ARKANSAS DEPARTMENT OF HUMAN SERVICES

Division of Medical Services
Program Planning & Development

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

DATE: **January 1, 2009**

SUBJECT: **Provider Manual Update Transmittal #105**

REMOVE		**INSERT**	
Section	**Date**	**Section**	**Date**
204.000	6-1-06	204.000	1-1-09
212.000	10-13-03	212.000	1-1-09
214.000	4-15-05	214.000	1-1-09
214.100	10-13-03	214.100	1-1-09
214.400	12-1-07	214.400	1-1-09
214.410	9-1-08	214.410	1-1-09
215.000	8-1-06	215.000	1-1-09
—	—	215.100	1-1-09
216.000	blank	216.000	blank
216.100	4-15-05	216.100	1-1-09
216.200	10-13-03	—	—
216.300	7-1-06	216.300	1-1-09
216.305	3-1-06	216.305	1-1-09
216.310	3-1-06	216.310	1-1-09
216.315	3-1-06	216.315	1-1-09
262.400	8-1-06	262.400	1-1-09

Explanation of Updates

Section 204.000 is updated to include clarification of the extent of documentation required from an Individualized Education Plan (IEP) as related to therapy audits or retrospective review.

Section 212.000 is updated to further clarify benefits within the scope of therapy services and to change the term “recipient” to the correct Medicaid term “beneficiary”.

Section 214.000 is updated to change the term “recipient” to the correct Medicaid term “beneficiary” and relocate information formerly within paragraph F to a separate paragraph addition of I. Additional information and wording changes are included for clarification on the required use of form DMS-640 for referral and prescription of occupational, physical and speech therapy services.

Section 214.100 is updated to change the term “recipient” to the correct Medicaid term “beneficiary” and to change the name of the Field Audit Unit to the correct new title of Program Integrity Unit.

Section 214.400 is updated to remove the reference to an available standardized form in C #2.

Section 214.410 is updated to remove the reference to an available standardized form in E #8 and F #9.

Section 215.000 is updated to change the referenced section number for ACD evaluation benefits.

Section 215.100 is a new section, added to locate ACD information in sequence.

Section 216.000 is updated to change the section title.

Section 216.100 is updated to change the section title and to include minor wording changes in descriptive terms.

Section 216.200 is deleted and ACD information relocated in new section 215.100 to appear in appropriate sequence.

Section 216.300 is updated to change the section title and to include minor wording changes in descriptive terms.

Section 216.305 is updated to make minor wording changes in descriptive terms.

Section 216.310 is updated to change the section title and to make minor wording changes in descriptive terms.

Section 216.315 is updated to correct paragraph alignment.

Section 262.400 is updated to make minor wording changes in descriptive terms.

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 501-682-8323 (Local); 1-800-482-5850, extension 2-8323 (Toll-Free) or to obtain access to these numbers through voice relay, 1-800-877-8973 (TTY Hearing Impaired).

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.

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Roy Jeffus, Director

TOC required

204.000 Required Documentation 1-1-09

A. The provider must contemporaneously establish and maintain records that completely and accurately explain all evaluations, care, diagnoses and any other activities of the provider in connection with its delivery of medical assistance to any Medicaid beneficiary.

B. Beneficiary records must support the levels of service billed to Medicaid.

C. Providers furnishing any Medicaid-covered good or service for which a prescription, admission order, physician's order, care plan or other order for service initiation, authorization or continuation is required by law, by Medicaid rule, or both, must obtain a copy of the aforementioned prescription, care plan or order within five (5) business days of the date it is written. Providers also must maintain a copy of each prescription, care plan or order in the beneficiary's medical record and follow all prescriptions, care plans, and orders as required by law, by Medicaid rule, or both.

D. All records must be kept for a period of five (5) years from the ending date of service or until all audit questions, appeal hearings, investigations or court cases are resolved, whichever is longer. Failure to furnish medical records upon request may result in sanctions being imposed. (See Section I of this manual.)

E. The provider must make available to the Division of Medical Services, its contractors and designees and the Medicaid Fraud Control Unit all records related to any Medicaid beneficiary. When records are stored off-premise or are in active use, the provider may certify, in writing, that the records in question are in active use or in off-premise storage and set a date and hour within three (3) working days, at which time the records will be made available. However, the provider will not be allowed to delay for matters of convenience, including availability of personnel.

F. All documentation must be made available to representatives of the Division of Medical Services at the time of an audit conducted by the Medicaid Program Integrity Unit. All documentation must be available at the provider's place of business. If an audit determines that recoupment is necessary, there will be only thirty (30) days after the date of the recoupment notice in which additional documentation will be accepted. Additional documentation will not be accepted at a later date.

G. Providers of therapy services are required to maintain the following records for each beneficiary of therapy services.

1. A written referral for occupational therapy, physical therapy or speech-language pathology services is required from the patient's primary care physician (PCP) unless the beneficiary is exempt from PCP Managed Care Program requirements.
    a. If the beneficiary is exempt from the PCP process, then the beneficiary's attending physician will make referrals for therapy services.
    b. Providers of therapy services are responsible for obtaining renewed PCP referrals every 6 months. Please refer to Section I of this manual for policies and procedures regarding PCP referrals.
2. A written prescription for occupational, physical therapy and speech-language pathology services signed and dated by the PCP or attending physician.

a. The beneficiary's PCP or the physician specialist must sign the prescription.

b. A prescription for therapy services is valid for 1 year unless the prescribing physician specifies a shorter period.

3. A treatment plan or plan of care (POC) for the prescribed therapy, developed and signed by providers credentialed and licensed in the prescribed therapy or by a physician. The plan must include goals that are functional, measurable and specific for each individual client.

4. Where applicable, an Individualized Family Service Plan (IFSP), Individual Program Plan (IPP) or *Individual Educational Plan (*IEP), established pursuant to Part C of the Individuals with Disabilities Education Act. *The entire volume of the IEP is not required for documentation purposes of retrospective review or audit of a facility's therapy services. Pages one (1) and two (2), the Goals and Objectives page (pertinent to the therapy requested) and the Signature Page of the IEP are all that are normally required for verification as review documentation.

5. Where applicable, an *Individual Educational Plan (*IEP) established pursuant to Part B of the Individuals with Disabilities Education Act *The entire volume of the IEP is not required for documentation purposes of retrospective review or audit of a facility's therapy services. Pages one (1) and two (2), the Goals and Objectives page (pertinent to the therapy requested) and the Signature Page of the IEP are all that are normally required for verification as review documentation.

6. Description of specific therapy or speech-language pathology service(s) provided with date, actual time service(s) were rendered, and the name of the individual providing the service(s).

7. All therapy evaluation reports, dated progress notes describing the beneficiary's progress signed by the individual providing the service(s) and any related correspondence.

8. Discharge notes and summary.

H. Any individual providing therapy services or speech-language pathology services must have on file:

1. Verification of his or her qualifications. Refer to Section 202.000 of this manual.

2. When applicable, any written contract between the individual and the school district, education service cooperative or the Division of Developmental Disabilities Services.

I. Any group provider enrolled as a Medicaid provider is responsible for maintaining appropriate employment records for all qualified therapists, speech-language pathologists and for all therapy or speech-language pathology assistants employed by the group.

J. School districts or education service cooperatives must have on file all appropriate employment records for qualified therapists, speech-language pathologists and for all therapy or pathology assistants employed by the group. A copy of verification of the employee credentials and qualifications is to be maintained in the group provider's employee files.

K. A cooperative for multiple school districts that provides, by contractual agreement, the qualified speech-language pathologist to supervise speech-language pathology assistants or speech therapists must have on file the contractual agreement.

212.000 Scope 1-1-09

Occupational therapy, physical therapy and speech-language pathology services are those services defined by applicable state and federal rules and regulations. These services are covered only when the following conditions exist.

A. Services are provided only by appropriately licensed individuals who are enrolled as Medicaid providers in keeping with the participation requirements in Section 201.000 of this manual.

B. Services are provided as a result of a referral from the beneficiary's primary care physician (PCP). If the beneficiary is exempt from the PCP process, then the attending physician must make the referrals.

C. Treatment services must be provided according to a written prescription signed by the PCP, or the attending physician, as appropriate.

D. Treatment services must be provided according to a treatment plan or a plan of care (POC) for the prescribed therapy, developed and signed by providers credentialed or licensed in the prescribed therapy or by a physician.

E. Medicaid covers occupational therapy, physical therapy and speech therapy services when provided to eligible Medicaid beneficiaries under age 21 in the Child Health Services (EPSDT) Program by qualified occupational, physical or speech therapy providers.

F. Speech therapy services ONLY are covered for beneficiaries in the ARKids First-B program benefits.

G. Therapy services for individuals over age 21 are only covered when provided through the following Medicaid Programs: Developmental Day Treatment Clinic Services (DDTCS), Hospital/Critical Access Hospital (CAH), Rehabilitative Hospital, Home Health, Hospice and Physician. Refer to these Medicaid provider manuals for conditions of coverage and benefit limits.

214.000 Occupational, Physical and Speech Therapy Services 1-1-09

A. Occupational, physical and speech therapy services require a referral from the beneficiary's primary care physician (PCP) unless the beneficiary is exempt from PCP Program requirements. If the beneficiary is exempt from the PCP process, referrals for therapy services are required from the beneficiary's attending physician. All therapy services for beneficiaries under the age of 21 years require referrals and prescriptions be made utilizing the "Occupational, Physical and Speech Therapy for Medicaid Eligible Recipients Under Age 21" form DMS-640.

B. Occupational, physical and speech therapy services also require a written prescription signed by the PCP or attending physician, as appropriate.

1. Providers of therapy services are responsible for obtaining renewed PCP referrals every six months even if the prescription for therapy is for one year.
2. A prescription for therapy services is valid for the length of time specified by the prescribing physician, up to one year.

C. When a school district is providing therapy services in accordance with a child's Individualized Education Program (IEP), a PCP referral is required at the beginning of each school year. The PCP referral for the therapy services related to the IEP can be for the 9-month school year, and a 6-month referral renewal is not necessary unless the PCP specifies otherwise.

D. The PCP or attending physician is responsible for determining medical necessity for therapy treatment.

1. The individual's diagnosis must clearly establish and support that the prescribed therapy is medically necessary.
2. Diagnosis codes and nomenclature must comply with the coding conventions and requirements established in **Internal Classification of Disease, 9th revision, Clinical Modification (ICD-9-CM); Volumes I and II**, in the edition Medicaid has certified as current for the patient's dates of service.
3. Please note that diagnosis codes V57.1, V57.2 and V57.3 are not specific enough to identify the medical necessity for therapy treatment and may not be used.

E. Providers of therapy services must use form DMS-640 – "Occupational, Physical and Speech Therapy for Medicaid Eligible Recipients Under Age 21 Prescription/Referral" – to obtain the PCP referral and the written prescription for therapy services for any beneficiary under the age of 21 years. **View or print form DMS-640**. Exclusive use of this form will facilitate the process of obtaining referrals and prescriptions from the PCP or attending physician. A copy of the prescription must be maintained in the beneficiary's records. The original prescription is to be maintained by the physician. Form DMS-640 must be used for the initial referral for evaluation and a separate DMS-640 is required for the prescription. After the initial referral using the form DMS-640 and initial prescription utilizing a separate form DMS-640, subsequent referrals and prescriptions for continued therapy may be made at the same time using the same DMS-640. Instructions for completion of form DMS-640 are located on the back of the form. Medicaid will accept an electronic signature provided that it is compliance with Arkansas Code 25-31-103.

To order copies from EDS use Form EDS-MFR-001 – Medicaid Forms Request. **View or Print the Medicaid Form Request EDS-MFR-001**.

F. A treatment plan developed and signed by a provider who is credentialed and licensed in the prescribed therapy or by a physician is required for the prescribed therapy.

1. The plan must include goals that are functional, measurable, and specific for each individual child.
2. Services must be provided in accordance with the treatment plan, with clear documentation of service rendered. Refer to section 204.000, subpart D, of this manual for more information on required documentation.

G. Make-up therapy sessions are covered in the event a therapy session is canceled or missed if determined medically necessary and prescribed by the beneficiary's PCP. Any make-up therapy session requires a separate prescription from the original prescription previously received. Form DMS-640 must be used by the PCP or attending physician for any make-up therapy session prescriptions.

H. Therapy services carried out by an unlicensed therapy student may be covered only when the following criteria are met:

1. Therapies performed by an unlicensed student must be under the direction of a licensed therapist, and the direction is such that the licensed therapist is considered to be providing the medical assistance.
2. To qualify as providing the service, the licensed therapist must be present and engaged in student oversight during the entirety of any encounter that the provider expects Medicaid to cover.

I. Refer to section 260.000 of this manual for procedure codes and billing instructions and section 216.100 of this manual for information regarding extended therapy benefits.

214.100 Utilization Review and Program Integrity 1-1-09

A. The Utilization Review and Program Integrity Sections of the Arkansas Medicaid Program have the responsibility for assuring quality medical care for Medicaid beneficiaries and for protecting the integrity of state and federal funds supporting the Medical Assistance Program. Those responsibilities are mandated by federal regulations.

B. The Utilization Review and Program Integrity teams shall:

1. Conduct on-site medical audits for the purpose of verifying the nature and extent of services paid for by the Medicaid Program,
2. Research all inquiries from beneficiaries in response to the Explanation of Medicaid Benefits and
3. Retrospectively evaluate medical practice patterns and providers' patterns by comparing each provider's pattern to norms and limits set by all the providers of the same specialty.

214.400 Speech-Language Therapy Guidelines for Retrospective Review 1-1-09

A. Speech-language therapy services must be medically necessary to the treatment of the individual's illness or injury. 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 a 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.)

A diagnosis alone is not sufficient documentation to support the medical necessity of therapy. Assessment for speech-language therapy includes a comprehensive evaluation of the patient's speech language deficits and functional limitations, treatment planned and goals to address each identified problem.

B. Evaluations:

In order to determine that speech-language therapy services are medically necessary, an evaluation must contain the following information:

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 gestational age.

5. Standardized test results, including all subtest scores, if applicable. Test results, if applicable, 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.
6. An assessment of the results of the evaluation including recommendations for frequency and intensity of treatment.
7. The child should be tested in his or her native language; if not, an explanation must be provided in the evaluation.
8. Signature and credentials of the therapist performing the evaluation.

C. Feeding/Swallowing/Oral Motor:

1. Can be formally or informally assessed.
2. Must have an in-depth functional profile on oral motor structures and function. An in-depth functional profile of oral motor structure and function is a description of a child's oral motor structure that specifically notes how such structure is impaired in its function and justifies the medical necessity of feeding/swallowing/oral motor therapy services.
3. If swallowing problems and/or signs of aspiration are noted, then a formal medical swallow study must be submitted.

D. Voice:

A medical evaluation is a prerequisite to voice therapy.

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.

214.410 Accepted Tests for Speech-Language Therapy 1-1-09

Tests used must be norm referenced, standardized, age appropriate and specific to the therapy provided. The following list of tests is not all-inclusive. When using a test that is not listed below, the provider must include documentation in the evaluation to support the reliability and validity of the test. This additional information will be used as reference information if the chart is selected by Medicaid for review. An explanation of why a test from the approved list could not be used to evaluate the child should be included. The *Mental Measurement Yearbook (MMY)* is the standard reference to determine the reliability and validity of the test(s) administered in the evaluation. Providers should refer to the *MMY* for additional information regarding specific tests. The following definitions of terms are applied to the lists of accepted tests:

- STANDARD: Evaluations that are used to determine deficits.
- SUPPLEMENTAL: Evaluations that are used to justify deficits and support other results. Supplemental tests may not supplant standard tests.

- CLINICAL OBSERVATIONS: Clinical observations have a supplemental role in the evaluation and should always be included. Detail, precision and comprehensiveness of clinical observations are especially important when standard scores do not qualify the patient for therapy and the clinical notes constitute the primary justification of medical necessity.

A. Speech-Language Tests – Standardized

1. Preschool Language Scale, Third Ed. (PLS-3)
2. Preschool Language Scale, Fourth Ed. (PLS-4)
3. Test of Early Language Development, Third Ed. (TELD-3)
4. Peabody Picture Vocabulary Test, Third Ed. (PPVT-3)
5. Clinical Evaluation of Language Fundamentals – Preschool (CELF-P)
6. Clinical Evaluation of Language Fundamentals, Third Ed. (CELF-3)
7. Clinical Evaluation of Language Fundamentals, Fourth Ed. (CELF-4)
8. Communication Abilities Diagnostic Test (CADT)
9. Test of Auditory Comprehension of Language, Third Ed. (TACL-3)
10. Comprehensive Assessment of Spoken Language (CASL)
11. Oral and Written Language Scales (OWLS)
12. Test of Language Development – Primary, Third Ed. (TOLD-P: 3)
13. Test of Word Finding, Second Ed. (TWF-2)
14. Test of Auditory Perceptual Skills, Revised (TAPS-R)
15. Language Processing Test, Revised (LPT-R)
16. Test of Pragmatic Language (TOPL)
17. Test of Language Competence, Expanded Ed. (TLC-E)
18. Test of Language Development – Intermediate, Third Ed. (TOLD-I: 3)
19. Fullerton Language Test for Adolescents, Second Ed. (FLTA)
20. Test of Adolescent and Adult Language, Third Ed. (TOAL-3)
21. Receptive One-Word Picture Vocabulary Test, Second Ed. (ROWPVT-2)
22. Expressive One-Word Picture Vocabulary Test, 2000 Ed. (EOWPVT)
23. Comprehensive Receptive and Expressive Vocabulary Test, Second Ed. (CREVT-2)
24. Kaufman Assessment Battery for Children (KABC)
25. Receptive-Expressive Emergent Language Test, Third Edition (REEL-3)

B. Speech-Language Tests – Supplemental

1. Receptive-Expressive Emergent Language Test, Second Ed. (REEL-2)
2. Nonspeech Test for Receptive/Expressive Language
3. Rossetti Infant-Toddler Language Scale (RITLS)
4. Mullen Scales of Early Learning (MSEL)
5. Reynell Developmental Language Scales
6. Illinois Test of Psycholinguistic Abilities, Third Ed. (ITPA-3)
7. Social Skills Rating System – Preschool & Elementary Level (SSRS-1)
8. Social Skills Rating System – Secondary Level (SSRS-2)
9. Kaufman Speech Praxis Test (KSPT)

C. Literacy/Comprehension – Supplemental

1. The Clinical Assessment of Literacy and Language
2. The Literacy Comprehension Test 2
3. Test of Reading Comprehension 3 (TORC3)

D. Written Language/Comprehension – Supplemental

1. Test of Written Language 3 (TWL3)

E. Birth to Age 3:

1. A (minus) -1.5 SD (standard score of 77) below the mean in two areas (expressive, receptive) or a (minus) -2.0 SD (standard score of 70) below the mean in one area to qualify for language therapy.
2. Two language tests must be reported, with at least one of these being a global, norm-referenced, standardized test with good reliability and validity. The second test may be criterion referenced.
3. All subtests, components and scores must be reported for all tests.
4. All sound errors must be reported for articulation, including positions and types of errors.
5. If phonological testing is submitted, a traditional articulation test must also be submitted with a standardized score.
6. Information regarding the child's functional hearing ability must be included as a part of the therapy evaluation report.
7. Non-school-age children must be evaluated annually.
8. If the provider indicates that the child cannot complete a norm-referenced test, the provider must submit an in-depth functional profile of the child's functional communication abilities. An in-depth functional profile is a description of a child's communication behaviors that specifically notes where such communication behaviors are impaired and justifies the medical necessity of therapy.
9. Children must be evaluated at least annually. Children (birth to age 2) in the Child Health Management Services (CHMS) Program must be evaluated every 6 months.

F. Ages 3 to 20:

1. A (minus) -1.5 SD (standard score of 77) below the mean in two areas (expressive, receptive, articulation) or (minus) -2.0 SD (standard score of 70) below the mean in one area (expressive, receptive, articulation)
2. Two language tests must be reported, with at least one of these being a global, norm-referenced, standardized test with good reliability and validity. Criterion-referenced tests will not be accepted for this age group.
3. All subtests, components and scores must be reported for all tests.
4. All sound errors must be reported for articulation including positions and types of errors.
5. If phonological testing is submitted, a traditional articulation test must also be submitted with a standardized score.
6. Information regarding the child's functional hearing ability must be included as a part of the therapy evaluation report.
7. Non-school-age children must be evaluated annually.
8. School-age children must have a full evaluation every three years (a yearly update is required) if therapy is school related; outside of school, annual

evaluations are required. "School related" means the child is of school age, attends public school and receives therapy provided by the school.

9. If the provider indicates that the child cannot complete a norm-referenced test, the provider must submit an in-depth functional profile of the child's functional communication abilities. An in-depth functional profile is a description of a child's communication behaviors that specifically notes where such communication behaviors are impaired and justifies the medical necessity of therapy.
10. 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.**

215.000 Augmentative Communication Device (ACD) Evaluation 1-1-09

Arkansas Medicaid covers evaluations for augmentative communication devices (ACDs) under the following conditions.

A. Prior authorization by the Division of Medical Services Utilization Review Section is required for approval of the ACD evaluation. (See section 231.000 of this manual for prior authorization procedures for ACD evaluations.)

B. A multidisciplinary team must conduct the ACD evaluation. The evaluation team must meet the following requirements:

1. A speech-language pathologist who has earned a Master's Degree in speech-language pathology must lead the team. The individual is also required to have a Certification of Clinical Competence from the American Speech-Language and Hearing Association.
2. The team must also include an occupational therapist, licensed by the Arkansas State Medical Board.
3. Both the speech-language pathologist and occupational therapist must have verifiable training and experience in the use and evaluation of ACD equipment. Their knowledge must include, but not be limited to, the equipment's use and its working capabilities, mounting and training requirements, warranties and maintenance.
4. A physical therapist may be added to the team if it is determined that there is a need for assistance in the evaluation as it relates to the positioning and seating in utilizing specific ACD equipment.
5. The team may include regular and special educators, caregivers and parents. Vocational rehabilitation counselors may be included for beneficiaries of all ages.
6. The team must use an interdisciplinary approach in the evaluation, incorporating the goals, objectives, skills and knowledge of various disciplines.
7. The team must evaluate at least three ACD systems, with written documentation of each usage included in the ACD assessment.

C. After the team has completed the evaluation, the evaluation report must be submitted to the prosthetics provider who will request prior authorization for the ACD.

The evaluation report must meet the following requirements.

1. The report must indicate the medical reason for the ACD.

2. The report must give specific recommendations of the system and justify why one system is more appropriate than another.
3. The speech-language pathologist must sign the ACD evaluation report.

Refer to section 215.100 of this manual for ACD evaluation benefits and section 260.000 of this manual for procedure codes and billing instructions.

215.100 Augmentative Communication Device (ACD) Evaluation Benefit 1-1-09

One augmentative communication device (ACD) evaluation may be performed by a speech-language pathologist every three years, based on medical necessity.

216.000 Therapy Benefits

216.100 Extended Therapy Services 1-1-09

Arkansas Medicaid applies the following therapy benefits to all therapy services in this program:

A. Medicaid will reimburse up to four (4) occupational, physical and speech therapy evaluation units (1 unit = 30 minutes) per discipline, per state fiscal year (July 1 through June 30) without authorization. Additional evaluation units will require an extended therapy request.

B. Medicaid will reimburse up to four (4) occupational, physical and speech therapy units (1 unit = 15 minutes) daily, per discipline, without authorization. Additional therapy units will require an extended therapy request.

C. All requests for extended therapy services must comply with sections 216.300 through 216.315.

216.300 Process for Requesting Extended Therapy Services 1-1-09

A. Requests for extended 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**. The request must meet the medical necessity requirement, and adequate documentation must be provided to support this request.

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

B. Form DMS-671, Request for Extension of Benefits for Clinical, Outpatient, Laboratory, and X-Ray Services, must be utilized for requests for extended therapy services. **View or print form DMS-671**. Consideration of requests 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 must sign, including

credentials, and date the request form. An electronic signature is accepted provided it is in compliance with Arkansas Code 25-31-103. All applicable documentation that supports the medical necessity of the request should be attached.

C. AFMC will approve, deny, 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. Approved requests will be returned to the provider with an authorization number that is required to be submitted with the billing for the approved services.

216.305 Documentation Requirements 1-1-09

A. To request extended therapy services, all applicable documentation that support the medical necessity of extended benefits are required.

B. Documentation requirements are as follows. Clinical records must:

1. Be legible and include documentation supporting the specific request
2. Be signed by the performing provider
3. Include the physician referral and prescription for additional therapy based on clinical records and progress reports furnished by the performing provider

216.310 AFMC Extended Therapy Services Review Process 1-1-09

The following is a step-by-step outline of AFMC's extended services review process:

A. Requests received via mail are screened for completeness and researched to determine the beneficiary's eligibility for Medicaid when the service was provided and payment/denial status of the requested claim.

B. The documentation submitted is reviewed by a registered nurse (R.N.). If, in the judgment of the R.N., the documentation supports the medical necessity, the R.N. may approve the request. An approval letter is generated and mailed to the provider the following day.

C. If the R.N. reviewer determines the documentation does not justify the service or it appears that the service is not medically necessary, the R.N. will refer the case to the appropriate physician adviser for a decision.

D. The physician adviser's rationale for approval or denial is entered into the system and the appropriate notification is created. If services are denied for medical necessity, the physician adviser's reason for the decision is included in the denial letter. A denial letter is mailed to the provider and the beneficiary the following work day.

E. Providers may request administrative reconsideration of an adverse decision or the provider and/or the beneficiary may appeal as provided in section 160.000 of this manual.

F. During administrative reconsideration of an adverse decision, if the extended therapy services original denial was due to incomplete documentation, but complete documentation that supports medical necessity is submitted with the reconsideration request, the R.N. may approve the extension of benefits without referral to a physician adviser.

G. During administrative reconsideration of an adverse decision, if the extended therapy services original denial was due to lack of proof of medical necessity or the

documentation does not allow for approval by the R.N., the original documentation, reason for the denial and new information submitted will be referred to a different physician adviser for reconsideration.

H. All parties will be notified in writing of the outcome of the reconsideration. Reconsiderations approved generate an approval number and is mailed to the provider for inclusion with billing for the requested service. Adverse decisions that are upheld through the reconsideration remain eligible for an appeal by the provider and/or the beneficiary as provided in section 160.000 of this manual.

216.315 Administrative Reconsideration 1-1-09

A request for administrative reconsideration of the denial of services must be in writing and sent to AFMC within 30 calendar days of the denial. The request must include a copy of the denial letter and additional supporting documentation.

The deadline for receipt of the reconsideration request will be enforced pursuant to sections 190.012 and 190.013 of this manual. A request received by AFMC within 35 calendar days of a denial will be deemed timely. Reconsideration requests must be mailed and will not be accepted via facsimile or email.

262.400 Special Billing Procedures 1-1-09

Services must be billed according to the care provided and to the extent each procedure is provided. Occupational, physical and speech therapy services do not require prior authorization with the exception of ACD evaluations. ACD evaluations do require prior authorization. Refer to section 215.000 for information about the augmentative communication device evaluation.

Extended therapy services may be requested for all medically necessary therapy services for beneficiaries under age 21. Refer to sections 216.000 through 216.310 of this manual for more information.

ARKANSAS DEPARTMENT OF HUMAN SERVICES

Division of Medical Services
Program Planning & Development

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TO: **Arkansas Medicaid Health Care Providers – Physician/Independent Lab/CRNA/Radiation Therapy Center**

DATE: **January 1, 2009**

SUBJECT: **Provider Manual Update Transmittal #162**

REMOVE		**INSERT**	
Section	**Date**	**Section**	**Date**
203.210	10-13-03	203.210	1-1-09
227.000	2-1-06	227.000	1-1-09
227.300	12-1-07	227.300	1-1-09
227.310	9-1-08	227.310	1-1-09
—	—	229.200	blank
—	—	229.210	1-1-09
—	—	229.220	1-1-09
—	—	229.230	1-1-09
—	—	229.240	1-1-09
292.700	11-1-07	292.700	1-1-09

Explanation of Updates

Section 203.210 is updated to change the term “recipient” to “beneficiary”; to include accepted treatment location information regarding therapy services for beneficiaries over age 21.

Section 227.000 is updated to clarify therapy benefits for physical and speech therapy services.

Section 227.300 is included to delete a reference to the standardized form availability in C #2.

Section 227.310 is included to delete a reference to the standardized form availability in E #8 and F#9.

Sections 229.200; 229.210; 229.220; 229.230; and 229.240 are added to specifically address extended therapy services for beneficiaries under 21 years.

Section 292.700 is updated to add “Billing” to the section title for physical and speech therapy services to correct a duplicated section title. The billing codes table is being split for separation of speech and physical therapies for clarity. Minor wording changes regarding extended therapy services are also being made.

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 501-682-8323 (Local); 1-800-482-5850, extension 2-8323 (Toll-Free) or to obtain access to these numbers through voice relay, 1-800-877-8973 (TTY Hearing Impaired).

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

TOC required

203.210 Physician's Role in the Occupational, Physical and Speech Therapy Program 1-1-09

Medicaid covers occupational therapy, physical therapy and speech therapy services when provided to eligible Medicaid beneficiaries under age 21 in the Child Health Services (EPSDT) Program by qualified occupational, physical or speech therapy providers. Occupational evaluations and occupational therapy services are payable only to a qualified occupational therapist. Speech therapy evaluations may be performed by the physician; however, treatment for speech-language therapy disorders must be referred to a qualified speech therapist. Physical therapy evaluations may be performed by the physician and physical therapy sessions may be performed by the qualified physician. Physical therapy treatment may also be referred to a qualified physical therapist.

Speech therapy services ONLY are covered for beneficiaries in the ARKids First-B Program benefits.

All occupational, physical and speech therapy evaluations and services must be medically necessary and require a referral from the beneficiary's primary care physician (PCP) or the attending physician if the beneficiary is exempt from PCP Managed Care Program requirements. Therapy treatment services also require a prescription written by the physician who refers the patient to the therapist for specified services. For beneficiaries under age 21, form DMS-640 must be used for the initial referral for evaluation and a separate DMS-640 is required for the prescription. **View or Print form DMS-640.** An electronic signature is accepted provided it is compliance with Arkansas Code 25-31-103. The physician must maintain the original Occupational, Physical and Speech Therapy for Medicaid Eligible Recipients Under Age 21 Prescription/Referral form–DMS-640–for each prescription in the beneficiary's medical records. The therapy provider must retain a copy of the DMS-640 in their established beneficiary medical chart/record. After the initial referral using the form DMS-640 and initial prescription utilizing a separate form DMS-640, subsequent referrals and prescriptions for continued therapy may be made at the same time using the same DMS-640.

Therapy services for individuals over age 21 are only covered when provided through the following Medicaid Programs: Developmental Day Treatment Clinic Services (DDTCS), Hospital/Critical Access Hospital (CAH), Rehabilitative Hospital, Home Health, Hospice and Physician. Refer to these Medicaid provider manuals for conditions of coverage and benefit limits.

227.000 Physical and Speech Therapy Services 1-1-09

A. Arkansas Medicaid applies the following physical and speech therapy benefits for beneficiaries of all ages.

1. Medicaid will reimburse up to four (4) physical and speech therapy evaluation units (1 unit = 30 minutes) per discipline, for an eligible beneficiary per state fiscal year (July 1 through June 30) without authorization.
2. Medicaid will reimburse up to four (4) physical therapy units (1 unit = 15 minutes) daily for an eligible beneficiary without authorization.
3. Speech therapy (individual and group sessions) are payable only to a qualified speech therapist.

4. For beneficiaries under age 21, Arkansas Medicaid will reimburse the physician for make-up therapy sessions in the event a physical therapy session is canceled or missed. Make-up therapy sessions are covered when medically necessary and prescribed by the beneficiary's primary care physician (PCP) or attending physician, if the beneficiary is exempt from PCP Managed Care Program requirements. A new prescription, signed by the PCP, is required for each make-up therapy session.

B. Extended therapy services may be provided for physical and speech therapy services based on medical necessity for Medicaid beneficiaries under age 21. Refer to section 229.200 through 229.240 of this manual for procedures for obtaining extended services.

C. Benefit Extensions may be provided for physical therapy, based on medical necessity, for Medicaid beneficiaries 21 years of age and over when provided within a covered program in accordance with sections 229.100 through 229.140 of this manual.

227.300 Speech-Language Therapy Guidelines for Retrospective Review 1-1-09

A. Speech-language therapy services must be medically necessary to the treatment of the individual's illness or injury. 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 medical necessity definition in the Glossary of the Arkansas Medicaid manual.)

A diagnosis alone is not sufficient documentation to support the medical necessity of therapy. Assessment for speech-language therapy includes a comprehensive evaluation of the patient's speech language deficits and functional limitations, treatment planned and goals to address each identified problem.

B. Evaluations:

In order to determine that speech-language therapy services are medically necessary, an evaluation must contain the following information:

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 gestational age.
5. Standardized test results, including all subtest scores, 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.

6. An assessment of the results of the evaluation, including recommendations for frequency and intensity of treatment.
7. The child should be tested in their native language; if not, an explanation must be provided in the evaluation.
8. Signature and credentials of the therapist performing the evaluation.

C. Feeding/Swallowing/Oral Motor:

1. Can be formally or informally assessed.
2. Must have an in-depth functional profile on oral motor structures and function. An in-depth functional profile of oral motor structure and function is a description of a child's oral motor structure that specifically notes how such structure is impaired in its function and justifies the medical necessity of feeding/swallowing/oral motor therapy services.
3. If swallowing problems and/or signs of aspiration are noted, a formal medical swallow study must be submitted.

D. Voice:

A medical evaluation is a prerequisite to voice therapy.

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.

227.310 Accepted Tests for Speech-Language Therapy 1-1-09

Tests used must be norm referenced, standardized, age appropriate and specific to the therapy provided. The following list of tests is not all-inclusive. When using a test not listed here, the provider must include additional documentation to support the reliability and validity of the test. This additional information will be used as reference information if the chart is ever selected by Medicaid for review. An explanation of why a test from the approved list could not be used to evaluate the child must also be included. The *MMY* is the standard reference to determine the reliability and validity of the test(s) administered in an evaluation. Providers should refer to the *MMY* for additional information regarding specific tests.

A. Speech-Language Tests – Standardized

1. Preschool Language Scale, Third Ed. (PLS-3)
2. Preschool Language Scale, Fourth Ed. (PLS-4)
3. Test of Early Language Development, Third Ed. (TELD-3)
4. Peabody Picture Vocabulary Test, Third Ed. (PPVT-3)
5. Clinical Evaluation of Language Fundamentals – Preschool (CELF-P)
6. Clinical Evaluation of Language Fundamentals, Third Ed. (CELF-3)
7. Clinical Evaluation of Language Fundamentals, Fourth Ed. (CELF-4)
8. Communication Abilities Diagnostic Test (CADeT)

9. Test of Auditory Comprehension of Language, Third Ed. (TACL-3)
10. Comprehensive Assessment of Spoken Language (CASL)
11. Oral and Written Language Scales (OWLS)
12. Test of Language Development – Primary, Third Ed. (TOLD-P:3)
13. Test of Word Finding, Second Ed. (TWF-2)
14. Test of Auditory Perceptual Skills, Revised (TAPS-R)
15. Language Processing Test, Revised (LPT-R)
16. Test of Pragmatic Language (TOPL)
17. Test of Language Competence, Expanded Ed. (TLC-E)
18. Test of Language Development – Intermediate, Third Ed. (TOLD-I:3)
19. Fullerton Language Test for Adolescents, Second Ed. (FLTA)
20. Test of Adolescent and Adult Language, Third Ed. (TOAL-3)
21. Receptive One-Word Picture Vocabulary Test, Second Ed. (ROWPVT-2)
22. Expressive One-Word Picture Vocabulary Test, 2000 Ed. (EOWPVT)
23. Comprehensive Receptive and Expressive Vocabulary Test, Second Ed. (CREVT-2)
24. Kaufman Assessment Battery for Children (KABC)
25. Receptive/Expressive Emergent Language Test, Third Edition (REEL-3)

B. Speech Language Tests – Supplemental

1. Receptive/Expressive Emergent Language Test, Second Ed. (REEL-2)
2. Nonspeech Test for Receptive/Expressive Language
3. Rossetti Infant-Toddler Language Scale (RITLS)
4. Mullen Scales of Early Learning (MSEL)
5. Reynell Developmental Language Scales
6. Illinois Test of Psycholinguistic Abilities, Third Ed. (ITPA-3)
7. Social Skills Rating System – Preschool & Elementary Level (SSRS-1)
8. Social Skills Rating System – Secondary Level (SSRS-2)

C. Literacy/Comprehension – Supplemental

1. The Clinical Assessment of Literacy and Language
2. The Literacy Comprehension Test 2
3. Test of Reading Comprehension 3 (TORC3)

D. Written Language/Comprehension – Supplemental

1. Test of Written Language 3 (TWL3)

E. Birth to Age 3:

1. A (minus) -1.5 SD (standard score of 77) below the mean in two areas (expressive, receptive) or a (minus) -2.0 SD (standard score of 70) below the mean in one area to qualify for language therapy.
2. Two language tests must be reported with at least one of these being a global norm-referenced standardized test with good reliability/validity. The second test may be criterion referenced.
3. All subtests, components, and scores must be reported for all tests.
4. All sound errors must be reported for articulation, including positions and types of errors.

5. If phonological testing is submitted, a traditional articulation test must also be submitted with a standardized score.
6. Information regarding the child's functional hearing ability must be included as a part of the therapy evaluation report.
7. Non-school-aged children must be evaluated annually.
8. If the provider indicates the child cannot complete a norm-referenced test, the provider must submit an in-depth functional profile of the child's functional communication abilities. An in-depth functional profile is a description of a child's communication behaviors that specifically notes where such communication behaviors are impaired and justifies the medical necessity of therapy.
9. Children must be evaluated at least annually. Children (birth to age 2) in the Child Health Management Services (CHMS) Program must be evaluated every 6 months.

F. Ages 3 – 21:

1. A (minus) -1.5 SD (standard score of 77) below the mean in two areas (expressive, receptive, articulation) or a (minus) -2.0 SD (standard score of 70) below the mean in one area (expressive, receptive, articulation).
2. Two language tests must be reported with at least one of these being a global norm-referenced standardized test with good reliability/validity. Criterion-referenced tests will not be accepted for this age group.
3. All subtests, components and scores must be reported for all tests.
4. All sound errors must be reported for articulation, including positions and types of errors.
5. If phonological testing is submitted, a traditional articulation test must also be submitted with a standardized score.
6. Information regarding child's functional hearing ability must be included as a part of the therapy evaluation report.
7. Non-school-age children must be evaluated annually.
8. School-age children must have a full evaluation every three years (a yearly update is required) if therapy is school related; outside of school, annual evaluations are required. "School related" means the child is of school age, attends public school and receives therapy provided by the school.
9. If the provider indicates the child cannot complete a norm-referenced test, the provider must submit an in-depth functional profile of the child's functional communication abilities. An in-depth functional profile is a description of a child's communication behaviors that specifically notes where such communication behaviors are impaired and justifies the medical necessity of therapy.
10. IQ scores are required on all children who are school age and receiving language therapy. **Exception: IQ scores will not be required for children under ten (10) years of age.**

229.200 Procedures for Obtaining Extended Therapy Services for Beneficiaries Under 21 Years

229.210 Process for Requesting Extended Therapy Services 1-1-09

A. Requests for extended 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**. Requests must be mailed and will not be accepted via facsimile or email. The request must meet the medical necessity requirement, and adequate documentation must be provided to support this request.

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

B. Form DMS-671, Request for Extension of Benefits for Clinical, Outpatient, Laboratory, and X-Ray Services, must be utilized for requests for extended therapy services. **View or print form DMS-671**. Consideration of requests 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 must sign, include credentials and date the request form. An electronic signature is accepted provided it is in compliance with Arkansas Code 25-31-103. All applicable documentation that supports the medical necessity of the request should be attached.

C. AFMC will approve, deny, or ask for additional information within 30 calendar days of receiving the request. AFMC reviewers will simultaneously advise the provider and the beneficiary when a request is denied. Approved requests will be returned to the provider with an authorization number that is required to be submitted with the billing for the approved services.

229.220 Documentation Requirements 1-1-09

A. To request extended therapy services, all applicable documentation that supports the medical necessity of extended benefits is required.

B. Documentation requirements are as follows. Clinical records must:

1. Be legible and include documentation supporting the specific request
2. Be signed by the performing provider
3. Include the physician referral and prescription for additional therapy based on clinical records and progress reports furnished by the performing provider

229.230 AFMC Extended Therapy Services Review Process 1-1-09

The following is a step-by-step outline of AFMC's extended services review process:

A. Requests received via mail are screened for completeness and researched to determine the beneficiary's eligibility for Medicaid when the service was provided and payment/denial status of the claim request.

B. The documentation submitted is reviewed by a registered nurse (R.N.). If, in the judgment of the R.N., the documentation supports the medical necessity, they may

approve the request. An approval letter is generated and mailed to the provider the following day.

C. If the R.N. reviewer determines the documentation does not justify the service or it appears the service is not medically necessary, they will refer the case to the appropriate physician adviser for a decision.

D. The physician adviser's rationale for approval or denial is entered into the system and the appropriate notification is created. If services are denied for lack of medical necessity justification, the physician adviser's reason for the decision is included in the denial letter. A denial letter is mailed to the provider and the beneficiary the following work day.

E. Providers may request administrative reconsideration of an adverse decision or they may appeal as provided in section 160.000 of this manual.

F. During administrative reconsideration of an adverse decision, if the extended therapy services original denial was due to incomplete documentation, but complete documentation that supports medical necessity is submitted with the reconsideration request, the R.N. may approve the extension of benefits without referral to a physician adviser.

G. During administrative reconsideration of an adverse decision, if the extended therapy services original denial was due to lack of proof of medical necessity or the documentation does not allow for approval by the R.N., the original documentation, reason for the denial and new information submitted will be referred to a different physician adviser for reconsideration.

H. All parties will be notified in writing of the outcome of the reconsideration. Reconsiderations approved generate an approval number and is mailed to the provider for inclusion with billing for the requested service. Adverse decisions that are upheld through the reconsideration remain eligible for an appeal by the provider and/or the beneficiary as provided is section 160.000 of this manual.

229.240 Administrative Reconsideration 1-1-09

A request for administrative reconsideration of the denial of services must be in writing and sent to AFMC within 30 calendar days of the denial. The request must include a copy of the denial letter and additional supporting documentation.

The deadline for receipt of the reconsideration request will be enforced pursuant to sections 190.012 and 190.013 of this manual. A request received by AFMC within 35 calendar days of a denial will be deemed timely. Reconsideration requests must be mailed and will not be accepted via facsimile or email.

292.700 Physical and Speech Therapy Services Billing 1-1-09

Occupational therapy evaluations and services are payable only to a qualified occupational therapist. Speech therapy and physical therapy evaluations are payable to the physician. Physical therapy may be payable to the physician when directly provided in accordance with the Occupational, Physical and Speech Therapy Services Manual. The following procedure codes must be used when filing claims for physician provided therapy services. See Glossary - Section IV - for definitions of "group" and "individual" as they relate to therapy services.

Speech Therapy

Procedure Code	Modifier(s)	Description	Benefit Limit
92506		Evaluation of speech, language, voice, communication, auditory processing and/or aural rehabilitation	30-minute unit. Maximum of 4 units per State Fiscal Year (July 1 through June 30)

Physical Therapy

Procedure Code	Modifier(s)	Description	Benefit Limit
97001		Evaluation for Physical Therapy	30-minute unit. Maximum of 4 units per State Fiscal Year (July 1 through June 30)
97110		Individual Physical Therapy	15-minute unit. Maximum of 4 units per day
97110	UB	Individual Physical Therapy by Physical Therapy Assistant	15-minute unit. Maximum of 4 units per day
97150		Group Physical Therapy	15-minute unit. Maximum of 4 units per day; Maximum of 4 clients per group
97150	UB	Group Physical Therapy by Physical Therapy Assistant	15-minute unit. Maximum of 4 units per day; Maximum of 4 clients per group

A provider must furnish a full unit of service to bill Medicaid for a unit of service. Partial units are not reimbursable. Extended therapy services may be requested for physical and speech therapy, if medically necessary, for eligible Medicaid beneficiaries of all ages.

Refer to section 227.000 of this manual for more information on therapy benefits.

ARKANSAS DEPARTMENT OF HUMAN SERVICES

Division of Medical Services
Program Planning & Development

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TO: **Arkansas Medicaid Health Care Providers – Home Health**

DATE: **January 1, 2009**

SUBJECT: **Provider Manual Update Transmittal #119**

REMOVE		**INSERT**	
Section	**Date**	**Section**	**Date**
212.312	6-1-04	212.312	1-1-09
212.340	11-1-06	—	—
212.341	11-1-05	—	—
212.342	11-1-06	—	—
212.343	11-1-06	—	—
213.200	11-1-06	213.200	1-1-09
218.000	11-1-05	218.000	1-1-09
218.100	11-1-05	218.100	1-1-09
218.110	12-1-07	—	—
218.120	11-1-05	—	—
218.130	11-1-05	—	—
218.140	11-1-05	—	—
218.150	11-1-05	—	—
218.160	11-1-05	—	—
218.161	10-1-07	—	—
218.162	11-1-06	—	—
218.163	11-1-05	—	—
218.164	11-1-05	—	—
218.165	11-1-05	—	—
—	—	218.200	1-1-09

Explanation of Updates

Section 212.312 is updated to change the reference section numbers to refer to the new location of information.

Sections 212.340 through 212.343 are deleted and the information relocated to Section 218.100.

Section 213.200 is updated to change the section title and to change the referenced section numbers directing to the new location of information.

Section 218.000 is updated to clarify information and required usage of form DMS-640 for physical therapy referrals and physical therapy prescriptions for beneficiaries under age 21.

Section 218.100 is updated and information from deleted sections 212.340 through 212.343 is clarified and condensed into this section.

Sections 218.110 through 218.140 are deleted and the information is reformatted and relocated to Section 218.100.

Sections 218.150 through 218.165 are deleted and the information is reformatted and relocated within new section 218.200.

Section 218.200 is a new section formatted to contain condensed information from deleted sections 218.150 through 218.165.

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 501-682-8323 (Local); 1-800-482-5850, extension 2-8323 (Toll-Free) or to obtain access to these numbers through voice relay, 1-800-877-8973 (TTY Hearing Impaired).

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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

TOC required (sections deleted)

212.312 Physical Therapy as a Component of a Home Health Plan of Care 1-1-09

A. When the PCP or authorized attending physician prescribes medically necessary home health physical therapy as a component of a home health plan of care, the physical therapy treatment plan must be incorporated into the home health plan of care.

B. If the patient is under the age of 21, see sections 218.000 through 218.200 for additional requirements.

213.200 Physical Therapy Services Benefits 1-1-09

Home health physical therapy is limited to one visit per day for beneficiaries of all ages, but there is no weekly, monthly or annual limit on the number of prescribed, medically necessary home health physical therapy visits that a beneficiary may receive.

A. Home health physical therapy must be prescribed by the beneficiary's PCP or authorized attending physician and established on a current home health plan of care.

B. Home health physical therapy for beneficiaries under the age of 21 is subject to additional documentation requirements; See sections 218.000 through 218.200.

218.000 Additional Documentation Requirements for Physical Therapy Patients Under the Age of 21 1-1-09

A. Providers must maintain documentation supporting medical necessity of physical therapy services. The PCP or attending physician is responsible for determining medical necessity for therapy treatment.

1. Medicaid requires a referral from the primary care physician (PCP) or a referral from the authorized attending physician if the beneficiary is exempt from mandatory PCP enrollment. All therapy services for beneficiaries under the age of 21 require referrals be made utilizing the "Occupational, Physical and Speech Therapy for Medicaid Eligible Recipients Under Age 21" form DMS-640.

2. Medicaid requires a written prescription for physical therapy signed and dated by the PCP or the authorized attending physician. For beneficiaries under age 21 the prescription must be completed on a separate DMS-640 form. **View or print form DMS-640.** After the initial referral using the form DMS-640 and initial prescription, utilizing a separate form DMS-640, subsequent referrals and prescriptions for continued therapy may be made at the same time using the same DMS-640 for beneficiaries under age 21. Instructions for completion of form DMS-640 are located on the back of the form. Providers of therapy services are responsible for obtaining renewed PCP referrals every six months even if the prescription for therapy is for one year. A prescription for therapy services is valid for the length of time specified by the prescribing physician, up to one year.

   a. The PCP or authorized attending physician must complete and sign form DMS-640/prescription with their original signature. Medicaid will accept an electronic signature provided that it is in compliance with Arkansas Code 25-31-103. A rubber stamp signature is not

acceptable.

b. The PCP or authorized attending physician must maintain the original prescription (form DMS-640) in the beneficiary's medical record.

c. The home health provider must maintain a copy of the original prescription form in the patient's medical record.

3. Medicaid requires that a physical therapy treatment plan be developed, signed and dated by a qualified physical therapist and/or a physician. The plan must include individualized goals that are functional, measurable and specific to the beneficiary's medical needs.

B. Documentation must include, when applicable, an Individualized Family Services Plan (IFSP) established in accordance with part C of the Individuals with Disabilities Education Act (IDEA).

C. Medicaid requires, when applicable, an Individualized Education Program (IEP) established in accordance with part B of IDEA.

D. Documentation must be supported by therapy evaluation reports to substantiate medical necessity, signed or initialed and dated progress notes and any related correspondence.

E. Documentation must include discharge notes and summary.

218.100 Retrospective Review of Physical Therapy for Beneficiaries Under the Age of 21 1-1-09

A. Physical therapy services are medically prescribed services for the diagnosis and treatment of movement dysfunction, which results in functional disabilities.

Physical therapy services must be medically necessary to the treatment of the individual's illness or injury. 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 physical therapist.

3. There must be a 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.)

A diagnosis alone is not sufficient documentation to support the medical necessity of therapy. Assessment for physical therapy includes a comprehensive evaluation of the patient's physical deficits and functional limitations, treatment planned and goals to address each identified problem.

B. Evaluations:

To determine therapy services are medically necessary, an annual evaluation must contain the following information:

1. Date of evaluation.

2. Child's name and date of birth.

3. Diagnosis applicable to specific therapy.

4. Background information including pertinent medical history and gestational age.
5. Standardized test results, including all subtest scores, if applicable. Test results, if applicable, should be adjusted for prematurity (less than 37 weeks gestation) if the child is 12 months of age or younger. The test results should be noted in the evaluation.
6. 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 of the child's functional mobility skills.
7. Assessment of the results of the evaluation including recommendations for frequency and intensity of treatment.
8. Signature and credentials of the therapist performing the evaluation.

Non-school age children must be evaluated annually.

School-age children must have a full evaluation every three years (a yearly update is required) if therapy is school related; outside of school, annual evaluations are required. "School related" means the child is of school age, attends public school and receives therapy provided by the school.

C. Standardized Testing:

1. Test used must be norm referenced, standardized and specific to the therapy provided.
2. Test must be age appropriate for the child being tested.
3. 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.
4. A score of -1.50 standard deviations or more from the mean in at least one subtest area or composite score is required to qualify for 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 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/validity. Refer to sections 218.200 for a list of standardized tests accepted by Arkansas Medicaid for retrospective reviews.

D. Other Objective Tests and Measures:

1. Range of Motion: A limitation of greater than ten degrees and/or documentation of how a deficit limits function.
2. Muscle Tone: Modified Ashworth Scale.
3. 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.
4. Transfer Skills: Documented as the amount of assistance required to perform transfer, i.e., maximum, moderate, or minimal assistance. A deficit is defined as the inability to perform a transfer safely and independently.

E. Frequency, Intensity and Duration of Physical Therapy Services:

The frequency, intensity and duration of physical 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 insure 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 therapy services. These services can be provided to the child as part of a home program implemented by the child's caregivers and do not necessarily require the skilled services of a physical 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, services should be discontinued and monitoring or establishment of a home program should be implemented.

F. 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 co-sign progress notes.

The Quality Improvement Organization (QIO), under contract to the Arkansas Division of Medical Services, performs retrospective reviews of medical records to determine the medical necessity of services reimbursed by Medicaid. **View or print QSource of Arkansas contact information.**

Failure to follow the instructions in the Arkansas Medicaid provider manual and failure to respond to requests made by the QIO in a complete and timely manner are considered technical failures to establish eligibility for therapy services. The QIO does not have the authority to allow reconsideration of technical denials.

218.200 Accepted Tests for Physical Therapy 1-1-09

Tests used must be norm referenced, standardized, age appropriate and specific to the therapy provided. The following list of tests is not all-inclusive. When using a test that is not listed below, the provider must include documentation in the evaluation to support the reliability and validity of the test. This additional information will be used as reference information if the chart is selected by Medicaid for review. An explanation of why a test from the approved list could not be used to evaluate a child should be included. The *Mental Measurement Yearbook (MMY)* is the standard reference to determine the reliability and validity of the tests administered in the evaluation. Providers should refer

to the *MMY* for additional information regarding specific tests. The following definitions of terms are applied to the lists of accepted tests:

- STANDARD: Evaluations that are used to determine deficits.
- SUPPLEMENTAL: Evaluations that are used to identify deficits and support other results. Supplemental tests may not supplant standard tests.
- CLINICAL OBSERVATIONS: Clinical observations have a supplemental role in the evaluation and should always be included. Detail, precision and comprehensiveness of clinical observations are especially important when standard scores do not qualify the patient for therapy and the clinical notes constitute the primary justifications of medical necessity.

A. Norm Reference

1. Adaptive Areas Assessment
2. Test of Gross Motor Development (TGMD-2)
3. Peabody Developmental Motor Scales, Second Ed. (PDMS-2)
4. Bruininks-Oseretsky Test of Motor Proficiency (BOMP)
5. Bruininks-Oseretsky Test of Motor Proficiency, Second Edition (BOT-2)
6. Pediatric Evaluation of Disability Inventory (PEDI)
7. Test of Gross Motor Development – 2 (TGMD-2)
8. Peabody Developmental Motor Scales (PDMS)
9. Alberta Infant Motor Scales (AIM)
10. Toddler and Infant Motor Evaluation (TIME)
11. Functional Independence Measure for Children (WeeFIM)
12. Gross Motor Function Measure (GMFM)
13. Adaptive Behavior Scale – School, Second Ed. (AAMR-2)
14. Movement Assessment Battery for Children (Movement ABC)
15. Test of Infant Motor Performance (TIMP)
16. Functional Independence Measure – 7 years of age to adult (FIM)

B. Physical Therapy – Supplemental

1. Bayley Scales of Infant Development, Second Ed. (BSID-2)
2. Neonatal Behavioral Assessment Scale (NBAS)
3. Mullen Scales of Early Learning Profile (MSEL)
4. Hawaii Early Learning Profile (HELP)
5. Battelle Developmental Inventory (BDI)

C. Physical Therapy Criteria

1. Developmental assessment for students with severe disabilities, Second Ed. (DASH-2)
2. Milani-Comparetti Developmental Examination

D. Physical Therapy – Traumatic Brain Injury (TBI) – Standardized

1. Comprehensive Trail-Making Test
2. Adaptive Behavior Inventory

E. Physical Therapy – Piloted

Assessment of Persons Profoundly or Severely Impaired

ARKANSAS DEPARTMENT OF HUMAN SERVICES

Division of Medical Services
Program Planning & Development

P.O. Box 1437, Slot S-295 · Little Rock, AR 72203-1437
501-682-8368 · Fax: 501-682-2480

TO: **Arkansas Medicaid Health Care Providers – Nurse Practitioner**

DATE: **January 1, 2009**

SUBJECT: **Provider Manual Update Transmittal #108**

REMOVE		**INSERT**	
Section	**Date**	**Section**	**Date**
214.800	3-1-05	214.800	1-1-09

Explanation of Updates

Section 214.800 is updated to expand and clarify therapy service coverage and procedures.

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 501-682-8323 (Local); 1-800-482-5850, extension 2-8323 (Toll-Free) or to obtain access to these numbers through voice relay, 1-800-877-8973 (TTY Hearing Impaired).

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.

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Roy Jeffus, Director

TOC not required

214.800 Occupational, Physical and Speech Therapy 1-1-09

A. Medicaid covers occupational, physical, and speech therapy services for eligible beneficiaries under age 21 in the Child Health Services (EPSDT) Program by qualified occupational, physical or speech therapy providers. Therapy services are not covered as nurse practitioner services. The following is provided for the nurse practitioner's information.

B. Speech therapy services ONLY are covered for beneficiaries in the ARKids First-B program benefits.

C. Therapy services for individuals age 21 and older are only covered when provided through the following Medicaid Programs: Developmental Day Treatment Clinic Services (DDTCS), Hospital/Critical Access Hospital (CAH), Rehabilitative Hospital, Home Health, Hospice and Physician. Refer to these Medicaid provider manuals for conditions of coverage and benefit limits.

D. All therapy services for beneficiaries under age 21 require a referral for evaluation utilizing the form DMS-640 and a separate form DMS-640 for the written prescription from the patient's primary care physician (PCP) or attending physician if the beneficiary is exempt from PCP Managed Care Program requirements. A referral for therapy services must be renewed every six months. After the initial referral using the form DMS-640 and initial prescription, utilizing a separate form DMS-640, subsequent referrals and prescriptions for continued therapy may be made at the same time using the same DMS-640. The prescription for treatment is valid for one year unless the prescribing physician specifies a shorter period.

E. The PCP or attending physician must complete and sign the DMS-640 for beneficiaries under age 21. The PCP or attending physician must initiate a referral and prescription for beneficiaries over age 21. An original signature is required when making a referral or prescribing a therapy service. An electronic signature is acceptable on either document, provided it is in compliance with Arkansas Code 25-31-103. A copy of the prescription must be maintained in the beneficiary's records. The original prescription is to be maintained by the physician. **View or print form DMS-640** (for beneficiaries under age 21)

F. Medicaid will reimburse up to four (4) occupational, physical and speech therapy evaluation units (1 unit = 30 minutes) per discipline, for an eligible beneficiary per state fiscal year (July 1 through June 30) without authorization.

Medicaid will reimburse up to four (4) occupational, physical and speech therapy units (1 unit = 15 minutes) daily, per discipline, for an eligible beneficiary without authorization.

Extended therapy services may be provided based on medical necessity, for Medicaid beneficiaries under age 21.

Occupational, physical and speech therapies are subject to the benefit limit of 12 outpatient hospital visits per state fiscal year (SFY) for beneficiaries age 21 and over. Benefit Extensions may be provided for therapy services, based on medical necessity, for Medicaid beneficiaries 21 years of age and over when provided within a covered program.

ARKANSAS DEPARTMENT OF HUMAN SERVICES

Division of Medical Services
Program Planning & Development

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TO: **Arkansas Medicaid Health Care Providers – Hospital/Critical Access Hospital (CAH)/End Stage Renal Disease (ESRD)**

DATE: **January 1, 2009**

SUBJECT: **Provider Manual Update Transmittal #148**

REMOVE		**INSERT**	
Section	**Date**	**Section**	**Date**
215.021	11-1-05	215.021	1-1-09
—	—	218.110	1-1-09
—	—	218.115	1-1-09
218.200	9-1-08	218.200	1-1-09
218.210	9-1-08	218.210	1-1-09
—	—	218.250	1-1-09
—	—	218.260	1-1-09
—	—	218.270	1-1-09
—	—	218.280	1-1-09

Explanation of Updates

Section 215.021 is updated to detail and clarify policy regarding benefit limits for occupational, physical and speech therapies for beneficiaries 21 years of age and older.

Section 218.110 is a new section, added to detail and clarify policy regarding therapy services for beneficiaries under age 21 in the Child Health Services (EPSDT) program.

Section 218.115 is a new section, added to detail and clarify policy regarding speech therapy benefits for beneficiaries under age 18 in the ARKids First-B program.

Section 218.200 is updated to clarify the title – the section applies to beneficiaries under age 21 – and to remove reference to the available standardized form in C #2.

Section 218.210 is updated to remove reference to the available standardized form in E #8 and F #9.

Sections 218.250, 218.260, 218.270 and 218.280 are new sections added to detail and clarify policy and processes for requesting extended therapy services for beneficiaries under age 21.

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 501-682-8323 (Local); 1-800-482-5850, extension 2-8323 (Toll-Free) or to obtain access to these numbers through voice relay, 1-800-877-8973 (TTY Hearing Impaired).

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

TOC required

215.021 Benefit Limit for Occupational, Physical and Speech Therapies For Beneficiaries 21 Years of Age and Older 1-1-09

A. Occupational, physical and speech therapies are subject to the benefit limit of 12 outpatient hospital visits per state fiscal year (SFY), as explained in section 215.020, for beneficiaries age 21 and over.

1. Outpatient therapy services furnished by acute care hospitals and rehabilitative hospitals are combined when tallying utilization of this benefit.
2. This limit does not apply to eligible Medicaid beneficiaries under the age of 21.
3. Outpatient occupational, physical and speech therapy services for beneficiaries over age 21 require a referral from the beneficiary's primary care physician (PCP) unless the beneficiary is exempt from PCP Program requirements; if exempt from PCP, a referral from their attending physician is required.

B. Medicaid will reimburse up to four (4) occupational, physical and speech therapy evaluation units (1 unit = 30 minutes) per discipline, for an eligible beneficiary, per state fiscal year (July 1 through June 30) .

C. Medicaid will reimburse up to four (4) occupational, physical and speech therapy units (1 unit = 15 minutes) daily, per discipline, for an eligible beneficiary.

D. All requests for benefit extensions for therapy services for beneficiaries over age 21 must comply with sections 215.100 through 215.110.

218.110 Therapy Services For Beneficiaries Under Age 21 In Child Health Services (EPSDT) 1-1-09

Outpatient occupational, physical and speech therapy services require a referral from the beneficiary's primary care physician (PCP) unless the beneficiary is exempt from PCP Program requirements. If the beneficiary is exempt from the PCP process, referrals for therapy services are required from the beneficiary's attending physician. All therapy services for beneficiaries under the age of 21 years require referrals and prescriptions be made utilizing the "Occupational, Physical and Speech Therapy for Medicaid Eligible Recipients Under Age 21" form DMS-640. A prescription for therapy services is valid for the length of time specified by the prescribing physician, up to one year. Providers of therapy services are responsible for obtaining renewed PCP referrals every six months even if the prescription for therapy is for one year. The PCP or attending physician is responsible for determining medical necessity for therapy treatment. Outpatient treatment limits do not apply to eligible Medicaid beneficiaries under the age of 21.

Arkansas Medicaid applies the following therapy benefits to all therapy services in the Child Health Services (EPSDT) program for children under age 21:

A. Medicaid will reimburse up to four (4) occupational, physical and speech therapy evaluation units (1 unit = 30 minutes) per discipline, for an eligible beneficiary, per state fiscal year (July 1 through June 30) without authorization. Additional evaluation units will require an extended therapy request.

B. Medicaid will reimburse up to four (4) occupational, physical and speech therapy units (1 unit = 15 minutes) daily, per discipline, for an eligible beneficiary without authorization. Additional therapy units will require an extended therapy request.

C. All requests for extended therapy services for beneficiaries under age 21 must comply with sections 218.250 through 218.180.

218.115 Speech Therapy Services For Beneficiaries Age 18 and Under In ARKids First – B 1-1-09

Arkansas Medicaid applies the following speech therapy benefits in ARKids First-B program for children age 18 and under:

A. Medicaid will reimburse up to four (4) speech therapy evaluation units (1 unit = 30 minutes) for an eligible beneficiary, per state fiscal year (July 1 through June 30) without authorization. Additional evaluation units will require an extended therapy request.

B. Medicaid will reimburse up to four (4) speech therapy units (1 unit = 15 minutes) daily for an eligible beneficiary without authorization. Additional daily therapy units will require an extended therapy request.

C. All requests for extended speech therapy services for beneficiaries age 18 and under must comply with sections 218.250 through 218.180.

218.200 Speech-Language Therapy Guidelines for Retrospective Review for Beneficiaries Under Age 21 1-1-09

A. Medical Necessity

Speech-language therapy services must be medically necessary to the treatment of the individual's illness or injury. 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 a 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.)

A diagnosis alone is not sufficient documentation to support the medical necessity of therapy. Assessment for speech-language therapy includes a comprehensive evaluation of the patient's speech language deficits and functional limitations, treatment planned and goals to address each identified problem.

B. Evaluations

In order to determine that speech-language therapy services are medically necessary, an evaluation must contain the following information:

1. Date of Evaluation.
2. Patient's name and date of birth.
3. Diagnosis specific to therapy.
4. Background information including pertinent medical history and gestational age.

5. Standardized test results, including all subtest scores if applicable. Test results if applicable, 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.
6. An assessment of the results of the evaluation, including recommendations for frequency and intensity of treatment.
7. An explanation why the child was not tested in his or her native language; if not, an explanation must be provided in the evaluation.
8. Signature and credentials of the therapist performing the evaluation.

C. Feeding/Swallowing/Oral Motor

1. The patient may be formally or informally assessed.
2. The patient must have an in-depth functional profile on oral motor structures and function. An in-depth functional profile of oral motor structure and function is a description of a patient's oral motor structure that specifically notes how such structure is impaired in its function and justifies the medical necessity of feeding/swallowing/oral motor therapy services.
3. If swallowing problems and/or signs of aspiration are noted, then a formal medical swallow study must be submitted.

D. Voice

A medical evaluation is a prerequisite for voice therapy.

E. Progress Notes

Progress notes must be legible and must include the following information.

1. Patient'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. Descriptions of specific therapy services provided daily and activities rendered during each therapy session, along with a form of measurement.
6. Measurements of progress with respect to treatment goals and objectives.
7. Therapist's full signature and credentials for each date of service.
8. The supervising speech and language pathologist's co-signature on graduate students' progress notes.

218.210 Accepted Tests for Speech-Language Therapy 1-1-09

Tests used must be norm referenced, standardized, age appropriate and specific to the therapy provided. The following list of tests is not all-inclusive. When using a test that is not listed below, the provider must include documentation in the evaluation to support the reliability and validity of the test. This additional information will be used as reference information if the chart is selected by Medicaid for review. An explanation of why a test from the approved list could not be used to evaluate the child should be included. The Mental Measurement Yearbook (MMY) is the standard reference to determine the reliability and validity of the test(s) administered in the evaluation. Providers should refer to the MMY for additional information regarding specific tests. The following definitions of terms are applied to the lists of accepted tests:

- **Standard**: Evaluations that are used to determine deficits.

- **Supplemental**: Evaluations that are used to identify deficits and support other results. Supplemental tests may not supplant standard tests.
- **Clinical observations**: Clinical observations have a supplemental role in the evaluation and should always be included. Detail, precision and comprehensiveness of clinical observations are especially important when standard scores do not qualify the patient for therapy and the clinical notes constitute the primary justification of medical necessity.

A. Speech-Language Tests – Standardized

1. Preschool Language Scale, Third Ed. (PLS-3)
2. Preschool Language Scale, Fourth Ed. (PLS-4)
3. Test of Early Language Development, Third Ed. (TELD-3)
4. Peabody Picture Vocabulary Test, Third Ed. (PPVT-3)
5. Clinical Evaluation of Language Fundamentals – Preschool (CELF-P)
6. Clinical Evaluation of Language Fundamentals, Third Ed. (CELF-3)
7. Clinical Evaluation of Language Fundamentals, Fourth Ed. (CELF-4)
8. Communication Abilities Diagnostic Test (CADeT)
9. Test of Auditory Comprehension of Language, Third Ed. (TACL-3)
10. Comprehensive Assessment of Spoken Language (CASL)
11. Oral and Written Language Scales (OWLS)
12. Test of Language Development – Primary, Third Ed. (TOLD-P:3)
13. Test of Word Finding, Second Ed. (TWF-2)
14. Test of Auditory Perceptual Skills, Revised (TAPS-R)
15. Language Processing Test, Revised (LPT-R)
16. Test of Pragmatic Language (TOPL)
17. Test of Language Competence, Expanded Ed. (TLC-E)
18. Test of Language Development – Intermediate, Third Ed. (TOLD-I:3)
19. Fullerton Language Test for Adolescents, Second Ed. (FLTA)
20. Test of Adolescent and Adult Language, Third Ed. (TOAL-3)
21. Receptive One-Word Picture Vocabulary Test, Second Ed. (ROWPVT-2)
22. Expressive One-Word Picture Vocabulary Test, 2000 Ed. (EOWPVT)
23. Comprehensive Receptive and Expressive Vocabulary Test, Second Ed. (CREVT-2)
24. Kaufman Assessment Battery for Children (KABC)
25. Receptive/Expressive Emergent Language Test, Third Edition (REEL-3)

B. Speech-Language Tests – Supplemental

1. Receptive/Expressive Emergent Language Test, Second Ed. (REEL-2)
2. Nonspeech Test for Receptive/Expressive Language
3. Rossetti Infant-Toddler Language Scale (RITLS)
4. Mullen Scales of Early Learning (MSEL)
5. Reynell Developmental Language Scales
6. Illinois Test of Psycholinguistic Abilities, Third Ed. (ITPA-3)
7. Social Skills Rating System – Preschool & Elementary Level (SSRS-1)
8. Social Skills Rating System – Secondary Level (SSRS-2)

9. Kaufman Speech Praxis Test (KSPT)

C. Literacy/Comprehension – Supplemental

1. The Clinical Assessment of Literacy and Language
2. The Literacy Comprehension Test 2
3. Test of Reading Comprehension 3 (TORC3)

D. Written Language/Comprehension – Supplemental

1. Test of Written Language 3 (TWL3)

E. Birth to Age 3:

1. A (minus) -1.5 SD (standard score of 77) below the mean in two areas (expressive, receptive) or a (minus) -2.0 SD (standard score of 70) below the mean in one area is required to qualify for language therapy.
2. Two language tests must be reported, with at least one of these being a global, norm-referenced, standardized test with good reliability and validity. The second test may be criterion referenced.
3. All subtests, components and scores must be reported for all tests.
4. All sound errors must be reported for articulation, including positions and types of errors.
5. If phonological testing is submitted, a traditional articulation test must also be submitted with a standardized score.
6. Information regarding the child's functional hearing ability must be included as a part of the therapy evaluation report.
7. Non-school-age children must be evaluated annually.
8. If the provider indicates that the child cannot complete a norm-referenced test, the provider must submit an in-depth functional profile of the child's functional communication abilities. An in-depth functional profile is a description of a child's communication behaviors that specifically notes where such communication behaviors are impaired and justifies the medical necessity of therapy.
9. Children must be evaluated at least annually. Children (birth to age 2) in the Child Health Management Services (CHMS) Program must be evaluated every 6 months.

F. Ages 3 through 20

1. A (minus) -1.5 SD (standard score of 77) below the mean in two areas (expressive, receptive, articulation) or a (minus) -2.0 SD (standard score of 70) below the mean in one area (expressive, receptive, articulation)
2. Two language tests must be reported, with at least one of these being a global, norm-referenced, standardized test with good reliability and validity. Criterion-referenced tests will not be accepted for this age group.
3. All subtests, components and scores must be reported for all tests.
4. All sound errors must be reported for articulation including positions and types of errors.
5. If phonological testing is submitted, a traditional articulation test must also be submitted with a standardized score.
6. Information regarding the child's functional hearing ability must be included as a part of the therapy evaluation report.
7. Non-school-age children must be evaluated annually.

8. School-age children must have a full evaluation every three years (a yearly update is required) if therapy is school related; outside of school, annual evaluations are required. "School related" means the child is of school age, attends public school and receives therapy provided by the school.
9. If the provider indicates that the child cannot complete a norm-referenced test, the provider must submit an in-depth functional profile of the child's functional communication abilities. An in-depth functional profile is a description of a child's communication behaviors that specifically notes where such communication behaviors are impaired and justifies the medical necessity of therapy.
10. 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.**

218.250 Process for Requesting Extended Therapy Services for Beneficiaries Under Age 21 — 1-1-09

A. Requests for extended 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**. The request must meet the medical necessity requirement, and adequate documentation must be provided to support this request.

1. Requests for extended therapy services are considered only after a claim is denied due to regular benefits exceeded.
2. The request must be received by AFMC within 90 calendar days of the date of the benefits-exceeded denial. The count begins on the next working day after the date of the Remittance and Status Report (RA) on which the benefits-exceeded denial appears.
3. Submit with the request a copy of the Medical Assistance Remittance and Status Report reflecting the claim's benefits-exceeded denial. Do not send a claim.
4. AFMC will not accept 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 extended therapy services. **View or print form DMS-671**. Consideration of requests 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 must sign, include credentials and date the request form. An electronic signature is accepted provided it is in compliance with Arkansas Code 25-31-103. All applicable records that support the medical necessity of the request should be attached.

C. AFMC will approve, deny, or ask for additional information within 30 calendar days of receiving the request. AFMC reviewers will simultaneously advise the provider and the beneficiary when a request is denied. Approved requests will be returned to the provider with an authorization number that is required to be submitted with the billing for the approved services.

218.260 Documentation Requirements — 1-1-09

A. To request extended therapy services, all applicable documentation that supports the medical necessity of extended benefits is required.

B. Documentation requirements are as follows. Clinical records must:

1. Be legible and include documentation supporting the specific request
2. Be signed by the performing provider
3. Include the physician referral and prescription for additional therapy based on clinical records and progress reports furnished by the performing provider

218.270 AFMC Extended Therapy Services Review Process 1-1-09

The following is a step-by-step outline of AFMC's extended services review process:

A. Requests received via mail are screened for completeness and researched to determine the beneficiary's eligibility for Medicaid when the service was provided and payment/denial status of the claim request.

B. The documentation submitted is reviewed by a registered nurse (R.N.). If, in the judgment of the R.N., the documentation supports the medical necessity, they may approve the request. An approval letter is generated and mailed to the provider the following day.

C. If the R.N. reviewer determines the documentation does not justify the service or it appears that the service is not medically necessary, they will refer the case to the appropriate physician adviser for a decision.

D. The physician adviser's rationale for approval or denial is documented and the appropriate notification is created. If services are denied for medical necessity, the physician adviser's reason for the decision is included in the denial letter. A denial letter is mailed to the provider and the beneficiary the following work day.

E. Providers may request administrative reconsideration of an adverse decision or they and/or the beneficiary may appeal as provided in section 160.000 of this manual.

F. During administrative reconsideration of an adverse decision, if the extended therapy services original denial was due to incomplete documentation, but complete documentation supporting medical necessity is submitted with the reconsideration request, the R.N. may approve the extension of benefits without referral to a physician adviser.

G. During administrative reconsideration of an adverse decision, if the extended therapy services original denial was due to lack of medical necessity documentation or the documentation does not allow for approval by the R.N., the original documentation, reason for the denial and new information submitted will be referred to a different physician adviser for reconsideration.

H. All parties will be notified in writing of the outcome of the reconsideration. Reconsiderations approved generate an approval number and is mailed to the provider for inclusion with billing for the requested service. Adverse decisions that are upheld through the reconsideration remain eligible for an appeal by the provider and/or the beneficiary as provided in section 160.000 of this manual.

218.280 Administrative Reconsideration 1-1-09

A request for administrative reconsideration of the denial of services must be in writing and sent to AFMC within 30 calendar days of the denial. The request must include a copy of the denial letter and additional supporting documentation.

The deadline for receipt of the reconsideration request will be enforced pursuant to sections 190.012 and 190.013 of this manual. A request received by AFMC within 35 calendar days of a denial will be deemed timely. Reconsideration requests must be mailed and will not be accepted via facsimile or email.

ARKANSAS DEPARTMENT OF HUMAN SERVICES

Division of Medical Services
Program Planning & Development

P.O. Box 1437, Slot S-295 · Little Rock, AR 72203-1437
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TO: **Arkansas Medicaid Health Care Providers – Child Health Management Services (CHMS)**

DATE: **January 1, 2009**

SUBJECT: **Provider Manual Update Transmittal #115**

REMOVE		**INSERT**	
Section	**Date**	**Section**	**Date**
218.200	1-1-07	218.200	1-1-09
245.200	12-1-07	245.200	1-1-09
245.210	9-1-08	245.210	1-1-09

Explanation of Updates

Section 218.200 is updated to include clarification on the required use of form DMS-640 for referral and prescription of occupational, physical and speech therapy services.

Section 245.200 is updated to remove a reference to availability of a standardized form for in-depth functional profile documentation in C#2.

Section 245.210 is updated to remove a reference to availability of a standardized form for in-depth functional profile documentation in E #8 and F #9.

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 501-682-8323 (Local); 1-800-482-5850, extension 2-8323 (Toll-Free) or to obtain access to these numbers through voice relay, 1-800-877-8973 (TTY Hearing Impaired).

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.

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Roy Jeffus, Director

218.200 Individual Treatment Planning 1-1-09

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 when required. 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.** 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 during evaluation.

For those children receiving intervention/treatment services on a daily/weekly basis, the individualized treatment plan will be written for a period of 12 months and will be updated as needed. The treatment plan for children birth to 3 years of age may be in the form of the state accepted Individualized Family Services Plan (IFSP). A continuing PCP referral is required every 6 months.

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.

245.200 Speech-Language Therapy Guidelines for Retrospective Review 1-1-09

A. Speech-language therapy services must be medically necessary for the treatment of the individual's illness or injury. 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.)

A diagnosis alone is not sufficient documentation to support the medical necessity of therapy. Assessment for speech-language therapy includes a comprehensive evaluation of the patient's speech language deficits and functional limitations, treatment planned and goals to address each identified problem.

B. Evaluations:

In order to determine that speech-language therapy services are medically necessary, an evaluation must contain the following information:

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 gestational age.
5. Standardized test results, including all subtest scores, if applicable. Test results, if applicable, should be adjusted for prematurity (less than 37 weeks gestation) if the child is 12 months old or younger and this should be noted in the evaluation.
6. An assessment of the results of the evaluation including recommendations for frequency and intensity of treatment.
7. The child should be tested in his or her native language; if not, an explanation must be provided in the evaluation.
8. Signature and credentials of the therapist performing the evaluation.

C. Feeding/Swallowing/Oral Motor:

1. Can be formally or informally assessed.
2. Must have in-depth functional profile on oral motor structures and function. An in-depth functional profile of oral motor structure and function is a description of a child's oral motor structure that specifically notes how such structure is impaired in its function and justifies the medical necessity of feeding/swallowing/oral motor therapy services.

D. Voice

A medical evaluation is a prerequisite for voice therapy.

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.

245.210 Accepted Tests for Speech-Language Therapy 1-1-09

Tests used must be norm referenced, standardized, age appropriate and specific to the therapy provided. The following list of tests is not all-inclusive. When using a test that is not listed below, the provider must include documentation in the evaluation to support the reliability and validity of the test. This additional information will be used as reference information if the chart is ever selected by Medicaid for audit review. An explanation of why a test from the approved list could not be used to evaluate a child must also be included. The *Mental Measurement Yearbook (MMY)* is the standard reference to determine the reliability and validity of the test(s) administered in the evaluation.

Providers should refer to the *MMY* for additional information regarding specific tests. The following definitions of terms are applied to the lists of accepted tests:

- STANDARD: Evaluations that are used to determine deficits.
- SUPPLEMENTAL: Evaluations that are used to identify deficits and support other results. Supplemental test may not supplant standard tests.
- CLINICAL OBSERVATIONS: Clinical observations have a supplemental role in the evaluation and should always be included. Detail, precision and comprehensiveness of clinical observations are especially important when standard scores do not qualify the patient for therapy and the clinical notes constitute the primary justification of medical necessity.

A. Speech-Language Tests – Standardized

1. Preschool Language Scale, Third Ed. (PLS-3)
2. Preschool Language Scale, Fourth Ed. (PLS-4)
3. Test of Early Language Development, Third Ed. (TELD-3)
4. Peabody Picture Vocabulary Test, Third Ed. (PPVT-3)
5. Clinical Evaluation of Language Fundamentals – Preschool (CELF-P)
6. Clinical Evaluation of Language Fundamentals, Third Ed. (CELF-3)
7. Clinical Evaluation of Language Fundamentals, Fourth Ed. (CELF-4)
8. Communication Abilities Diagnostic Test (CADT)
9. Test of Auditory Comprehension of Language, Third Ed. (TACL-3)
10. Comprehensive Assessment of Spoken Language (CASL)
11. Oral and Written Language Scales (OWLS)
12. Test of Language Development – Primary, Third Ed. (TOLD-P:3)
13. Test of Word Finding, Second Ed. (TWF-2)
14. Test of Auditory Perceptual Skills, Revised (TAPS-R)
15. Language Processing Test, Revised (LPT-R)
16. Test of Pragmatic Language (TOPL)
17. Test of Language Competence, Expanded Ed. (TLC-E)
18. Test of Language Development – Intermediate, Third Ed. (TOLD-I:3)
19. Fullerton Language Test for Adolescents, Second Ed. (FLTA)
20. Test of Adolescent and Adult Language, Third Ed. (TOAL-3)
21. Receptive One-Word Picture Vocabulary Test, Second Ed. (ROWPVT-2)
22. Expressive One-Word Picture Vocabulary Test, 2000 Ed. (EOWPVT)
23. Comprehensive Receptive and Expressive Vocabulary Test, Second Ed. (CREVT-2)
24. Kaufman Assessment Battery for Children (KABC)
25. Receptive-Expressive Emergent Language Test, Third Edition (REEL-3)

B. Speech Language Tests – Supplemental

1. Receptive/Expressive Emergent Language Test, Second Ed. (REEL-2)
2. Nonspeech Test for Receptive/Expressive Language
3. Rossetti Infant-Toddler Language Scale (RITLS)
4. Mullen Scales of Early Learning (MSEL)
5. Reynell Developmental Language Scales

6. Illinois Test of Psycholinguistic Abilities, Third Ed. (ITPA-3)
7. Social Skills Rating System – Preschool & Elementary Level (SSRS-1)
8. Social Skills Rating System – Secondary Level (SSRS-2)
9. Kaufman Speech Praxis Test (KSPT)

C. Literacy/Comprehension – Supplemental

1. The Clinical Assessment of Literacy and Language
2. The Literacy Comprehension Test 2
3. Test of Reading Comprehension 3 (TORC3)

D. Written Language/Comprehension – Supplemental

1. Test of Written Language 3 (TWL3)

E. Birth to Age 3:

1. A (minus) -1.5 SD (standard score of 77) below the mean in two areas (expressive, receptive) or a (minus) -2.0 SD (standard score of 70) below the mean in one area to qualify for language therapy.
2. Two language tests must be reported, with at least one of these being a global, norm-referenced, standardized test with good reliability and validity. The second test may be criterion referenced.
3. All subtests, components and scores must be reported for all tests.
4. All sound errors must be reported for articulation including positions and types of errors.
5. If phonological testing is submitted, a traditional articulation test must also be submitted with a standardized score.
6. Information regarding the child's functional hearing ability must be included as a part of the therapy evaluation report.
7. Non-school-age children must be evaluated annually.
8. If the provider indicates that the child cannot complete a norm-referenced test, the provider must submit an in-depth functional profile of the child's functional communication abilities. An in-depth functional profile is a description of a child's communication behaviors that specifically notes where such communication behaviors are impaired and justifies the medical necessity of therapy.
9. Children must be evaluated at least annually. Children (birth to age 2) in the Child Health Management Services (CHMS) Program must be evaluated every 6 months.

F. Ages 3 to 21:

1. A (minus) -1.5 SD (standard score of 77) below the mean in two areas (expressive, receptive, articulation) or a (minus) -2.0 SD (standard score of 70) below the mean in one area (expressive, receptive, articulation)
2. Two language tests must be reported, with at least one of these being a global, norm-referenced, standardized test with good reliability and validity. Criterion-referenced tests will not be accepted for this age group.
3. All subtests, components and scores must be reported for all tests.
4. All sound errors must be reported for articulation including positions and types of errors.
5. If phonological testing is submitted, a traditional articulation test must also be submitted with a standardized score.

6. Information regarding child's functional hearing ability must be included as a part of the therapy evaluation report.
7. Non-school-age children must be evaluated annually.
8. School-age children must have a full evaluation every three years (a yearly update is required) if therapy is school related; outside of school annual evaluations are required. "School related" means the child is of school age, attends public school and receives therapy provided by the school.
9. If the provider indicates that the child cannot complete a norm-referenced test, the provider must submit an in-depth functional profile of the child's functional communication abilities. An in-depth functional profile is a description of a child's communication behaviors that specifically notes where such communication behaviors are impaired and justifies the medical necessity of therapy.
10. 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.**

ARKANSAS DEPARTMENT OF HUMAN SERVICES

Division of Medical Services
Program Planning & Development

P.O. Box 1437, Slot S-295 · Little Rock, AR 72203-1437
501-682-8368 · Fax: 501-682-2480

TO: **Arkansas Medicaid Health Care Providers – Rehabilitative Hospital**

DATE: **January 1, 2009**

SUBJECT: **Provider Manual Update Transmittal #107**

REMOVE		**INSERT**	
Section	**Date**	**Section**	**Date**
—	—	214.130	1-1-09
216.000	10-1-08	216.000	1-1-09
—	—	216.110	1-1-09
—	—	216.111	1-1-09
—	—	216.112	1-1-09
—	—	216.113	1-1-09
—	—	216.114	1-1-09
—	—	216.115	1-1-09
—	—	216.116	1-1-09
216.200	9-1-08	216.200	1-1-09
216.210	9-1-08	216.210	1-1-09

Explanation of Updates

Section 214.130 is a new section to detail and clarify policy regarding benefit limits for occupational, physical and speech therapies for beneficiaries 21 years of age and older.

Section 216.000 is updated to clarify the section title as applying to beneficiaries under age 21.

Section 216.110 is a new section, added to detail and clarify policy regarding therapy services for beneficiaries under age 21 and in the Child Health Services (EPSDT) program.

Section 216.111 is a new section, added to detail and clarify policy regarding speech therapy benefits for beneficiaries under age 18 in the ARKids First-B program.

Sections 216.112, 216.113, 216.114, 216.115 and 216.116 are new sections added to detail and clarify policy regarding requests for extended therapy services for beneficiaries under age 21.

Section 216.200 is updated to remove reference to the available standardized form in C #2.

Section 216.210 is updated to remove reference to the available standardized form in E #8 and F #9.

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 501-682-8323 (Local); 1-800-482-5850, extension 2-8323 (Toll-Free) or to obtain access to these numbers through voice relay, 1-800-877-8973 (TTY Hearing Impaired).

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Thank you for your participation in the Arkansas Medicaid Program.

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Roy Jeffus, Director

TOC required

214.130 Benefit Limit for Occupational, Physical and Speech Therapies For Beneficiaries 21 Years of Age and Older 1-1-09

A. Occupational, physical and speech therapies are subject to the benefit limit of 12 outpatient hospital visits per state fiscal year (SFY), as explained in section 214.120, for beneficiaries age 21 and over.

1. Outpatient therapy services, as well as other outpatient services, furnished by acute care hospitals and rehabilitative hospitals are combined when tallying utilization of this benefit.
2. This limit does not apply to eligible Medicaid beneficiaries under the age of 21 (see section 216.110 – 216.111).
3. Outpatient occupational, physical and speech therapy services for beneficiaries over age 21 require a referral from the beneficiary's primary care physician (PCP) unless the beneficiary is exempt from PCP Program requirements; if exempt from PCP, a referral from their attending physician is required.

B. Medicaid will reimburse up to four (4) occupational, physical and speech therapy evaluation units (1 unit = 30 minutes) per discipline, for an eligible beneficiary, per state fiscal year (July 1 through June 30).

C. Medicaid will reimburse up to four (4) occupational, physical and speech therapy units (1 unit = 15 minutes) daily, per discipline, for an eligible beneficiary.

D. All requests for benefit extensions for therapy services for beneficiaries over age 21 must comply with sections 215.120 through 215.130.

216.000 Retrospective Review of Occupational, Physical and Speech Therapy Services for Beneficiaries Under Age 21 1-1-09

The Quality Improvement Organization (QIO), QSource of Arkansas, under contract with the Arkansas Medicaid Program, performs retrospective reviews of medical records to determine the medical necessity of services paid for by Medicaid.

Specific guidelines have been developed for retrospective review of occupational, physical and speech-language therapy services furnished to Medicaid beneficiaries under the age of 21. Those guidelines are included in this manual to assist providers in determining and documenting medical necessity. The guidelines are located in sections 216.100 through 216.108.

216.110 Therapy Services For Beneficiaries Under Age 21 In Child Health Services (EPSDT) 1-1-09

Outpatient occupational, physical and speech therapy services require a referral from the beneficiary's primary care physician (PCP) unless the beneficiary is exempt from PCP Program requirements. If the beneficiary is exempt from the PCP process, referrals for therapy services are required from the beneficiary's attending physician. All therapy services for beneficiaries under the age of 21 years require referrals and prescriptions be made utilizing the "Occupational, Physical and Speech Therapy for Medicaid Eligible Recipients Under Age 21" form DMS-640. A prescription for therapy services is valid for the length of time specified by the prescribing physician, up to one year. Providers of therapy services are responsible for obtaining renewed PCP referrals every six months

even if the prescription for therapy is for one year. The PCP or attending physician is responsible for determining medical necessity for therapy treatment.

Arkansas Medicaid applies the following therapy benefits to all therapy services in the Child Health Services (EPSDT) program for children under age 21:

A. Medicaid will reimburse up to four (4) occupational, physical and speech therapy evaluation units (1 unit = 30 minutes) per discipline, for an eligible beneficiary, per state fiscal year (July 1 through June 30) without authorization. Additional evaluation units will require an extended therapy request.

B. Medicaid will reimburse up to four (4) occupational, physical and speech therapy units (1 unit = 15 minutes) daily, per discipline, for an eligible beneficiary without authorization. Additional daily therapy units will require an extended therapy request.

C. All requests for extended therapy services for beneficiaries under age 21 must comply with sections 216.112 through 216.116.

216.111 Speech Therapy Services For Beneficiaries Age 18 and Under In ARKids First – B

1-1-09

Speech therapy services ONLY are covered for beneficiaries in the ARKids First-B program benefits.

Arkansas Medicaid applies the following speech therapy benefits in ARKids First-B program for children age 18 and under:

A. Medicaid will reimburse up to four (4) speech therapy evaluation units (1 unit = 30 minutes) for an eligible beneficiary, per state fiscal year (July 1 through June 30) without authorization. Additional evaluation units will require an extended therapy request.

B. Medicaid will reimburse up to four (4) speech therapy units (1 unit = 15 minutes) daily for an eligible beneficiary without authorization. Additional daily therapy units will require an extended therapy request.

C. All requests for extended speech therapy services for beneficiaries age 18 and under must comply with sections 216.112 through 216.116.

216.112 Process for Requesting Extended Therapy Services for Beneficiaries Under Age 21

1-1-09

A. Requests for extended 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**. The request must meet the medical necessity requirement, and adequate documentation must be provided to support this request.

1. Requests for extended therapy services are considered only after a claim is denied due to regular benefits exceeded.
2. The request must be received by AFMC within 90 calendar days of the date of the benefits-exceeded denial. The count begins on the next working day after the date of the Remittance and Status Report (RA) on which the benefits-exceeded denial appears.
3. Submit with the request a copy of the Medical Assistance Remittance and Status Report reflecting the claim's benefits-exceeded denial. Do not send a claim.

4. AFMC will not accept requests sent via electronic facsimile (FAX) or e-mail.

B. Form DMS-671, Request for Extension of Benefits for Clinical, Outpatient, Laboratory, and X-Ray Services, must be utilized for requests for extended therapy services. **View or print form DMS-671**. Consideration of requests 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 must sign, include credentials and date the request form. An electronic signature is accepted provided it is in compliance with Arkansas Code 25-31-103. All applicable documentation that supports the medical necessity of the request should be attached.

C. AFMC will approve, deny, or ask for additional information within 30 calendar days of receiving the request. AFMC reviewers will simultaneously advise the provider and the beneficiary when a request is denied. Approved requests will be returned to the provider with an authorization number that is required to be submitted with the billing for the approved service.

216.113 Documentation Requirements 1-1-09

A. To request extended therapy services, all applicable documentation that supports the medical necessity of extended benefits are required.

B. Documentation requirements are as follows. Clinical records must:

1. Be legible and include documentation supporting the specific request.
2. Be signed by the performing provider.
3. Include the physician referral and prescription for additional therapy based on clinical records and progress reports furnished by the performing provider.

216.114 AFMC Extended Therapy Services Review Process 1-1-09

The following is a step-by-step outline of AFMC's extended services review process:

A. Requests received via mail are screened for completeness and researched to determine the beneficiary's eligibility for Medicaid when the service was provided and payment/denial status of the claim request.

B. The documentation submitted is reviewed by a registered nurse (R.N.). If, in the judgment of the R.N., the documentation supports the medical necessity, the R.N. may approve the request. An approval letter is generated and mailed to the provider the following day.

C. If the R.N. reviewer determines the documentation does not justify the service or it appears that the service is not medically necessary, the R.N. will refer the case to the appropriate physician adviser for a decision.

D. The physician adviser's rationale for approval or denial is documented and the appropriate notification is created. If services are denied for lack of medical necessity, the physician adviser's reason for the decision is included in the denial letter. A denial letter is mailed to the provider and the beneficiary the following work day.

E. Providers may request administrative reconsideration of an adverse decision or they and/or the beneficiary may appeal as provided in section 160.000 of this manual.

F. During administrative reconsideration of an adverse decision, if the extended therapy services original denial was due to incomplete documentation, but complete documentation supporting medical necessity is submitted with the reconsideration request, the R.N. may approve the extension of benefits without referral to a physician adviser.

G. During administrative reconsideration of an adverse decision, if the extended therapy services original denial was due to lack of medical necessity documentation or the documentation does not allow for approval by the R.N., the original documentation, reason for the denial and new information submitted will be referred to a different physician adviser for reconsideration.

H. All parties will be notified in writing of the outcome of the reconsideration. Reconsiderations approved generate an approval number and is mailed to the provider for inclusion with billing for the requested service. Adverse decisions that are upheld through the reconsideration remain eligible for an appeal by the provider and/or the beneficiary as provided in section 160.000 of this manual.

216.115 Administrative Reconsideration 1-1-09

A request for administrative reconsideration of the denial of services must be in writing and sent to AFMC within 30 calendar days of the denial. The request must include a copy of the denial letter, all previously submitted documentation and pertinent additional supporting documentation to justify the medical necessity of additional services.

The deadline for receipt of the reconsideration request will be enforced pursuant to sections 190.012 and 190.013 of this manual. A request received by AFMC within 35 calendar days of a denial will be deemed timely. Reconsideration requests must be mailed and will not be accepted via facsimile or email.

216.116 Appealing an Adverse Action 1-1-09

When the state Medicaid agency or its designee denies an extended therapy request, the beneficiary or the provider may appeal the decision and request a fair hearing.

An appeal request must be in writing and must be received by the Appeals and Hearings Section of the Department of Human Services (DHS) within 30 days of the date on the letter from DMS explaining the denial. **View or print the Department of Human Services, Appeals and Hearings Section contact information.**

216.200 Speech-Language Therapy Guidelines for Retrospective Review for Beneficiaries Under Age 21 1-1-09

A. Medical Necessity

Speech-language therapy services must be medically necessary to the treatment of the individual's illness or injury. 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).

A diagnosis alone is not sufficient documentation to support the medical necessity of therapy. Assessment for speech-language therapy includes a comprehensive evaluation of the patient's speech-language deficits and functional limitations, treatment(s) planned and goals to address each identified problem.

B. Evaluations

In order to determine that speech-language therapy services are medically necessary, an evaluation must contain the following information:

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 gestational age.
5. Standardized test results, including all subtest scores if applicable. Test results, if applicable, 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.
6. An assessment of the results of the evaluation, including recommendations for frequency and intensity of treatment.
7. The child should be tested in his or her native language; if not, an explanation must be provided in the evaluation.
8. Signature and credentials of the therapist performing the evaluation.

C. Feeding/Swallowing/Oral Motor

1. The patient may be formally or informally assessed.
2. The patient must have an in-depth functional profile on oral motor structures and function. An in-depth functional profile of oral motor structure and function is a description of a patient's oral motor structure that specifically notes how such structure is impaired in its function and justifies the medical necessity of feeding/swallowing/oral motor therapy services.
3. If swallowing problems and/or signs of aspiration are noted, a formal medical swallow study must be submitted.

D. Voice

A medical evaluation is a prerequisite for voice therapy.

E. Progress Notes

Progress notes must be legible and must include the following information:

1. Patient'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. Descriptions of specific therapy services provided daily and activities rendered during each therapy session, along with a form of measurement.
6. Measurements of progress with respect to treatment goals and objectives.

7. Therapist's must sign each date of entry with a full signature and credentials.
8. The supervising speech and language pathologist's co-signature on graduate students' progress notes.

216.210 Accepted Tests for Speech-Language Therapy 1-1-09

Tests used must be norm referenced, standardized, age appropriate and specific to the therapy provided. The following list of tests is not all-inclusive. When using a test that is not listed below, the provider must include documentation in the evaluation to support the reliability and validity of the test. This additional information will be used as reference information if the chart is selected by Medicaid for review. An explanation of why a test from the approved list could not be used to evaluate a patient must be included in the documentation. The *Mental Measurement Yearbook (MMY)* is the standard reference for determining the reliability and validity of test(s) administered in an evaluation. Providers should refer to the MMY for additional information regarding specific tests. The following definitions of terms are applied to the lists of accepted tests:

- **Standard:** Evaluations that are used to determine deficits.
- **Supplemental:** Evaluations that are used to identify deficits and support other results. Supplemental tests may not supplant standard tests.
- **Clinical observations:** Clinical observations have a supplemental role in the evaluation and should always be included. Detail, precision and comprehensiveness of clinical observations are especially important when standard scores do not qualify the patient for therapy and the clinical notes constitute the primary justification of medical necessity.

A. Speech-Language Tests – Standardized

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2. Preschool Language Scale, Fourth Ed. (PLS-4)
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4. Peabody Picture Vocabulary Test, Third Ed. (PPVT-3)
5. Clinical Evaluation of Language Fundamentals – Preschool (CELF-P)
6. Clinical Evaluation of Language Fundamentals, Third Ed. (CELF-3)
7. Clinical Evaluation of Language Fundamentals, Fourth Ed. (CELF-4)
8. Communication Abilities Diagnostic Test (CADeT)
9. Test of Auditory Comprehension of Language, Third Ed. (TACL-3)
10. Comprehensive Assessment of Spoken Language (CASL)
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24. Kaufman Assessment Battery for Children (KABC)
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4. Mullen Scales of Early Learning (MSEL)
5. Reynell Developmental Language Scales
6. Illinois Test of Psycholinguistic Abilities, Third Ed. (ITPA-3)
7. Social Skills Rating System – Preschool & Elementary Level (SSRS-1)
8. Social Skills Rating System – Secondary Level (SSRS-2)
9. Kaufman Speech Praxis Test (KSPT)

C. Literacy/Comprehension – Supplemental

1. The Clinical Assessment of Literacy and Language
2. The Literacy Comprehension Test 2
3. Test of Reading Comprehension 3 (TORC3)

D. Written Language/Comprehension – Supplemental

1. Test of Written Language 3 (TWL3)

E. Birth to Three

1. A (minus) -1.5 SD (standard deviation) (standard score of 77) below the mean in two areas (expressive, receptive) or (minus) -2.0 SD (standard score of 70) below the mean in one area to qualify for language therapy.
2. Two language tests must be reported with at least one of these being a global, norm-referenced, standardized test with good reliability and validity. The second test may be criterion referenced.
3. All subtests, components, and scores must be reported for all tests.
4. All sound errors must be reported for articulation, including positions and types of errors.
5. If phonological testing is used, a traditional articulation test must also be included with a standardized score.
6. Information regarding the child's functional hearing ability must be included in the therapy evaluation report.
7. Non school-age children must be evaluated annually.
8. If the provider indicates the child cannot complete a norm-referenced test, the provider must submit an in-depth functional profile of the child's functional communication abilities. An in-depth functional profile is a description of a child's communication behaviors that specifically notes where such communication behaviors are impaired and justifies the medical necessity of therapy.
9. Children must be evaluated at least annually. Children (birth to age 2) in the Child Health Management Services (CHMS) Program must be evaluated every six (6) months.

F. Ages 3 through 20

1. A (minus) -1.5 SD (standard score of 77) from the mean in two areas (expressive, receptive, articulation) or a (minus) -2.0 SD (standard score of 70) below the mean in one area (expressive, receptive, articulation)
2. Two language tests must be reported, with at least one of these being a global, norm-referenced, standardized test with good reliability and validity. Criterion-referenced tests will not be accepted for this age group.
3. All subtests, components and scores must be reported for all tests.
4. All sound errors must be reported for articulation, including positions and types of errors.
5. If phonological testing is submitted, a traditional articulation test must also be submitted with a standardized score.
6. Information regarding child's functional hearing ability must be included as a part of the therapy evaluation report.
7. Non-school-age children must be evaluated annually.
8. School-aged children must have a full evaluation every three years (a yearly update is required) if therapy is school related; outside of school, annual evaluations are required. "School related" means the child is of school age, attends public school and receives therapy provided by the school.
9. If the provider indicates that the child cannot complete a norm-referenced test, the provider must submit an in-depth functional profile of the child's functional communication abilities. An in-depth functional profile is a description of a child's communication behaviors that specifically notes where such communication behaviors are impaired and justifies the medical necessity of therapy.
10. 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.**