Arkansas Department of Health and Human Services

Division of Medical Services

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TO: **Arkansas Medicaid Health Care Providers – Occupational, Physical, Speech Therapy Services**

DATE: **July 1, 2006**

SUBJECT: **Provider Manual Update Transmittal #60**

REMOVE		**INSERT**	
Section	**Date**	**Section**	**Date**
201.000	11-1-05	201.000	7-1-06
201.110	7-1-05	201.110	7-1-06
203.000	10-13-03	203.000	7-1-06
216.300	3-1-06	216.300	7-1-06

Explanation of Updates

Section 201.000 is included to add a new statement regarding provider participation requirements.

Section 201.110 is included to correct the section reference mentioned at 201.110, B which was creating confusion for providers.

Section 203.000 is included to add information from Official Notice DMS-2003-FF-2 that outlined specific rules for providers to follow when providing supervision to a therapy assistant or speech-language pathology assistant.

Section 216.300 is included to explain how Arkansas Foundation for Medical Services, Inc (AFMC) determines that a request for extension of benefits for therapy services has been requested timely.

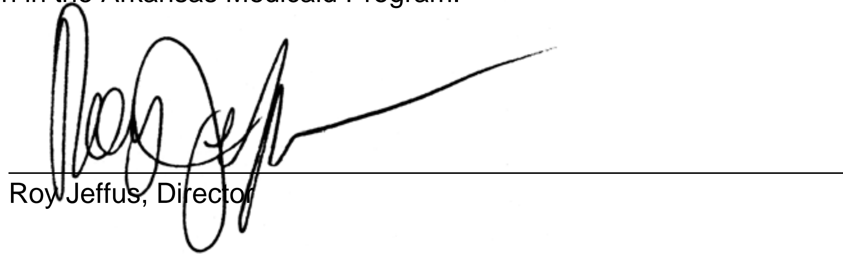
Paper versions of this update transmittal have updated pages attached to file in your provider manual. See Section I for instructions on updating the paper version of the manual. For electronic versions, these changes have already been incorporated.

If you need this material in an alternative format, such as large print, please contact our Americans with Disabilities Act Coordinator at (501) 682-6789 (TDD only).

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.

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.

Thank you for your participation in the Arkansas Medicaid Program.



Roy Jeffus, Director

201.000 Arkansas Medicaid Participation Requirements 7-1-06

Individual and group providers of occupational therapy, physical therapy and speech-language pathology services must meet the following criteria to be eligible to participate in the Arkansas Medicaid Program.

A. A provider of therapy services must meet the enrollment criteria for the type of therapy to be provided as established and outlined in section 202.000 of this manual.

B. A provider of therapy services has the option of enrolling in the Title XVIII (Medicare) Program. When a beneficiary is dually eligible for Medicare and Medicaid, providers must bill Medicare prior to billing Medicaid. The beneficiary may not be billed for the charges. Providers enrolled to participate in the Title XVIII (Medicare) Program must notify the Arkansas Medicaid Program of their Medicare provider number. Claims filed by Medicare "nonparticipating" providers do not automatically cross over to Medicaid for payment of deductibles and coinsurance.

C. The provider 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). **View or print a provider application (form DMS-652), Medicaid contract (form DMS-653) and Request for Taxpayer Identification Number and Certification (Form W-9).**

D. The following documents must accompany the provider application and the Medicaid contract.

   1. A copy of all certifications and licenses verifying compliance with enrollment criteria for the therapy discipline to be practiced. (See section 202.000 of this manual.)

   2. If enrolled in the Title XVIII (Medicare) Program, an out-of-state provider must submit a copy of verification that reflects current enrollment in that program.

E. Enrollment as a Medicaid provider is conditioned upon approval of a completed provider application and the execution of a Medicaid provider contract. Persons and entities that are excluded or debarred under any state or federal law, regulation or rule are not eligible to enroll, or to remain enrolled, as Medicaid providers.

F. A copy of subsequent state license renewal must be forwarded to the Medicaid Provider Enrollment Unit within 30 days of issuance. If the renewal document(s) have not been received within this timeframe, the provider will have an additional and final 30 days to comply.

G. Failure to timely submit verification of license renewal will result in termination of enrollment in the Arkansas Medicaid Program.

H. The provider must adhere to all applicable professional standards of care and conduct.

201.110 School Districts and Education Service Cooperatives 7-1-06

If a school district or an education service cooperative **contracts** with an individual qualified therapist or speech-language pathologist, the criteria for group providers of therapy services apply. The qualified individual is considered the provider of therapy services and must complete an application and contract with the Division of Medical Services. (Refer to section 201.100.)

The following requirements apply only to Arkansas school districts and education service cooperatives that employ (via a form W-4 relationship) qualified therapists or qualified speech-language pathologists to provide therapy services.

A. The Arkansas Department of Education must certify a school district or education service cooperative.

1. The Arkansas Department of Education must provide a list, updated on a regular basis, of all school districts and education service cooperatives certified by the Arkansas Department of Education to the Medicaid Provider Enrollment Unit of the Division of Medical Services.

2. The Local Education Agency (LEA) number must be used as the license number for the school district or education service cooperative.

B. The school district or education service cooperative must enroll as a provider of therapy services. Refer to section 201.000 for the process to enroll as a provider and for information regarding applicable restrictions to enrollment.

203.000 Supervision 7-1-06

The Arkansas Medicaid Program uses the following criteria to determine when supervision occurs within the Occupational, Physical, and Speech Therapy Services Program.

A. The person who is performing supervision must be a paid employee of the enrolled Medicaid provider of therapy or speech-language pathology services who is filing claims for services.

B. The qualified therapist or speech-language pathologist must monitor and be responsible for the quality of work performed by the individual under his or her supervision.

1. The qualified therapist or speech-language pathologist must be immediately available to provide assistance and direction throughout the time the service is being performed. Availability by telecommunication is sufficient to meet this requirement.

2. When therapy services are provided by a licensed therapy assistant or speech-language pathology assistant who is supervised by a licensed therapist or speech-language pathologist, the supervising therapist or speech-language pathologist must observe a therapy session with the child and review the treatment plan and progress notes at a minimum of every 30 calendar days.

C. The qualified therapist or speech-language pathologist must review and approve all written documentation completed by the individual under his or her supervision prior to the filing of claims for the service provided.

1. Each page of progress note entries must be signed by the supervising therapist with his or her full signature, credentials and date of review.

2. The supervising therapist must document approval of progress made and any recommended changes in the treatment plan.

3. The services must be documented and available for review in the beneficiary's medical record.

D. The qualified therapist or speech-language pathologist may not be responsible for the supervision of more than 5 individuals.

216.300 Procedures for Obtaining Extension of Benefits for Therapy Services 7-1-06

A. Requests for extension of benefits for therapy services for beneficiaries under age 21 must be mailed to the Arkansas Foundation for Medical Care, Inc. (AFMC). **View or print the Arkansas Foundation for Medical Care, Inc. contact information**. A request for

extension of benefits must meet the medical necessity requirement, and adequate documentation must be provided to support this request.

1. Requests for extension of benefits are considered only after a claim is denied because a benefit is exhausted.
2. The request for extension of benefits must be received by AFMC within 90 calendar days of the date of the benefits-exhausted denial. The count begins on the next working day after the date of the Remittance and Status Report (RA) on which the benefits-exhausted denial appears.
3. Submit with the request a copy of the Medical Assistance Remittance and Status Report reflecting the claim's denial for exhausted benefits. Do not send a claim.
4. AFMC will not accept extension of benefits requests sent via electronic facsimile (FAX).

B. Form DMS-671, Request for Extension of Benefits for Clinical, Outpatient, Laboratory, and X-Ray Services, must be utilized for requests for extension of benefits for therapy services. **View or print form DMS-671**. Consideration of requests for extension of benefits requires correct completion of all fields on this form. The instructions for completion of this form are located on the back of the form. The provider's signature (with his or her credentials) and the date of the request are required on the form. Electronic signatures are accepted. All applicable records that support the medical necessity of the extended benefits request should be attached.

C. AFMC will approve or deny an extension of benefits request – or ask for additional information – within 30 calendar days of their receiving the request. AFMC reviewers will simultaneously advise the provider and the beneficiary when a request is denied.