voice and fluency skills.

j. An interpretation of the results of the evaluation including recommendations for frequency and intensity of treatment.

k. A description of functional strengths and limitations, a suggested treatment plan and potential goals that address each identified problem.

l. Signature and credentials of the therapist performing the evaluation.

4. SPEECH PRODUCTION (Voice): To establish medical necessity, results from a comprehensive assessment in the suspected area of deficit must be reported. (Refer to Section 245.200, part D, paragraphs 9-12 for required frequency of re-evaluations.) A comprehensive assessment for Speech Production (Voice) disorder must include:

a. A medical evaluation to determine the presence or absence of a physical etiology as a prerequisite for evaluation of voice disorder.

b. Date of evaluation.

c. Child’s name and date of birth.

d. Diagnosis specific to therapy.

e. Background information including pertinent medical history; and, if the child is 12 months of age or younger, gestational age. The child should be tested in his or her dominant language; if not, an explanation must be provided in the evaluation.

NOTE: To calculate a child’s gestational age, subtract the number of weeks born before 40 weeks of gestation from the chronological age. Therefore, a 7-month-old, former 28 week gestational age infant has a corrected age of 4 months according to the following equation:

 7 months - [(40 weeks) - 28 weeks) / 4 weeks]

 7 months - [(12) / 4 weeks]

 7 months - [3]

 4 months

f. Results from an assessment relevant to the suspected type of speech production disorder, including all relevant scores, quotients and/or indexes, if applicable. (To view a current list of Accepted Tests for Speech-Language Therapy, refer to Section 214.410 of the Occupational, Physical, Speech Therapy Services Manual.)

g. If applicable, test results should be adjusted for prematurity (less than 37 weeks gestation) if the child is12 months of age or younger, and this should be noted in the evaluation.

h. Oral-peripheral speech mechanism examination, which includes a description of the structure and function of orofacial structures.

i. Formal screening of language skills. Examples include, but are not limited to, the Fluharty-2, KLST-2, CELF-4 Screen or TTFC.

j. Formal or informal assessment of hearing, articulation and fluency skills.

k. An interpretation of the results of the evaluation including recommendations for frequency and intensity of treatment.

l. A description of functional strengths and limitations, a suggested treatment plan and potential goals that address each identified problem.

m. Signature and credentials of the therapist performing the evaluation.

5. SPEECH PRODUCTION (Fluency): To establish medical necessity, results from a comprehensive assessment in the suspected area of deficit must be reported. (Refer to Section 245.200, part D, paragraphs 9-12 for required frequency of re-evaluations.) A comprehensive assessment for Speech Production (Fluency) disorder must include:

a. Date of evaluation.

b. Child’s name and date of birth.

c. Diagnosis specific to therapy.

d. Background information including pertinent medical history; and, if the child is 12 months of age or younger, gestational age. The child should be tested in his or her dominant language; if not, an explanation must be provided in the evaluation.

NOTE: To calculate a child’s gestational age, subtract the number of weeks born before 40 weeks of gestation from the chronological age. Therefore, a 7-month-old, former 28 week gestational age infant has a corrected age of 4 months according to the following equation:

 7 months - [(40 weeks) - 28 weeks) / 4 weeks]

 7 months - [(12) / 4 weeks]

 7 months - [3]

 4 months

e. Results from an assessment specific to the suspected type of speech production disorder, including all relevant scores, quotients and/or indexes, if applicable. (To view a current list of Accepted Tests for Speech-Language Therapy, refer to Section 214.410 of the Occupational, Physical, Speech Therapy Services Manual.)

f. If applicable, test results should be adjusted for prematurity (less than 37 weeks gestation) if the child is12 months of age or younger, and this should be noted in the evaluation.

g. Oral-peripheral speech mechanism examination, which includes a description of the structure and function of orofacial structures.

h. Formal screening of language skills. Examples include, but are not limited to, the Fluharty-2, KLST-2, CELF-4 Screen or TTFC.

i. Formal or informal assessment of hearing, articulation and voice skills.

j. An interpretation of the results of the evaluation including recommendations for frequency and intensity of treatment.

k. A description of functional strengths and limitations, a suggested treatment plan and potential goals that address each identified problem.

l. Signature and credentials of the therapist performing the evaluation.

6. ORAL MOTOR/SWALLOWING/FEEDING: To establish medical necessity, results from a comprehensive assessment in the suspected area of deficit must be reported. (Refer to Section 245.200, part D, paragraphs 9-12 for required frequency of re-evaluations.) A comprehensive assessment for Oral Motor/Swallowing/Feeding disorder must include:

a. Date of evaluation.

b. Child’s name and date of birth.

c. Diagnosis specific to therapy.

d. Background information including pertinent medical history; and, if the child is 12 months of age or younger, gestational age. The child should be tested in his or her dominant language; if not, an explanation must be provided in the evaluation.

NOTE: To calculate a child’s gestational age, subtract the number of weeks born before 40 weeks of gestation from the chronological age. Therefore, a 7-month-old, former 28 week gestational age infant has a corrected age of 4 months according to the following equation:

 7 months - [(40 weeks) - 28 weeks) / 4 weeks]

 7 months - [(12) / 4 weeks]

 7 months - [3]

 4 months

e. Results from an assessment specific to the suspected type of oral motor/swallowing/feeding disorder, including all relevant scores, quotients and/or indexes, if applicable. (To view a current list of Accepted Tests for Speech-Language Therapy, refer to Section 214.410 of the Occupational, Physical, Speech Therapy Services Manual.)

f. If swallowing problems and/or signs of aspiration are noted, then include a statement indicating that a referral for a videofluoroscopic swallow study has been made.

g. If applicable, test results should be adjusted for prematurity (less than 37 weeks gestation) if the child is 12 months of age or younger, and this should be noted in the evaluation.

h. Formal or informal assessment of hearing, language, articulation, voice and fluency skills.

i. An interpretation of the results of the evaluation including recommendations for frequency and intensity of treatment.

j. A description of functional strengths and limitations, a suggested treatment plan and potential goals that address each identified problem.

k. Signature and credentials of the therapist performing the evaluation.

D. Interpretation and Eligibility: Ages Birth to 21

1. LANGUAGE: Two language composite or quotient scores (i.e., normed or standalone) in the area of suspected deficit must be reported, with at least one being a norm-referenced, standardized test with good reliability and validity. (Use of two one-word vocabulary tests alone will not be accepted.)

a. For children age birth to three: criterion-referenced tests will be accepted as a second measure for determining eligibility for language therapy.

b. For children age three to 21: criterion-referenced tests will not be accepted as a second measure when determining eligibility for language therapy. (When use of standardized instruments is not appropriate, see Section 245.200, part D, paragraph 8).

c. Age birth to three: Eligibility for language therapy will be based upon a composite or quotient score that is -1.5 standard deviations (SD) below the mean or greater from a norm-referenced, standardized test, with corroborating data from a criterion-referenced measure. When these two measures do not agree, results from a third measure that corroborate the identified deficits are required to support the medical necessity of services.

d. Age three to 21: Eligibility for language therapy will be based upon 2 composite or quotient scores that are -1.5 standard deviations (SD) below the mean or greater. When -1.5 SD or greater is not indicated by both of these scores, a third standardized score indicating a -1.5 SD or greater is required to support the medical necessity of services.

2. ARTICULATION AND/OR PHONOLOGY: Two tests and/or procedures must be administered, with at least one being from a norm-referenced, standardized test with good reliability and validity.

 Eligibility for articulation and/or phonological therapy will be based upon standard scores (SS) of -1.5 SD or greater below the mean from two tests. When -1.5 SD or greater is not indicated by both of these tests, corroborating data from accepted procedures can be used to support the medical necessity of services. (To view a current list of Accepted Tests for Speech-Language Therapy, refer to Section 214.410 of the Occupational, Physical, Speech Therapy Services Manual.)

3. APRAXIA: Two tests and/or procedures must be administered, with at least one being a norm-referenced, standardized test with good reliability and validity.

 Eligibility for apraxia therapy will be based upon standard scores (SS) of -1.5 SD or greater below the mean from two tests. When -1.5 SD or greater is not indicated by both of these tests, corroborating data from a criterion-referenced test and/or accepted procedures can be used to support the medical necessity of services. (To view a current list of Accepted Tests for Speech-Language Therapy, refer to Section 214.410 of the Occupational, Physical, Speech Therapy Services Manual.)

4. VOICE: Due to the high incidence of medical factors that contribute to voice deviations, a medical evaluation is a requirement for eligibility for voice therapy.

 Eligibility for voice therapy will be based upon a medical referral for therapy and a functional profile of voice parameters that indicates a moderate or severe deficit/disorder.

5. FLUENCY: At least one norm-referenced, standardized test with good reliability and validity and at least one supplemental tool to address affective components.

 Eligibility for fluency therapy will be based upon an SS of -1.5 SD below the mean or greater on the standardized test.

6. ORAL MOTOR/SWALLOWING/FEEDING: An in-depth, functional profile of oral motor structures and function.

 Eligibility for oral-motor/swallowing/feeding therapy will be based upon an in-depth functional profile of oral motor structures and function using a thorough protocol (e.g., checklist, profile) that indicates a moderate or severe deficit or disorder. When moderate or severe aspiration has been confirmed by videofluoroscopic swallow study, the patient can be treated for pharyngeal dysphagia via the recommendations set forth in the swallow study report.

7. All subtests, components and scores must be reported for all tests used for eligibility purposes.

8. When administration of standardized, norm-referenced instruments is inappropriate, the provider must submit an in-depth functional profile of the child’s communication abilities. An in-depth functional profile is a detailed narrative or description of a child’s communication behaviors that specifically explains and justifies the following:

a. The reason standardized testing is inappropriate for this child.

b. The communication impairment, including specific skills and deficits.

c. The medical necessity of therapy.

d. Supplemental instruments from Accepted Tests for Speech-Language Therapy may be useful in developing an in-depth functional profile.

9. Children (birth to age 21) receiving services outside of the schools must be evaluated annually.

10. Children (birth to 24 months) in the Child Health Management Services (CHMS) Program must be evaluated every 6 months.

11. Children (age three to 21) receiving services within schools as part of an Individual Program Plan (IPP) or an Individual Education Plan (IEP) must have a full evaluation every three years; however, an annual update of progress is required.

12. Children (age three to 21) receiving privately contracted services, apart from or in addition to those within the schools, must have a full evaluation annually.

13. IQ scores are required for all children who are school age and receiving language therapy. Exception: IQ scores are not required for children under ten (10) years of age.

E. Progress Notes

1. Child’s name.

2. Date of service.

3. Time in and time out of each therapy session.

4. Objectives addressed (should coincide with the plan of care).

5. A description of specific therapy services provided daily and the activities rendered during each therapy session, along with a form of measurement.

6. Progress notes must be legible.

7. Therapists must sign each date of entry with a full signature and credentials.

8. Graduate students must have the supervising speech-language pathologist co-sign progress notes.

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| 245.210 Accepted Tests for Speech-Language Therapy  | 3-15-12 |

To view a current list of Accepted Tests for Speech-Language Therapy, refer to Section 214.410 of the Occupational, Physical, Speech Therapy Services manual.

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| 245.220 Intelligence Quotient (IQ) Testing | 11-1-10 |

Children receiving language intervention therapy must have cognitive testing once they reach ten (10) years of age. This also applies to home-schooled children. If the IQ score is higher than the qualifying language scores, then the child qualifies for language therapy; if the IQ score is lower than the qualifying language test scores, the child would appear to be functioning at or above expected level. In this case, the child may be denied for language therapy. If a provider determines that therapy is warranted, an in-depth functional profile must be submitted. However, IQ scores are not required for children under ten (10) years of age.

A. IQ Tests — Traditional

| Test | Abbreviation |
| --- | --- |
| Stanford-Binet | S-B |
| The Wechsler Preschool & Primary Scales of Intelligence, Revised | WPPSI-R |
| Slosson |  |
| Wechsler Intelligence Scale for Children, Third Edition | WISC-III |
| Kauffman Adolescent & Adult Intelligence Test | KAIT |
| Wechsler Adult Intelligence Scale, Third Edition | WAIS-III |
| Differential Ability Scales | DAS |
| Reynolds Intellectual Assessment Scales | RAIS |

B. Severe and Profound IQ Test/Non-Traditional — Supplemental — Norm-Reference

| Test | Abbreviation |
| --- | --- |
| Comprehensive Test of Nonverbal Intelligence | CTONI |
| Test of Nonverbal Intelligence — 1997 | TONI-3 |
| Functional Linguistic Communication Inventory | FLCI |

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| 245.300 Recoupment Process | 7-1-15 |

The Division of Medical Services (DMS), Utilization Review Section (UR) is required to initiate the recoupment process for all services denied by the contracted Quality Improvement Organization (QIO), for not meeting the medical necessity requirement. Based on QIO findings during retrospective reviews, UR will initiate recoupment as appropriate.

Medicaid will send the provider an Explanation of Recoupment Notice that will include the claim date of service, Medicaid beneficiary name and ID number, service provided, amount paid by Medicaid, amount to be recouped, and the reason the claim has been denied.

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| 246.000 Appeal Process for Medicaid Beneficiaries | 1-1-07 |

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

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

Submit appeal requests to the Department of Health and Human Services (DHHS), Appeals and Hearings Section. [View or print Appeals and Hearings Section contact information.](../../Links/DHSAppealsHearings.doc)

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| 250.000 REIMBURSEMENT |  |
| 251.000 Method of Reimbursement | 10-13-03 |

The reimbursement methodology for some Child Health Management Services (CHMS) is a “fee schedule” methodology. Under the fee schedule methodology, reimbursement is based on the lesser of the billed amount or the Title XIX (Medicaid) maximum allowed for each procedure. The maximum allowable fee for a procedure is the same for all Child Health Management Services providers.

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| 251.010 Fee Schedules | 12-1-12 |

Arkansas Medicaid provides fee schedules on the Arkansas Medicaid website. The fee schedule link is located at [https://www.medicaid.state.ar.us](https://www.medicaid.state.ar.us/) under the provider manual section. The fees represent the fee-for-service reimbursement methodology.

Fee schedules do not address coverage limitations or special instructions applied by Arkansas Medicaid before final payment is determined.

Procedure codes and/or fee schedules do not guarantee payment, coverage or amount allowed. Information may be changed or updated at any time to correct a discrepancy and/or error. Arkansas Medicaid always reimburses the lesser of the amount billed or the Medicaid maximum.

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| 252.000 Rate Appeal Process | 1-1-07 |

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

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

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

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| 260.000 BILLING PROCEDURES |  |
| 261.000 Introduction to Billing | 7-1-07 |

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

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

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| 262.000 CMS-1500 Billing Procedures |  |
| 262.100 Child Health Management Services Procedure Codes |  |
| 262.110 Diagnosis and Evaluation Procedure Codes |  9-15-14 |

The following diagnosis and evaluation procedure codes are limited to two (2) diagnosis and evaluation encounters per state fiscal year (July 1 through June 30). If additional diagnosis and evaluation procedures are required, the CHMS provider must request an extension of benefits.

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| Procedure Codes |
| 92550 | 92551 | 92552 | 92553 | 92555 | 92557 | 92558 | 92567 |
| 92570 | 92582 | 92585 | 92586 | 92587 | 92588 | 96105 | 96111 |
| 96118\* | 99201 | 99202 | 99203 | 99204 | 99205 |  |  |

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

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

| Procedure Code | Required Modifier(s) | Description |
| --- | --- | --- |
| 90791 | U9 | ⁂(Diagnostic evaluation/review of records (1 unit = 15 minutes), maximum of 3 units; limited to 6 units per state fiscal year) |
| 90833 | U9 | ⁂(Individual psychotherapy, insight-oriented, behavior-modifying and/or supportive, in an office or outpatient facility, approximately 20 to 30 minutes, face-to-face with the patient with medical evaluation and management services) |
| 90836 | U9 | ⁂(Individual psychotherapy, insight-oriented, behavior-modifying and/or supportive, in an office or outpatient facility, approximately 45 to 50 minutes, face-to-face with the patient with medical evaluation and management services) |
| 90838 | U9  | ⁂(Individual psychotherapy, insight-oriented, behavior-modifying and/or supportive, in an office or outpatient facility, approximately 75 to 80 minutes, face-to-face with the patient with medical evaluation and management services) |
| 90887 |  | Interpretation of diagnosis (1 unit = 15 minutes), maximum of 3 units; limited to 6 units per state fiscal year |
| 92521 | UA | ⁂(Evaluation of speech fluency (e.g., stuttering, cluttering) (30-minute unit; maximum of 4 units per state fiscal year. July 1 through June 30) |
| 92522 | UA | ⁂(Evaluation of speech sound production (e.g., articulation, phonological process, apraxia, dysarthia) (30-minute unit; maximum of 4 units per state fiscal year, July 1 through June 30) |
| 92523 | UA | ⁂(Evaluation of speech production (e.g., articulation, phonological process, apraxia, dysarthia) with evaluation of language comprehension and expression (e.g., receptive and expressive language) (30-minute unit; maximum of 4 units per state fiscal year, July 1 through June 30) |
| 92524 | UA | ⁂(Behavioral and qualitative analysis of voice and resonance) (30-minute unit; maximum of 4 units per state fiscal year, July 1 through June 30) |
| 96101 | UA, UB | Psychological testing battery (1 unit = 15 minutes), maximum of 4 units; limited to 8 units per state fiscal yearEffective for dates of service on and after March 1, 2006, procedure code 96100 was replaced with procedure code 96101. |
| 97001 |  | Evaluation for physical therapy (1 unit = 30 minutes), maximum of 4 units per state fiscal year |
| 97003 |  | Evaluation for occupational therapy (1 unit = 30 minutes), maximum of 4 units per state fiscal year |
| 97802 |  | Nutrition Screening: Review of recent nutrition history, medical record, current laboratory and anthropometric data and conference with patient, caregiver or other CHMS professional (1 unit = 15 minutes). Maximum of 2 units; limited to 4 units per state fiscal year |
| 97802 | U1 | Nutrition Assessment: Assessment/evaluation of current nutritional status through history of nutrition, activity habits and current laboratory data, weight and growth history and drug profile; determination of nutrition needs; formulation of medical nutrition therapy plan and goals of treatment; a conference will be held with parents and/or other CHMS professionals or a written plan for medical nutrition therapy management will be provided (1 unit = 15 minutes). Maximum of 2 units; limited to 4 units per state fiscal year |
| 97802 | U2 | Comprehensive Nutrition Assessment: Assessment/evaluation of current nutritional status through initial history of nutrition, activity and behavioral habits; review of medical records; current laboratory data, weight and growth history, nutrient analysis and current anthropometric data (when available); determination of energy, protein, fat, carbohydrate and macronutrient needs; formulation of medical nutrition therapy plan and goals of treatment. May conference with parent(s)/guardian or caregivers and/or physician for implementation of medical nutrition therapy management or provide a written plan for implementation (1 unit = 15 minutes). Maximum of 4 units; limited to 8 units per state fiscal year |

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| 262.120 Treatment Procedure Codes | 7-1-17 |

The following treatment procedures are payable for services included in the child’s treatment plan. Prior authorization is required for *all* CHMS treatment procedures. See Section 240.000 of this manual for prior authorization requirements. See Glossary - Section IV - for definitions of “individual” and “group” as they relate to therapy services.

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| Procedure Codes |
| 90847 | 90849 | 97762\* | 99211 | 99212 |
| 99213 | 99214 | 99215 |  |  |

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

| Procedure Code | Required Modifier(s) | Description |
| --- | --- | --- |
| T1024 |  | Brief Consultation, on site — A direct service contact by a CHMS professional on-site with a patient for the purpose of: obtaining the full range of needed services; monitoring and supervising the patient's functioning; establishing support for the patient and gathering information relevant to the patient's individual treatment plan. |
| T1024 | U1 | Collateral Services, on site — Face-to-face contact on-site by a CHMS professional with other professionals, caregivers or other parties on behalf of an identified patient to obtain or provide relevant information necessary to the patient's assessment, evaluation or treatment. |
| 90846 | U4 | Family therapy, on-site, for therapy as part of the treatment plan, without the patient present (1 unit = 15 minutes) |
| 90847 | U4 | Family therapy, on site, for therapy as part of the treatment plan, with the patient present (1 unit = 15 minutes) |
| 99367 | UA  | Treatment Plan — Plan of treatment developed by CHMS professionals and the patient's caregiver(s). Plan must include short- and long-term goals and objectives and include appropriate activities to meet those goals and objectives (1 unit = 15 minutes). |
| H2011 | — | Crisis Management Visit, on site — An unscheduled/ unplanned direct service contact on site with the identified patient for the purpose of preventing physical injury, inappropriate behavior or placement in a more restrictive service delivery system (1 unit = 15 minutes) |
| S9470 | — | Nutrition Counseling/Consultation — Conference with parent/guardian and/or PCP to provide results of evaluation, discuss medical nutrition therapy plan and goals of treatment and education. May provide detailed menus for home use and information on sources of special nutrition products (1 unit = 30 minutes) |
| 90832 | U9 | ⁂(Individual psychotherapy, insight-oriented, behavior-modifying and/or supportive, in an office or outpatient facility, approximately 20 to 30 minutes, face-to-face with the patient) |
| 90834 | U9 | ⁂(Individual psychotherapy, insight-oriented, behavior-modifying and/or supportive, in an office or outpatient facility, approximately 45 to 50 minutes, face-to-face with the patient) |
| 90837 | U9 | ⁂(Individual psychotherapy, insight-oriented, behavior-modifying and/or supportive, in an office or outpatient facility, approximately 75 to 80 minutes, face-to-face with the patient) |
| 90853 | — | Group Psychotherapy/counseling (1 unit = 5 minutes) |
| 92507 | — | Individual Speech Session by Speech-Language Pathology Therapist (1 unit = 15 minutes), maximum of 6 units per week |
| 92507 | UB | Individual Speech Therapy by Speech-Language Pathology Assistant (1 unit = 15 minutes), maximum of 6 units per week |
| 92508 | — | Group Speech Session by Speech-Language Pathology Therapist (1 unit = 15 minutes), maximum of 6 units per week, maximum of 4 clients per group |
| 92508 | UB | Group Speech Therapy by Speech-Language Pathology Assistant (1 unit = 15 minutes), maximum of 6 units per week, maximum of 4 clients per group |
| 97110 | — | Individual Physical Therapy by Physical Therapist (1 unit = 15 minutes), maximum of 6 units per week |
| 97110 | UB | Individual Physical Therapy by Physical Therapy Assistant (1 unit = 15 minutes), maximum of 6 units per week |
| 97150 | — | Group Physical Therapy by Physical Therapist (1 unit = 15 minutes), maximum of 6 units per week, maximum of 4 clients per group |
| 97150 | U2 | Group Occupational Therapy by Occupational Therapist (1 unit = 15 minutes), maximum of 6 units per week, maximum of 4 clients per group |
| 97150 | U1, UB | Group Occupational Therapy by Occupational Therapy Assistant (1 unit = 15 minutes), maximum of 6 units per week, maximum of 4 clients per group |
| 97150 | UB | Group Physical Therapy by Physical Therapy Assistant (1 unit = 15 minutes), maximum of 6 units per week, maximum of 4 clients per group |
| 97530 | — | Individual Occupational Therapy by Occupational Therapist (1 unit = 15 minutes), maximum of 6 units per week |
| 97530 | UB | Individual Occupational Therapy by Occupational Therapy Assistant (1 unit = 15 minutes), maximum of 6 units per week |
| 97530 | U1 | Developmental Motor Activity Services — Individualized activities provided by, or under the direction of, an Early Childhood Developmental Specialist to improve general motor skills by increasing coordination, strength and/or range of motion. Activities will be directed toward accomplishment of a motor goal identified in the patient's individualized treatment plan as authorized by the responsible CHMS physician (1 unit = 15 minutes) |
| 97532 | — | Cognitive Development Services — Individualized activities to increase the patient's intellectual development and competency. Activities will be those appropriate to carry out the treatment plan for the patient as authorized by the responsible CHMS physician. Cognitive Development Services will be provided by or under the direction of an Early Childhood Developmental Specialist. Activities will address goals of cognitive and communication skills development: (1 unit = 15 minutes). |
| 97535 | UB | Self Care and Social/Emotional Developmental Services — Individualized activities provided by or under the direction of an Early Childhood Developmental Specialist to increase the patient's self-care skills and/or ability to interact with peers or adults in a daily life setting/situation. Activities will be those appropriate to carry out the treatment plan for the patient as authorized by the responsible CHMS physician. (1 unit = 15 minutes). |
| 97803 | — | Nutrition follow-up: Reassess recent nutrition history, new anthropometer and laboratory data to evaluate progress toward meeting medical nutritional goals. May include a conference with parent or other CHMS professional (1 unit = 15 minutes). |

Medicaid will reimburse up to six (6) occupational, physical and speech therapy units (1 unit = 15 minutes) weekly, per discipline, without authorization. Additional daily therapy units will require an extended therapy request for beneficiaries under age 21.

Please refer to the Occupational, Physical, Speech Therapy Services Manual for further instructions regarding prior authorization protocol.

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| 262.130 CHMS Procedure Codes – Foster Care Program | 7-1-17 |

Refer to Section 202.000 of this manual for Arkansas Medicaid Participation Requirements for Providers of Comprehensive Health Assessments for Foster Children.

The following procedure codes are to be used for the mandatory comprehensive health assessments of children entering the Foster Care Program. These procedures *do not* require prior authorization.

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

| Procedure Code | Required Modifier(s) | Description |
| --- | --- | --- |
| T1016 |  | Informing (1 unit = 15 minutes), maximum of 4 units |
| T1023 |  | Staffing (1 unit = 15 minutes), maximum of 4 units |
| T1025 |  | Developmental Testing |
| 90791 | U1, U9 | Diagnostic Interview, includes evaluation and reports (1 unit = 15 minutes), maximum of 8 units |
| 92521 | U1, UA | ⁂(Evaluation of speech fluency (e.g., stuttering, cluttering) (1 unit = 15 minutes; maximum of 4 units) |
| 92522 | U1, UA | ⁂(Evaluation of speech sound production (e.g., articulation, phonological process, apraxia, dysarthia) (1 unit = 15 minutes; maximum of 4 units) |
| 92523 | U1, UA | ⁂( Evaluation of speech production (e.g., articulation, phonological process, apraxia, dysarthia) with evaluation of language comprehension and expression (e.g. receptive and expressive language) (1 unit = 15 minutes; maximum of 4 units) |
| 92524 | U1, UA | ⁂(Behavioral and qualitative analysis of voice and resonance) (1 unit = 15 minutes; maximum of 4 units) |
| 92551 | U1 | Audio Screen |
| 92567 | U1 | Tympanometry |
| 92587\*\* | U1 | Evoked otoacoustic emissions; limited (single stimulus level, either transient or distortion products) |
| 95961 | UA | Cortical Function Testing |
| 96101\* | U1, UA | Psychological Testing, 2 or more (1 unit = 15 minutes), maximum of 8 units |
| 96101\* | UA | Interpretation (1 unit = 15 minutes), maximum of 8 units |
| 99173 |  | Visual Screen |
| 9920599215 | U1U1 | High Complex medical exam |

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

\*\*Effective for dates of service on and after January 1, 2007, procedure code 92587 is payable.

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| 262.200 National Place of Service (POS) Codes | 7-1-07 |

Electronic and paper claims now require the same National Place of Service code.

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| Place of Service | POS Codes |
| Doctor’s Office | 11 |

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| 262.300 Billing Instructions – Paper Only | 11-1-17 |

Bill Medicaid for professional services with form CMS-1500. The numbered items in the following instructions correspond to the numbered fields on the claim form. [View a sample form CMS-1500.](../../Forms/SampleCMS-1500.pdf)

Carefully follow these instructions to help the Arkansas Medicaid fiscal agent efficiently process claims. Accuracy, completeness, and clarity are essential. Claims cannot be processed if necessary information is omitted.

Forward completed claim forms to the Claims Department. [View or print the Claims Department contact information.](../../Links/Claims.doc)

NOTE: A provider delivering services without verifying beneficiary eligibility for each date of service does so at the risk of not being reimbursed for the services.

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| 262.310 Completion of CMS-1500 Claim Form | 9-1-14 |

| 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 completemailing 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. |
| 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 code in this field. The subset of approved Condition Codes is found at [www.nucc.org](http://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. |
| 14. DATE OF CURRENT:ILLNESS (First symptom) ORINJURY (Accident) ORPREGNANCY (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 Treatment304 Latest Visit or Consultation453 Acute Manifestation of a Chronic Condition439 Accident455 Last X-Ray471 Prescription090 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) referral is required for CHMS services. 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 | For tracking purposes, occupational, physical and speech therapy providers are required to enter one of the following therapy codes: |
| Code | Category |
| A | Individuals from birth through 2 years who are receiving therapy services under an Individualized Family Services Plan (IFSP) through the Division of Developmental Disabilities Services. |
| B | Individuals ages 0 through 5 years (if individual has not reached age 5 by September 15) who are receiving therapy services under an Individualized Plan (IP) through the Division of Developmental Disabilities Services. |
|  | **NOTE: This code is to be used only when all three of the following conditions are in place: 1) the individual receiving services has not attained age 5 by September 15 of the current school year, 2) the individual receiving services is receiving the services under an Individualized Plan, 3) the Individualized Plan is through the Division of Developmental Disabilities Services.** |
| When using code C or D, providers must also include the 4-digit LEA (local education agency) code assigned to each school district. For example: C1234 |  |
| C (and 4-digit LEA code) | Individuals ages 3 through 5 years (if individual has not reached age 5 by September 15) who are receiving therapy services under an Individualized Education Plan (IEP) through an education service cooperative. |
|  | **NOTE: This code is to be used only when all three of the following conditions are in place: 1) the individual receiving services is between the ages of 3 through 5 years and has not attained age 5 by September 15 of the current school year, 2) the individual receiving services is receiving the services under an Individualized Education Plan, 3) the Individualized Education Plan is through an education service cooperative.** |
| D (and 4-digit LEA code) | Individuals ages 5 (by September 15) to 21 years who are receiving therapy services under an Individualized Education Plan (IEP) through a school district. |
|  | **NOTE: This code is to be used only when all three of the following conditions are in place: 1) the individual receiving services is between the ages of 5 (by September 15 of the current school year) to 21 years. 2) the individual receiving services is receiving the services under an Individualized Education Plan, 3) the Individualized Education Plan is through a school district.** |
| E | Individuals ages 18 years and up who are receiving therapy services through the Division of Developmental Disabilities Services. |
| F | Individuals ages 18 years and up who are receiving therapy services through individual or group providers not included in any of the previous categories (A-E). |
| G | Individuals ages birth through 17 years who are receiving therapy/pathology services through individual or group providers not included in any of the previous categories (A-F). |
|  | Not used. |
| 20. OUTSIDE LAB? | Not required. |
|  $ CHARGES | Not required. |
| 21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY | Enter the applicable ICD indicator to identify which version of the 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 262.200 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 | One CPT or HCPCS procedure code for each detail. See Sections 262.100 through 262.140. |
|  MODIFIER | Modifier(s) if applicable. See Section 262.120. |
| 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 co-payments. |
| 30. RESERVED | Reserved for NUCC use. |
| 31. SIGNATURE OF PHYSICIAN 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.  |
| 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. |

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| 262.400 Special Billing Procedures | 10-13-03 |

Not applicable to this program.