Arkansas Department of Human Services
Division of Medical Services
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OFFICIAL NOTICE

DMS-2004-AR-3	**DMS-2004-I-2**	**DMS-2004-FF-3**	**DMS-2004-Y-4**
DMS-2004-C-5	**DMS-2004-L-6**	**DMS-2004-R-6**	**DMS-2004-YY-6**
DMS-2004-F-3	**DMS-2004-KK-5**	**DMS-2004-EE-2**	

TO: **Health Care Provider – ARKids First-B; Child Health Management Services (CHMS); Developmental Day Treatment Clinic Services (DDTCS); Home Health; Hospital; Nurse Practitioner; Occupational, Physical, Speech Therapy; Physician; Podiatrist; Rehabilitative Hospital and Rehabilitative Services for Persons with Mental Illness (RSPMI)**

DATE: **November 1, 2004**

SUBJECT: **Revision of Form DMS-640**

Effective for dates of service on or after November 1, 2004, form DMS-640, Occupational, Physical, and Speech Therapy for Medicaid Eligible Recipients Under Age 21 Prescription/Referral and the instructions for completion are revised. Primary care physicians (PCPs) are required to use the revised form as of November 1, 2004, when making referrals for therapy evaluation and when prescribing therapy treatment. A copy of form DMS-640 with instructions is attached.

The form is revised to substitute the word primary diagnosis for medical diagnosis. Developmental diagnosis and clinical indication for treatment are deleted. Lines are added for the PCP to enter the diagnosis as it relates to the prescribed treatment.

Expenditures, unduplicated recipient count, average units and cost for claims with a paid date during state fiscal year (SFY) 2003 for recipients under age 21 are also included as part of the revision.

Each year the Division of Medical Services (DMS) will update form DMS-640 to ensure that the expenditure data are from the most recently completed state fiscal year for which such figures are available. As soon as the update is complete, DMS will furnish providers with the current form.

PROPOSED

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

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

Thank you for your participation in the Arkansas Medicaid Program.

Roy Jeffus, Director

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 Division of Medical Services

Occupational, Physical and Speech Therapy for Medicaid Eligible Recipients Under Age 21
PRESCRIPTION/REFERRAL

The PCP or attending physician must use this form to prescribe medically necessary Medicaid therapy services or must use this form to make a referral for therapy services. The provider must check the appropriate box or boxes.

☐ Referral ☐ Treatment

EVALUATE/TREAT IS NOT A VALID PRESCRIPTION

Patient Name: _____ Medicaid ID #: _____

Date Child Was Last Seen In Office: _____

Primary Diagnosis or ICD-9 code: _____

Diagnosis as Related to Prescribed Treatment: _____

_____

Complete this block if this form is a prescription		
Occupational Therapy (OT)	**Physical Therapy (PT)**	**Speech Therapy (ST)**
_____Minutes per week	_____Minutes per week	_____Minutes per week
_____Duration (months)	_____Duration (months)	_____Duration (months)
☐ Therapy Not Medically Necessary	☐ Therapy Not Medically Necessary	☐ Therapy Not Medically Necessary

Other Information: _____

_____

Note:

	OT	***PT***	***ST***
Expenditures for SFY03	****$18,783,761***	****$13,653,480***	****$24,225,403***
Average Units Per Recipient	***88***	***83***	***84***
Average Cost Per Recipient	***$1,571***	***$1,438***	***$1,335***
Total Recipients Served	***11,959***	***9,494***	***18,146***

_____ _____
Primary Care Physician Name *(Please Print)* Medicaid Provider Number

_____ _____
Attending Physician Name *(Please Print)* Medicaid Provider Number

By signing as the Primary Care Physician (PCP) or Attending Physician, I hereby certify that I have carefully reviewed each element of the therapy treatment plan, that the goals are reasonable and appropriate for this patient, and in the event that this prescription is for a continuing plan I have reviewed the patients progress and adjusted the plan for his or her meeting or failure to meet the plan goals.

_____ _____
Physician Signature *(PCP or attending Physician)* Date

DMS-640 (Rev. 11-2004)

Instructions for Completion

Form DMS-640 – Occupational, Physical and Speech Therapy for Medicaid Eligible Recipients Under Age 21 PRESCRIPTION/REFERRAL

- If DMS-640 is used to make an initial referral for evaluation, check the referral box only. After receiving the evaluation results and determining that therapy is necessary, you must use a separate DMS-640 form to prescribe the therapy. Check the treatment box for prescription and complete the form following the instructions below. If the referral and prescription are for previously prescribed services, you may check both boxes.

- Patient Name – Enter the patient's full name.

- Medicaid ID # - Enter the patient's Medicaid ID number.

Physician/Physician's office staff must complete the following:

- Date Child Was Last Seen In Office – Enter the date of the last time you saw this child. (This could be either for a complete physical examination, a routine check-up or an office visit for other reasons requiring your personal attention.)

- Primary Diagnosis – Enter the primary medical diagnosis description or ICD-9 diagnosis code.

- Diagnosis as Related to Prescribed Treatment – Enter the diagnosis that indicates or establishes medical necessity for prescribed therapy.

- Prescription block – If the form is used for a prescription, enter the prescribed number of minutes per week and the prescribed duration (in months) of therapy.

- If therapy is not medically necessary at this time, check the box.

- Other Information – Any other information pertinent to the child's medical condition, plan of treatment, etc., may be entered.

- Primary Care Physician Name and Medicaid Provider Number – Print the name of the prescribing primary care physician and his or her Medicaid provider number.

- Attending Physician Name and Medicaid Provider Number – If the Medicaid-eligible child is exempt from PCP requirements, print the name of the prescribing attending physician and his or her Medicaid provider number.

- Physician Signature and Date – The prescribing physician must sign and date the prescription for therapy in his or her original signature.

***These therapy amounts include therapy provided in a Developmental Day Treatment Center (DDTCS)**

The original of the completed form DMS-640 must be maintained in the child's medical records by the prescribing physician. A copy of the completed form DMS-640 must be retained by the therapy provider.