



Arkansas Department of Human Services

Division of Medical Services

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TO: Health Care Provider - Prosthetics
DATE: August 15, 2002
SUBJECT: Update Transmittal No. 55

REMOVE

INSERT

<u>Page</u>	<u>Date</u>	<u>Page</u>	<u>Date</u>
Table of Contents	1-1-01	Table of Contents	8-15-02
II-6 through II-6C	Dates vary	II-6 through II-6D	8-15-02
II-12B through II-12F	Dates vary	II-12B through II-12F	8-15-02

Explanation of Updates

Page II-6, section 211, has been revised to clarify information regarding nutritional formulae, to transfer information regarding apnea monitors to Page 6A and to delete obsolete information.

Page II-6A, section 211, has been included to advise that a primary care physician (PCP) is not required for referrals for apnea monitors until an infant's Medicaid eligibility has been determined. No PCP referral for medical services is required for retroactive eligibility periods. Obsolete information has also been removed and minor text revisions have been made to improve readability.

Page II-6B, section 211, has been included because of repagination. The address for the Utilization Review has been transferred from Page II-6A, and the slot number for the unit has been corrected. Obsolete information and typographical errors have been removed.

Pages II-6C and II-6D, section 211, have been included because of repagination. Obsolete information has been removed and minor text revisions have been made to improve readability.

Pages II-12B and II-12C, section 221.2, have been included to add new criteria and guidelines regarding prior authorization of apnea monitors for infants under age 21. Minor text revisions have also been made on Page II-12C.

Pages II-12D through II-12F, section 221.31 through section 221.5, have been included to repaginate information. Section 221.42 was included to correct the mailing address for Utilization Review. Section 221.5 was included to transfer the information previously on page II-12F. Minor text revisions have been made to improve readability and to clarify policy.

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Page 2

Explanation of Updates (con't)

Page II-12G has been added to include the revised DMS 699 – Request for Extension of Benefits form. The previous version of the form was located on Page II-12E.

Attached are updated pages to file in your provider manual.

A change bar in the left margin denotes a revision.

If you need this material in an alternative format, such as large print, please contact our Americans with Disabilities Act Coordinator at (501) 682-8307 (voice) or (501) 682-6789 and 1-877-708-8191 (TDD).

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

Thank you for your participation in the Arkansas Medicaid Program.

Ray Hanley, Director
Division of Medical Services

Arkansas Medicaid provider manuals (including update transmittals), official notices and remittance advice (RA) messages are available for downloading from the Arkansas Medicaid website: www.medicaid.state.ar.us.

Arkansas Medicaid Manual: PROSTHETICS	Page: II-6
	Effective Date: 4-1-90
Subject: PROGRAM COVERAGE	Revised Date: 8-15-02

211

Scope (Continued)

Repair of a “rental only” item is covered in the rental fee. Repair of “purchased” items is covered separately. Total (cumulative) repair costs must not exceed 50% of the item’s total purchase cost.

- * Nutritional formulae may be covered by the Arkansas Medicaid Program when prescribed by a physician and documented as medically necessary **for recipients under age 21 participating in the Child Health Services (EPSDT) Program.** (Refer to section 316.10 for billing information for nutritional formulae.)

The covered formulae represent those nutritional supplements most requested for medical purposes. However, if none of the formulae are appropriate and another formula is prescribed by a physician as a result of Child Health Services (EPSDT) screening, the prescribed formula will be reviewed for medical necessity.

Formulae are covered as nutritional supplements rather than the sole source of nutrition. Recipients who require enteral nutrition as the sole source of nutrition and the formulae is administered through a nasogastric, jejunostomy or gastrostomy tube should be referred to a Medicaid Hyperalimentation provider.

One unit of service equals 100 calories with a maximum allowable of 30 units per day. This is a separate benefit limit from the limit established for medical supplies. Supplies provided in conjunction with the nutritional formulae through the Home Health or Prosthetics programs must be billed under the medical supply codes, if that supply is covered by the program.

There are certain nutritional formulae available to eligible recipients through the WIC Program and the Food Stamp Program. These two programs should be accessed by recipients prior to requesting Medicaid reimbursement for nutritional formulae. The coverage of these formulae through the Medicaid Program is limited to recipients requiring nutrition therapy due medical necessity and only when prescribed by a physician.

Arkansas Medicaid Manual: PROSTHETICS	Page: II-6A
	Effective Date: 1-1-91
Subject: PROGRAM COVERAGE	Revised Date: 8-15-02

211 Scope (Continued)

* Arkansas Medicaid covers apnea monitors only for infants under one (1) year of age. Use of the apnea monitor must be medically necessary and prescribed by a physician.

A primary care physician (PCP) is not required until an infant's Medicaid eligibility has been determined. No PCP referral for medical services is required for retroactive eligibility periods.

Prior authorization is not required for the initial one-month period. If the apnea monitor is needed longer than the initial month, prior authorization is required. When requesting prior authorization, Form DMS-679—Medical Equipment Request for Prior Authorization and Prescription, must be completed and submitted to the Utilization Review Section.

Consideration for prior authorization for use after the one month period will be given when a new prescription, proof of medical necessity and documentation of compliance is submitted in accordance with the prior authorization procedures described in section 221.2.

* The Arkansas Medicaid Program reimburses home health providers and prosthetic providers for covered medical supplies up to a maximum of \$250.00 per month, per recipient. The \$250.00 may be provided by the Home Health Program, the Prosthetics Program, or a combination of the two. However, a recipient may not receive more than a total \$250.00 of supplies per month unless an extension has been granted. Extensions will be considered for recipients under age 21 in the Child Health Services (EPSDT) Program if documentation verifies medical necessity. The provider must request an extension of the benefit limit for a Medicaid recipient under age 21 by completing the Request for Extension of Benefits for Medical Supplies for Medicaid Recipients Under Age 21 (Form DMS-602.) (Please refer to pages II-10A, II-10B and II-10C of this manual.)

* The Arkansas Medicaid Program covers medical supplies by means of a specific HCPCS procedure code for each specific item. Only supply items that are listed and have a corresponding payable HCPCS procedure code are covered. Covered procedure codes are located in section 315.12 of this manual. Reimbursement is made according to the rate paid by Medicare for that procedure code.

Arkansas Medicaid Manual: PROSTHETICS	Page: II-6B
	Effective Date: 3-1-00
Subject: PROGRAM COVERAGE	Revised Date: 8-15-02

211 Scope (Continued)

* Diapers and underpads are covered under the procedure codes described in section 315.13 of this manual. A benefit limit of \$130.00 per month, per recipient for diapers of any size and underpads has been established. The benefit limit will apply to each procedure code or any combination of the four codes assigned to these services. The \$130.00 benefit limit is a combined limit for diapers provided through the Prosthetics Program and Home Health Program. This benefit limit may be extended with proper documentation. This is a separate benefit limit from the limit established for home health and DME medical supplies. Diaper services must be medically necessary. Only patients with a medical diagnosis other than infancy which results in incontinence of the bladder and/or bowel may receive diapers through the Home Health and Prosthetics Programs. This coverage does not apply to infants who would otherwise be in diapers regardless of their medical condition. Providers should not bill for underpads or diapers if the recipient is under the age of 3 years.

* To obtain an extension of benefits for diapers and underpads, the following information must be submitted to:

Prosthetics Services Reviewer
DMS Utilization Review
P.O. Box 1437, Slot S413
Little Rock, AR 72203-1437

- a. A Medicaid claims form each month for which extension of benefits for diapers and underpads is being requested.
- b. An invoice for each diaper or underpad item included in the request showing the actual cost to the prosthetics provider for each item.
- c. Documentation supported by the medical record substantiating the medical necessity of an extension of benefits.

The Arkansas Medicaid Program covers orthotic appliances and prosthetic devices for individuals under age 21 in the Child Health Services (EPSDT) Program. Providers of orthotic appliances and prosthetic devices may be reimbursed by the Arkansas Medicaid Program when the items are prescribed by a physician and documented as medically necessary for recipients under age 21 participating in the Child Health Services (EPSDT) Program. No prior authorization is required to obtain these services for individuals under age 21. No benefit limits apply to orthotic appliances and prosthetic devices for individuals under age 21.

Arkansas Medicaid Manual: PROSTHETICS	Page: II-6C
	Effective Date: 3-1-00
Subject: PROGRAM COVERAGE	Revised Date: 8-15-02

211 Scope (Continued)

The orthotics/prosthetics provider should maintain accreditation by the American Board for Certification in Orthotics and Prosthetics. The provider should ensure that staff providing patient care (including but not limited to direct care, evaluations, diagnosis, fabrication fittings and follow up care) are accredited by the American Board for Certification in Orthotics and Prosthetics and meet all national licensing and certification requirements and all licensing and certifications required by the State of Arkansas.

Arkansas Medicaid covers orthotic appliances and prosthetic devices for individuals age 21 and over.

Prior authorization is required for orthotic appliances valued at or above the Medicaid maximum allowable reimbursement rate of \$500.00 per item for use by individuals age 21 and over. Prior authorization may be requested by submitting the Medical Equipment Request for Prior Authorization and Prescription form, (Form DMS-679) to the Utilization Review (UR) Section.

For individuals age 21 and over, a benefit limit of \$3,000 per state fiscal year has been established for reimbursement for orthotic appliances. No extension of benefits will be granted.

Prior authorization will be required for prosthetic device items valued at or in excess of the \$1000.00 per item Medicaid maximum allowable reimbursement rate for use by individuals age 21 and over. Prior authorization may be requested by submitting the Medical Equipment Request for Prior Authorization and Prescription form, (Form DMS-679) to the Utilization Review (UR) Section.

For individuals age 21 and over, a benefit limit of \$20,000 per state fiscal year (SFY) has been established for reimbursement for prosthetic devices. No extension of benefits will be granted.

The following restrictions apply to the coverage of orthotic appliances for individuals age 21 and over:

- A. Orthotic appliances may not be replaced for 12 months from the date of purchase. If a patient's condition warrants a modification or replacement, and the \$3000.00 State Fiscal Year (July 1 through June 30) benefit limit has not been met, the provider may submit documentation to the Division of Medical Services, Utilization Review Section, to substantiate medical necessity. The Utilization Review Section will issue a prior authorization number. Section 221 of this provider manual may be referenced for information regarding prior authorization procedures.
- B. Custom molded orthotics are not covered for a diagnosis of carpal tunnel syndrome prior to surgery.

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	Effective Date: 8-15-02
Subject: PROGRAM COVERAGE	Revised Date:

211 Scope (Continued)

The following restrictions apply to coverage of prosthetic devices for individuals age 21 and over:

- A. Prosthetic devices may be replaced only after five years have elapsed from their date of purchase. If the patient's condition warrants a modification or replacement, and the \$20,000 state fiscal year (July 1 through June 30) benefit limit has not been met, the provider may submit documentation to the Division of Medical Services, Utilization Review Section, to substantiate medical necessity. The Utilization Review Section will issue a prior authorization number. Section 221 of this provider manual may be referenced for information regarding prior authorization procedures.
- B. Myoelectric prosthetic devices may be purchased only when needed to replace myoelectric devices received by individuals who were under age 21 when they received the original device.

This manual includes six forms, listed below, related to evaluating the need of individuals aged 21 and over for orthotic appliances and prosthetic devices, and prescribing the needed appliances and equipment. The Medicaid Program does not require providers to use the forms, but the information the forms are designed to collect is required by Medicaid to process requests for prior authorization of orthotic appliances and prosthetic devices for individuals aged 21 and over.

The appropriate forms (or the required information in a different format) must accompany the DMS-679, titled Medical Equipment Request for Prior Authorization and Prescription. Copies of the forms may be made from those included in this manual or may be downloaded from the Arkansas Medicaid Website www.medicaid.state.ar.us.

The forms and their titles are as follows:

- A. DMS-646 Evaluation Form Lower Limb
- B. DMS-647 Gait Analysis: Full Body
- C. DMS-648 Prosthetic-Orthotic Upper-Limb Amputee Evaluation
- D. DMS-649 Upper-Limb Prosthetic Prescription
- E. DMS-650 Prosthetic-Orthotic Lower-Limb Amputee Evaluation
- F. DMS-651 Lower-Limb Prosthetic Prescription

Arkansas Medicaid Manual: PROSTHETICS	Page: II-12A
	Effective Date: 1-1-95
Subject: PRIOR AUTHORIZATION	Revised Date: 10-15-98

221.1 Oxygen Prior Authorization (Continued)

Prescription for oxygen must specify the oxygen flow rate, frequency and duration of use, estimate of the period of need for oxygen and method of delivery of oxygen to the patient (e.g., two liters per minute, 10 minutes per hour by nasal cannula for a period of two months). A prescription containing only "oxygen PRN" is not sufficient.

The following medical criteria will be utilized in evaluating coverage of oxygen:

1. Chronic Respiratory Disease
 - a. continuous oxygen therapy
resting PaO₂ less than 55mm Hg
 - b. nocturnal oxygen therapy
resting PaO₂ less than 60mm Hg
 - c. exercise oxygen therapy
PaO₂ with exercise less than 55mm Hg
2. Congestive Heart Failure
symptomatic at rest with PaO₂ less than 60mm Hg
3. Carcinoma of Lung
resting PaO₂ less than 60mm Hg
4. Others
reviewed on individual basis
5. Children
 - a. O₂ saturation below 94% by pulse oximeter with elevated PCO₂ by capillary blood gas or endtidal CO₂ on two separate occasions.

The prior authorization request for all oxygen and respiratory equipment must be submitted on Form DMS-679, Medical Equipment Request for Prior Authorization and Prescription, to Utilization Review for individuals of all ages.

Arkansas Medicaid Manual: PROSTHETICS	Page: II-12B
	Effective Date: 5-1-95
Subject: PRIOR AUTHORIZATION	Revised Date: 8-15-02

221.2 Apnea Monitor Prior Authorization

Prior authorization of the apnea monitor is required after an infant has been monitored for one month. A new referral and prescription is required. Documentation of compliance during the initial one month period and proof of medical necessity for the continuation of monitoring must be shown.

For the initial certification, the prescribing physician must sign form DMS-679 – Medical Equipment Request for Prior Authorization and Prescription. The physician’s signature must be an original, not a stamp. When an apnea monitor is prescribed during a hospital discharge, the physician ordering the apnea monitor must be a neonatologist or pulmonologist.

As necessary, the Primary Care Physician's (PCP) name and provider number must also be indicated on the DMS-679. The PCP's signature is not required on the initial certification but he or she must sign all re-certifications.

Documentation from the physician describing the education of the family regarding their understanding of the importance of the apnea monitor must be included after the initial one-month time period.

The following criteria, which follows the guidelines set by the *National Institute of Health Consensus Statement on Infantile Apnea on Home Monitoring, Consensus Development Conference Statement September 29-October 1, 1986*, will be utilized in evaluating the need for an apnea monitor after the initial one month period:

1. Cardio-respiratory monitoring for certain groups of infants at high risk for sudden death is medically indicated. The following indications will determine medical necessity.
 - a. Infants with one or more severe Apparent Life Threatening Events (ALTE) requiring mouth to mouth resuscitation or vigorous stimulation.
 - b. Symptomatic pre-term infant.
 - c. Siblings with two or more SIDS victims.
 - d. Infants with central hypoventilation.

2. Other groups with the following indications will be considered on a case-by-case basis:
 - a. Infants with less severe ALTEs
 - b. Infants with tracheotomies
 - c. Infants born of cocaine or opiate-abusing mothers
 - d. Asymptomatic pre-term infants with certain residual disease may be considered for monitoring.

3. Pneumograms will not be considered as screening tools.

Arkansas Medicaid Manual: PROSTHETICS	Page: II-12C
	Effective Date: 1-1-96
Subject: PRIOR AUTHORIZATION	Revised Date: 8-15-02

221.2 Apnea Monitor Prior Authorization (Continued)

4. Caregivers should receive:
 - a. A psychosocial assessment of the caregiver
 - b. Informed consent process
 - c. Guidance to help prepare the caregiver for the demands of home monitoring
 - d. Training and demonstrated proficiency in infant CPR and resuscitation methods
 - e. Written guidelines on home monitoring
 - f. Discharge planning, including discussion of follow-up services and procedures for discontinuation.

5. For an apnea monitor to be discontinued in the home, one or more of the following conditions must be met:
 - a. Four (4) weeks apnea free or one normal download
 - b. Patient off respiratory stimulants for two consecutive weeks
 - c. 48 week adjusted gestational age.

6. The caregiver must understand that he or she will be financially liable if he or she does not return the equipment to the DME company when the infant no longer requires monitoring according to the discontinuation criteria listed above.

Prior authorization for the apnea monitor must be submitted on Form DMS-679, Medical Equipment Request for Prior Authorization and Prescription, to Utilization Review.

221.3 Insulin Pump and Supplies Prior Authorization

Prior authorization is required for the insulin pump. A prescription and proof of medical necessity is required. The patient must be educated on the use of the pump, but the education is not a covered service.

The following criteria will be utilized in evaluating the need for the insulin pump:

1. Insulin dependent diabetes, that is difficult to control.
2. Fluctuation in blood sugars causing both high and low blood sugars in a patient on at least 3, if not 4, injections per day.
3. Patient's motivation level in controlling diabetes and willingness to do frequent blood glucose monitoring.
4. Patient's ability to learn how to use the pump effectively. This will have to be evaluated and documented by a professional with experience in the use of the pump.

Arkansas Medicaid Manual: PROSTHETICS	Page: II-12E
	Effective Date: 2-1-98
Subject: PRIOR AUTHORIZATION	Revised Date: 8-15-02

221.41 Prior Authorization Procedures for Augmentative Communication Devices for Medicaid Recipients Under Age 21

The following information must be submitted when requesting prior authorization for augmentative communication devices for Medicaid recipients under age 21.

1. Submit Form DMS-679 – Medical Equipment Request for Prior Authorization and Prescription. The form should be accompanied by:
 - A. A copy of the current EPSDT Screen dated within 12 months of the date of the prescription stating the medical need for an Augmentative Communication Device.
 - B. Current augmentative communication evaluation completed within the past twelve months, by a speech/language pathologist with expertise in this area, experience working with children with limited or no speech, and who uses a variety of devices during the evaluation. Team evaluations are preferred.
 - C. Written prescription from the physician that states the exact equipment needed (name of the device, any equipment such as switches, wheelchair mounts, carrying case, etc.)
 - D. Written denial from the insurance company, if child has other insurance.

This information **must** be submitted to the Utilization Review Section of the Division of Medical Services.

221.42 Extension of the \$7,500.00 Lifetime Benefit Limit

In order to obtain an extension of the \$7,500.00 lifetime benefit for recipients under 21 years of age, a medical necessity determination for additional equipment is required. The provider must submit a Request for Extension of Benefits (Form DMS-699), completed Medicaid claim and medical records substantiating medical necessity that the recipient cannot function using their existing equipment to:

Benefit Extension Requests
Utilization Review Section
P.O. Box 1437, Slot S413
Little Rock, AR 72203-1437

The Benefit Limits Review Committee, which consists of medical personnel, will review the medical records. Documentation should be specific and complete. The provider will be notified in writing of the approval or denial of the request for extended benefits. Notification of approval includes a benefit extension control number (PA number) to be entered on the claim.

Arkansas Medicaid Manual: PROSTHETICS	Page: II-12F
	Effective Date: 2-1-98
Subject: PRIOR AUTHORIZATION	Revised Date: 8-15-02

221.5 Home Blood Glucose Monitor Pregnant Women Only, All Ages

The Arkansas Medicaid Prosthetics Program covers the home blood glucose monitor for pregnant women of all ages. Prior authorization is not required for use of this device.

A. Patient Eligibility

1. Pregestational diabetes. Any women on an oral hypoglycemic or insulin when the pregnancy is diagnosed.
2. Women that are being followed by a physician for elevated fasting hyperglycemia, but not on an oral hypoglycemic or insulin when the pregnancy is diagnosed.
3. Women demonstrating glucose intolerance during the pregnancy as demonstrated by an elevated three-hour glucose tolerance test.

B. Criteria for glucose intolerance

1. Demonstration of an elevated one-hour glucose tolerance test of greater than 140 mg/deciliter on a nonfasting value.
2. Elevation of two or more values on a three-hour glucose tolerance test **above** the accepted cut-off points of:
 - a. Fasting, less than 105
 - b. One-hour, less than 190
 - c. Two-hour, less than 165
 - d. Three-hour, less than 145

Request for Extension of Benefits

Provider
Address
Address
City _____ State _____ Zip Code _____
Patient's Name _____
Address _____
City _____ State _____ Zip Code _____
Medicaid ID Number _____ Birthdate _____ Sex _____
Diagnoses _____

Benefit Extensions Requested

Procedure Code	Type of Service Code	Service From Date	Service To Date	Units

Attach a summary and medical records as needed to justify medical necessity.

Medicaid Provider Number _____
Provider's Signature _____ Date _____

Request Disposition *(To be completed by reviewer)*

Approved _____ Denied _____ Control Number _____

Procedure Code	Type of Service Code	Service From Date	Service To Date	Units

