ARKANSAS REGISTER

Transmittal Sheet

Use only for **FINAL** and **EMERGENCY RULES**

Secretary of State
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For Office Use Only:

Effective Date _____ Code Number _____

Name of Agency Department of Human Services

Department Division of Developmental Disabilities Services

Contact Elizabeth Pitman E-mail elizabeth.pitman@dhs.arkansas.gov Phone 501-682-4936

Statutory Authority for Promulgating Rules Arkansas Code Annotated 20-77-107

Rule Title: Therapy 1-18, Section V-3-18 and State Plan Amendment #2018-008

Intended Effective Date (Check One)		Date
☐ Emergency (ACA 25-15-204)	Legal Notice Published	04/09/2018
☐ 10 Days After Filing (ACA 25-15-204)	Final Date for Public Comment	05/08/2018
☑ Other July 1, 2018 (Must be more than 10 days after filing date.)	Reviewed by Legislative Council	06/15/2018
	Adopted by State Agency	07/01/2018

Electronic Copy of Rule e-mailed from: (Required under ACA 25-15-218)

Becky Murphy (Contact Person) becky.murphy@dhs.arkansas.gov (E-mail Address) _____ (Date)

CERTIFICATION OF AUTHORIZED OFFICER

I Hereby Certify That The Attached Rules Were Adopted
In Compliance with the Arkansas Administrative Act. (ACA 25-15-201 et. seq.)

Melissa Stone
Signature

(501) 682-8662 (Phone Number) melissa.stone@dhs.arkansas.gov (E-mail Address)

Director
Title

6/18/18
Date

Revised 7/2015 to reflect new legislation passed in the 2015 Regular Session (Act 1258). This act changed the effective date from 30 days to 10 days after filing the rule.

FINANCIAL IMPACT STATEMENT

PLEASE ANSWER ALL QUESTIONS COMPLETELY

DEPARTMENT Arkansas Department of Human Services

DIVISION Division of Developmental Disabilities Services

PERSON COMPLETING THIS STATEMENT Elizabeth Pitman

TELEPHONE 501-682-4936 **FAX** 501-682-8380 **EMAIL:** Elizabeth.pitman@dhs.arkansas.gov

To comply with Ark. Code Ann. § 25-15-204(e), please complete the following Financial Impact Statement and file two copies with the questionnaire and proposed rules.

SHORT TITLE OF THIS RULE Therapy 1-18; Section V 3-18 and State Plan Amendment #2018-008

1. Does this proposed, amended, or repealed rule have a financial impact? Yes ☐ No ☒

2. Is the rule based on the best reasonably obtainable scientific, technical, economic, or other evidence and information available concerning the need for, consequences of, and alternatives to the rule? Yes ☒ No ☐

3. In consideration of the alternatives to this rule, was this rule determined by the agency to be the least costly rule considered? Yes ☒ No ☐

   If an agency is proposing a more costly rule, please state the following:

   (a) How the additional benefits of the more costly rule justify its additional cost;

   (b) The reason for adoption of the more costly rule;

   (c) Whether the more costly rule is based on the interests of public health, safety, or welfare, and if so, please explain; and;

   (d) Whether the reason is within the scope of the agency's statutory authority; and if so, please explain.

4. If the purpose of this rule is to implement a federal rule or regulation, please state the following:

   (a) What is the cost to implement the federal rule or regulation?

Current Fiscal Year		**Next Fiscal Year**	
General Revenue	0	General Revenue	0
Federal Funds	0	Federal Funds	0
Cash Funds	0	Cash Funds	0
Special Revenue	0	Special Revenue	0
Other (Identify)	0	Other (Identify)	0
Total	0	Total	0

(b) What is the additional cost of the state rule?

Current Fiscal Year		Next Fiscal Year	
General Revenue	0	General Revenue	0
Federal Funds	0	Federal Funds	0
Cash Funds	0	Cash Funds	0
Special Revenue	0	Special Revenue	0
Other (Identify)	0	Other (Identify)	0
Total	0	Total	0

5. What is the total estimated cost by fiscal year to any private individual, entity and business subject to the proposed, amended, or repealed rule? Identify the entity(ies) subject to the proposed rule and explain how they are affected.

Current Fiscal Year	Next Fiscal Year
$ 0	$ 0

6. What is the total estimated cost by fiscal year to state, county, and municipal government to implement this rule? Is this the cost of the program or grant? Please explain how the government is affected.

Current Fiscal Year	Next Fiscal Year
$ 0	$ 0

7. With respect to the agency's answers to Questions #5 and #6 above, is there a new or increased cost or obligation of at least one hundred thousand dollars ($100,000) per year to a private individual, private entity, private business, state government, county government, municipal government, or to two (2) or more of those entities combined?

Yes ☐ No ☒

If YES, the agency is required by Ark. Code Ann. § 25-15-204(e)(4) to file written findings at the time of filing the financial impact statement. The written findings shall be filed simultaneously with the financial impact statement and shall include, without limitation, the following:

(1) a statement of the rule's basis and purpose;

(2) the problem the agency seeks to address with the proposed rule, including a statement of whether a rule is required by statute;

(3) a description of the factual evidence that:
   (a) justifies the agency's need for the proposed rule; and
   (b) describes how the benefits of the rule meet the relevant statutory objectives and justify the rule's costs;

(4) a list of less costly alternatives to the proposed rule and the reasons why the alternatives do not adequately address the problem to be solved by the proposed rule;

(5) a list of alternatives to the proposed rule that were suggested as a result of public comment and the reasons why the alternatives do not adequately address the problem to be solved by the proposed rule;

(6) a statement of whether existing rules have created or contributed to the problem the agency seeks to address with the proposed rule and, if existing rules have created or contributed to the problem, an explanation of why amendment or repeal of the rule creating or contributing to the problem is not a sufficient response; and

(7) an agency plan for review of the rule no less than every ten (10) years to determine whether, based upon the evidence, there remains a need for the rule including, without limitation, whether:

(a) the rule is achieving the statutory objectives;
(b) the benefits of the rule continue to justify its costs; and
(c) the rule can be amended or repealed to reduce costs while continuing to achieve the statutory objectives.

ARKANSAS DEPARTMENT OF HUMAN SERVICES

Division of Medical Services
Program Development & Quality Assurance

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TDD/TTY: 501-682-6789

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

EFFECTIVE DATE: July 1, 2018

SUBJECT: Provider Manual Update Transmittal THERAPY-1-18

REMOVE		INSERT	
Section	**Effective Date**	**Section**	**Effective Date**
201.110	8-15-08	201.110	7-1-18
202.330	10-13-03	202.330	7-1-18
204.000	10-15-09	204.000	7-1-18
207.000	10-13-03	207.000	7-1-18
208.000	10-13-03	208.000	7-1-18
211.000	7-1-05	211.000	7-1-18
212.000	1-1-09	212.000	7-1-18
214.000	10-1-15	214.000	7-1-18
214.200	7-1-15	214.200	7-1-18
214.210	10-1-08	214.210	7-1-18
214.220	3-1-06	214.220	7-1-18
214.230	3-1-06	214.230	7-1-18
214.240	3-1-06	214.240	7-1-18
214.300	9-1-13	214.300	7-1-18
214.400	5-1-16	214.400	7-1-18
216.300	1-1-09	216.300	7-1-18
216.305	1-1-09	216.305	7-1-18
216.310	1-1-09	216.310	7-1-18
216.315	1-1-09	216.315	7-1-18
231.000	8-1-06	231.000	7-1-18
262.400	1-1-09	262.400	7-1-18

Explanation of Updates

Section 201.110 has been updated to replace "developmental day treatment clinic" with "Early Intervention Day Treatment (EIDT) program or Adult Developmental Day Treatment (ADDT) program".

Section 202.330 has been updated with the most current information regarding State Licensure Exemptions Under Arkansas Code §17-100-104.

Section 204.000 has been updated to change the number of months providers of therapy services are responsible for obtaining renewed PCP referrals from "six (6) months" to "twelve (12) months".

Section 207.000 has been updated with the most current information regarding Referral to First Connections program, pursuant to Part C of Individuals with Disabilities Education Act ("IDEA").

Section 208.000 has been updated with the most current information regarding Coordination with Part B of the Individuals with Disabilities Education Act (IDEA) Amendments of 1997.

Sections 211.000 and 212.000 have been updated to replace "Developmental Day Treatment Clinic Services (DDTCS)" with "Adult Developmental Day Treatment (ADDT)."

Section 214.000 has been updated with the most current information regarding Occupational, Physical and Speech Therapy Services.

Section 214.200 has been updated with information regarding prior authorization of extension of benefits requirements.

Section 214.210 has been updated with the most current information regarding the Retrospective Therapy Review Process.

Section 214.220 has been updated with the most current information regarding Medical Necessity Review.

Section 214.230 has been updated with the most current information regarding Utilization Review.

Section 214.240 has been updated to remove the word "Retrospective".

Section 214.300 has been updated with the most current information regarding Occupational and Physical Therapy Guidelines for Review.

Section 214.400 has been updated with the most current information regarding Speech-Language Therapy Guidelines for Review.

Section 216.300 has been updated with the most current information regarding Process for Requesting Extended Therapy Services.

Section 216.305 has been updated with the most current information regarding Documentation Requirements.

Section 216.310 has been updated with the most current information regarding QIO Extended Therapy Services Review Process.

Section 216.315 has been updated with the most current information regarding Administrative Reconsideration.

Section 231.000 has been updated with the most current information regarding Prior Authorization Request Procedures for Augmentative Communication Device (ACD) Evaluation.

Section 262.400 has been updated with the most current information regarding Special Billing Procedures.

The paper version of this update transmittal includes revised pages that may be filed 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 have questions regarding this transmittal, please contact the Provider Assistance Center at 1-800-457-4454 (Toll-Free) within Arkansas or locally and Out-of-State at (501) 376-2211.

If you need this material in an alternative format, such as large print, please contact the Program Development and Quality Assurance Unit at (501) 320-6429.

Arkansas Medicaid provider manuals (including update transmittals), official notices, notices of rule making 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.

Rose M. Naff
Director

TOC required

201.110 School Districts, Education Service Cooperatives, and Early Intervention Day Treatment, or Adult Developmental Day Treatment 7-1-18

A school district, education service cooperative, Early Intervention Day Treatment (EIDT) program or Adult Developmental Day Treatment (ADDT) program may contract with or employ qualified therapy practitioners. Effective for dates of service on and after October 1, 2008, the individual therapy practitioner who actually performs a service on behalf of the facility must be identified on the claim as the performing provider when the facility bills for that service. This action is taken in compliance with the federal Improper Payments Information Act of 2002 (IPIA), Public Law 107-300 and the resulting Payment Error Rate Measurement (PERM) program initiated by the Centers for Medicare and Medicaid Services (CMS).

If a facility contracts with a qualified therapy practitioner, the criteria for group providers of therapy services apply (See Section 201.100 of the Occupational, Physical, Speech Therapy Services manual). The qualified therapy practitioner who contracts with the facility must be enrolled with Arkansas Medicaid. The contract practitioner who performs a service must be listed as the performing provider on the claim when the facility bills for that service.

If a facility employs a qualified therapy practitioner, that practitioner has the option of either enrolling with Arkansas Medicaid or requesting a Practitioner Identification Number (View or print form DMS-7708). The employed practitioner who performs a service must be listed as the performing provider on the claim when the facility bills for that service.

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

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

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

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

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

202.330 State Licensure Exemptions Under Arkansas Code §17-100-104 7-1-18

Arkansas Code §17-100-104, as amended, makes it lawful for a person to perform speech-language pathology services without Arkansas licensure as:

A. A person performing speech-language pathology services solely within the confines or under the jurisdiction of a public school system if that person holds a valid and current certificate as a speech therapist or speech-language pathologist issued by the Arkansas Department of Education. [Arkansas Code §17-100-104 (4)]

B. A person performing speech-language pathology services solely within the confines of the person's duties as an employee of the State of Arkansas, provided that the person was an employee of the State of Arkansas on January 1, 1993. [Arkansas Code §17-100-104(7)]

C. A person performing speech-language pathology services solely within the confines of the person's duties as an employee of any entity licensed or certified as a Developmental Disability Services community provider by the Division of Provider Services and Quality

Assurance (DPSQA). That person must hold a minimum of a bachelor's degree in speech-language pathology, must be supervised by a licensed speech-language pathologist and must comply with Arkansas regulations as a Speech-Language Pathology Support Personnel. [Arkansas Code §17-100-104(8)]

204.000 Required Documentation 7-1-18

All Provider Participation requirements detailed within Section 140.000 must be met. The additional documentation requirements below also apply to Occupational, Physical and Speech-Language Therapy providers:

A. 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 twelve (12) 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.

B. 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.

C. 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.

D. 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.

E. 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.

207.000 Referral to First Connections program, pursuant to Part C of Individuals with Disabilities Education Act ("IDEA") 7-1-18

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

Federal regulations under Part C of the IDEA require "primary referral sources" to refer any child suspected of having a developmental delay or disability for early intervention services. A physical, occupational, or speech therapist is considered a primary referral source under Part C of IDEA regulations.

Each provider must, within two (2) working days of first contact, refer all infants and toddlers from birth to thirty-six (36) months of age for whom there is a diagnosis or suspicion of a developmental delay or disability. The referral must be made to the DDS First Connections Central Intake Unit, which serves as the State of Arkansas's single point of entry to minimize duplication and expedite service delivery. Each provider is responsible for maintaining documentation evidencing that a proper and timely referral to First Connections has been made.

208.000 Coordination with Part B of the Individuals with Disabilities Education Act (IDEA) Amendments of 1997 7-1-18

Local Education Agencies ("LEA") have the responsibility to ensure that children from ages three (3) until entry into Kindergarten who have or are suspected of having a disability under Part B of IDEA ("Part B") receive a Free Appropriate Public Education.

For further clarification related to Special Education Services refer to the DPSQA EIDT Licensure Manual.

211.000 Introduction 7-1-18

The Arkansas Medicaid Occupational, Physical and Speech Therapy Program reimburses therapy services for Medicaid-eligible individuals under the age of 21 in the Child Health Services (EPSDT) Program.

Therapy services for individuals aged 21 and older are only covered when provided through the following Medicaid Programs: Adult Developmental Day Treatment (ADDT), Hospital/Critical Access Hospital (CAH)/End-Stage Renal Disease (ESRD), Home Health, Hospice and Physician/Independent Lab/CRNA/Radiation Therapy Center. Refer to these Medicaid provider manuals for conditions of coverage and benefit limits.

Medicaid reimbursement is conditional upon providers' compliance with Medicaid policy as stated in this provider manual, manual update transmittals and official program correspondence.

All Medicaid benefits are based on medical necessity. Refer to the Glossary for a definition of *medical necessity*.

212.000 Scope 7-1-18

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: Adult Developmental Day Treatment (ADDT), 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 7-1-18

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 Beneficiaries 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 at least once every twelve (12) months.

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.

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 **International Classification of Diseases Clinical Modification** in the edition Medicaid has certified as current for the patient's dates of service.

3. Please note the following diagnosis codes are not specific enough to identify the medical necessity for therapy treatment and may not be used.

E. Therapy services providers must use form DMS-640 – "Occupational, Physical and Speech Therapy for Medicaid Eligible Beneficiaries 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. When an electronic version of the DMS-640 becomes part of the physician or provider's electronic health record, the inclusion of extraneous patient and clinic information does not alter the form.

To order copies from the Arkansas Medicaid fiscal agent use Form MFR-001 – Medicaid Forms Request. View or Print the Medicaid Form Request 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, part 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.

214.200 Guidelines for Review of Occupational, Physical and Speech Therapy Services 7-1-18

Prior authorization of extension of benefits is required when a physician prescribes more than 90 minutes of therapy per week in one or more therapy discipline(s). Retrospective review of occupational, physical and speech therapy services is required for beneficiaries under age 21 who are receiving ninety (90) minutes per week or less of therapy services in each discipline or who are receiving rehabilitation therapy after an injury, illness or surgical procedure. The purpose of all review is the promotion of effective, efficient and economical delivery of health care services.

The Quality Improvement Organization (QIO), under contract to the Medicaid Program, performs retrospective reviews by reviewing medical records to determine if services delivered and reimbursed by Medicaid meet medical necessity requirements. **View or print QIO contact information.**

Specific guidelines have been developed for occupational, physical and speech therapy retrospective reviews. These guidelines may be found in Sections 214.300 and 214.400.

214.210 Retrospective Therapy Review Process 7-1-18

Retrospective therapy review encompasses occupational therapy (OT), speech language pathology (SLP) and physical therapy (PT) services that provide evaluation and treatment for the purpose of improving function and preventing long-term disabilities in Medicaid-eligible beneficiaries under age twenty-one (21). The primary care physician (PCP) or attending physician is responsible for referring the beneficiary for these interventions. Therapeutic intervention is covered in public schools and therapy clinics. A valid prescription written and signed by the PCP or attending physician on the revised DMS-640 form is required. This prescription is valid for the length of time indicated by the physician or up to one (1) year from the date of the physician's signature.

On a calendar quarterly basis, the Quality Improvement Organization (QIO) under contract with Arkansas Medicaid, will select and review a percentage random sample of all the therapy services billed and paid during the past three months (previous quarter) that were either (1) 90 minutes or less per week or (2) were provided pursuant to a rehabilitation diagnosis (related to an injury, illness or surgical procedure). The request for record copies is sent to each provider along with instructions for returning the records. The request asks for the child's parent/guardian name and address and lists the child's name, date of birth, Medicaid identification number, dates of services, type of therapy, date of request and a listing of the documentation required for review. The provider(s) must provide the information to the QIO within thirty (30) calendar days of the request date printed in the record request cover letter. If the requested information is not received within the thirty-(30) day timeframe, a medical necessity denial is issued.

Post payment review of therapies is a dual process: The utilization review determines whether billed services were prescribed and delivered as billed, and the medical necessity review determines whether the amount, duration and frequency of services provided were medically necessary.

Providers must send the requested record copies to the QIO. When the records are received, each record is stamped with the receipt date and entered into the computer review and tracking system. This system automatically generates a notification to the provider that the record(s) has been received. The Receipt of Requested Therapy Records letter is an acknowledgement of receipt of the record(s) only. Individual records have not been assessed for completeness of documentation. Additional documentation may be requested from the provider at a later date in order to complete a retrospective therapy review audit.

Records will not be accepted via facsimile or email.

214.220 Medical Necessity Review 7-1-18

The record is initially reviewed by a registered nurse using screening guidelines developed from the promulgated Medicaid therapy manual. The nurse reviewer screens the chart to determine whether the correct information was submitted for review. If it is determined that the requested information was submitted correctly, the nurse reviewer can then review the documentation in more detail to determine whether it meets Medicaid eligibility criteria for medical necessity. The medical necessity review includes verifying that all therapy services will be or have been provided under a valid PCP prescription (form DMS-640). A prescription is considered valid if it contains the following information: the child's name, Medicaid ID number, a valid diagnosis that clearly establishes and supports that the prescribed therapy is medically necessary, minutes and duration of therapy and is signed and dated by the PCP or attending physician. All therapy prescriptions must be on the revised DMS-640 form. Rubber-stamped signatures, those signed by the physician's nurse or a nurse practitioner and those without a signature date are not considered valid. Changes made to the prescription that alter the type and quantity of services prescribed are invalid unless changes are initialed and dated by the physician.

If the guidelines are met when being retrospectively reviewed and medical necessity is approved, the nurse reviewer proceeds to the utilization portion of the review. If guidelines are not met or the prescription is invalid, the nurse reviewer refers the record to an appropriate therapist adviser for further review.

The therapist adviser may determine there is medical necessity even though the guidelines are not met, or make recommendation to the Associate Medical Director (AMD) for possible denial of all or part of the services provided. The AMD will review the recommendation and make a final decision to approve or deny. If the services are partially or completely denied, the provider, the beneficiary and the ordering physician are notified in writing of the denial. Each denial letter contains a rationale for the denial that is case specific. Each party is provided information about requesting reconsideration review or a fair hearing.

214.230 Utilization Review 7-1-18

When the billed services are determined to be medically necessary during retrospective review, the nurse reviewer proceeds to the utilization portion of the review. The computer review system lists all claims for services paid during the previous quarter for each beneficiary selected. This listing includes the procedure code and modifier, if required, dates of service billed and units paid. The nurse reviewer compares the paid claims data to the progress notes submitted. The previously mentioned screening guidelines are utilized to verify that the proper procedure code and modifier, if required, were billed, time in/out is documented, a specific description of the therapy services provided, activities rendered during the therapy session and some form of measurement is documented for each daily therapy session along with the providing therapist's signature (full name and credentials). If the documentation submitted supports the billed services, the nurse reviewer approves the utilization portion of the retrospective review. When

documentation submitted does not support the billed services, the nurse reviewer refers the services not supported by documentation to an appropriate therapist for further review.

The therapist reviews the documentation and either approves the services as billed or provides a recommendation to the AMD to deny some or all of the services. If the AMD agrees with the denial, a denial letter is mailed to the provider, the ordering physician and the beneficiary. The letter includes case specific rationale explaining why the services did not meet established criteria.

214.240 Denial/Due Process 7-1-18

Therapy Reviews may result in either a medical necessity or a utilization denial. For utilization only denials, the service provider is notified in writing of the denied services. The denial notification provides case specific rationale for the denial and will include instructions for requesting reconsideration. If the denial is for medical necessity, the PCP or attending physician and the services provider(s) will be notified in writing of the medical necessity denial. Each denial letter contains case specific denial rationale. The PCP denial letter informs the physician that a denial for therapy services on a specific Medicaid beneficiary has been issued. It states that he is being notified for information only because he might be called upon by the providers(s) to assist in the request for reconsideration. For either denial type, the provider is allowed 35 calendar days to submit additional information for reconsideration. Reconsideration review will not be performed if the additional information does not contain substantially different information than that previously submitted. Only one reconsideration is allowed per denial.

The beneficiary is notified in writing of all medical necessity denials at the same time the provider is notified. The beneficiary's denial letter includes case specific denial rationale and includes instructions for requesting a fair hearing. The beneficiary is not notified of utilization denials.

214.300 Occupational and Physical Therapy Guidelines for Review 7-1-18

A. Medical Necessity

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

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

B. Evaluations and Report Components

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

1. Date of evaluation.
2. Child's name and date of birth.
3. Diagnosis specific to therapy.
4. Background information including pertinent medical history; and, if the child is 12 months of age or younger, gestational age. The child should be tested in the child's dominant language; if not, an explanation must be provided in the evaluation.

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

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

7 months - [(12) / 4 weeks]

7 months - [3]

4 months

5. Standardized test results, including all subtest scores, if applicable. Test results must be reported as standard scores, Z scores, T scores or percentiles. Age-equivalent scores and percentage of delay cannot be used to qualify for services.
6. If applicable, test results should be adjusted for prematurity (less than 37 weeks gestation) if the child is 12 months of age or younger, and this should be noted in the evaluation.
7. Objective information describing the child's gross/fine motor abilities/deficits, e.g., range of motion measurements, manual muscle testing, muscle tone or a narrative description of the child's functional mobility skills (strengths and weaknesses).
8. An interpretation of the results of the evaluation, including recommendations for therapy/minutes per week.
9. A description of functional strengths and limitations, a suggested treatment plan and potential goals to address each identified problem.
10. Signature and credentials of the therapist performing the evaluation.

C. Interpretation and Eligibility: Ages Birth to 21

1. Tests used must be norm-referenced, standardized and specific to the therapy provided.
2. Tests must be age appropriate for the child being tested.
3. All subtests, components and scores must be reported for all tests used for eligibility purposes.
4. Eligibility for therapy will be based upon a score of -1.5 standard deviations (SD) below the mean or greater in at least one subtest area or composite score on a norm-referenced, standardized test. When a -1.5 SD or greater is not indicated by the test, a criterion-referenced test along with informed clinical opinion must be included to support the medical necessity of services.
5. If the child cannot be tested with a norm-referenced, standardized test, criterion-based testing or a functional description of the child's gross/fine motor deficits may be used. Documentation of the reason 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 the Accepted Tests sections for a list of standardized tests accepted by Arkansas Medicaid for retrospective reviews.
7. Range of Motion: A limitation of greater than ten degrees and/or documentation of how a deficit limits function.
8. Muscle Tone: Modified Ashworth Scale.
9. Manual Muscle Test: A deficit is a muscle strength grade of fair (3/5) or below that impedes functional skills. With increased muscle tone, as in cerebral palsy, testing is unreliable.

10. Transfer Skills: Documented as the amount of assistance required to perform transfer, i.e., maximum, moderate or minimal assistance. A deficit is defined as the inability to perform a transfer safely and independently.
11. Children (birth to age 21) receiving services outside of the public schools, and adults receiving services in an Adult Developmental Day Treatment (ADDT) program, must be evaluated annually.
12. Children (age three to 21) receiving services within public schools, as a part of an Individual Program Plan (IPP) or an Individual Education Plan (IEP), must have an annual update of progress with a full evaluation every three years; "School-related" means the child is of school age, attends public school and receives therapy provided by the school.

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

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

1. Monitoring: May be used to ensure that the child is maintaining a desired skill level or to assess the effectiveness and fit of equipment such as orthotics and other durable medical equipment. Monitoring frequency should be based on a time interval that is reasonable for the complexity of the problem being addressed.
2. Maintenance Therapy: Services that are performed primarily to maintain range of motion or to provide positioning services for the patient do not qualify for physical or occupational therapy services. These services can be provided to the child as part of a home program implemented by the child's caregivers and do not necessarily require the skilled services of a physical or occupational therapist to be performed safely and effectively.
3. Duration of Services: Therapy services should be provided as long as reasonable progress is made toward established goals. If reasonable functional progress cannot be expected with continued therapy, then services should be discontinued and monitoring or establishment of a home program should be implemented.

E. Progress Notes

1. Child's name.
2. Date of service.
3. Time in and time out of each therapy session.
4. Objectives addressed (should coincide with the plan of care).
5. A description of specific therapy services provided daily and the activities rendered during each therapy session, along with a form measurement.
6. Progress notes must be legible.
7. Therapists must sign each date of entry with a full signature and credentials.
8. Graduate students must have the supervising physical therapist or occupational therapist co-sign progress notes.

214.400 Speech-Language Therapy Guidelines for Review 7-1-18

A. Medical Necessity

Speech-language therapy services must be medically necessary to the treatment of the individual's illness or injury. A diagnosis alone is not sufficient documentation to support

the medical necessity of therapy. To be considered medically necessary, the following conditions must be met:

1. The services must be considered under accepted standards of practice to be a specific and effective treatment for the patient's condition.
2. The services must be of such a level of complexity or the patient's condition must be such that the services required can be safely and effectively performed only by or under the supervision of a qualified speech and language pathologist.
3. There must be 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.)

B. Types of Communication Disorders

1. Language Disorders — Impaired comprehension and/or use of spoken, written and/or other symbol systems. This disorder may involve the following components: forms of language (phonology, morphology, syntax), content and meaning of language (semantics, prosody), function of language (pragmatics) and/or the perception/processing of language. Language disorders may involve one, all or a combination of the above components.
2. Speech Production Disorders — Impairment of the articulation of speech sounds, voice and/or fluency. Speech Production disorders may involve one, all or a combination of these components of the speech production system.

   A speech production disorder may manifest as an individual sound deficiency, i.e., traditional articulation disorder, incomplete or deviant use of the phonological system, i.e., phonological disorder, or poor coordination of the oral-motor mechanism for purposes of speech production, i.e., verbal and/or oral apraxia, dysarthria.
3. Oral Motor/Swallowing/Feeding Disorders — Impairment of the muscles, structures and/or functions of the mouth (physiological or sensory-based) involved with the entire act of deglutition from placement and manipulation of food in the mouth through the oral and pharyngeal phases of the swallow. These disorders may or may not result in deficits to speech production.

C. Evaluation and Report Components

1. STANDARDIZED SCORING KEY:

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

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

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

   Profound: Scores of 63 or lower; -2.0+ standard deviations
2. LANGUAGE: To establish medical necessity, results from a comprehensive assessment in the suspected area of deficit must be reported. (Refer to Section 214.400, part D, paragraphs 9-12 for required frequency of re-evaluations.) A comprehensive assessment for Language disorder must include:
   a. Date of evaluation.
   b. Child's name and date of birth.
   c. Diagnosis specific to therapy.
   d. Background information including pertinent medical history; and, if the child is 12 months of age or younger, gestational age. The child should be tested in the child's dominant language; if not, an explanation must be provided in the evaluation.

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

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

7 months - [(12) / 4 weeks]

7 months - [3]

4 months

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

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

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

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

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

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

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

3. SPEECH PRODUCTION (Articulation, Phonological, Apraxia): To establish medical necessity, results from a comprehensive assessment in the suspected area of deficit must be reported. (Refer to Section 214.400, part D, paragraphs 9-12 for required frequency of re-evaluations.) A comprehensive assessment for Speech Production (Articulation, Phonological, Apraxia) disorder must include:

a. Date of evaluation.

b. Child's name and date of birth.

c. Diagnosis specific to therapy.

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

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

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

7 months - [(12) / 4 weeks]

7 months - [3]

4 months

e. Results from an assessment specific to the suspected type of speech

production disorder, including all relevant scores, quotients and/or indexes, if applicable. All errors specific to the type of speech production disorder must be reported (e.g., positions, processes, motor patterns). (Review Section 214.410 — Accepted Tests for Speech-Language Therapy.)

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

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

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

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

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

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

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

4. SPEECH PRODUCTION (Voice): To establish medical necessity, results from a comprehensive assessment in the suspected area of deficit must be reported. (Refer to Section 214.400, part D, paragraphs 9-12 for required frequency of re-evaluations.) A comprehensive assessment for Speech Production (Voice) disorder must include:

a. A medical evaluation to determine the presence or absence of a physical etiology is not a prerequisite for evaluation of voice disorder; however, it is required for the initiation of treatments related to the voice disorder. See Section 214.400 D4.

b. Date of evaluation.

c. Child's name and date of birth.

d. Diagnosis specific to therapy.

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

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

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

7 months - [(12) / 4 weeks]

7 months - [3]

4 months

f. Results from an assessment relevant to the suspected type of speech production disorder, including all relevant scores, quotients and/or indexes, if applicable. (Review Section 214.410 — Accepted Tests for Speech-Language Therapy.)

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

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

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

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

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

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

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

5. SPEECH PRODUCTION (Fluency): To establish medical necessity, results from a comprehensive assessment in the suspected area of deficit must be reported. (Refer to Section 214.400, part D, paragraphs 9-12 for required frequency of re-evaluations.) A comprehensive assessment for Speech Production (Fluency) disorder must include:

a. Date of evaluation.

b. Child's name and date of birth.

c. Diagnosis specific to therapy.

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

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

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

7 months - [(12) / 4 weeks]

7 months - [3]

4 months

e. Results from an assessment specific to the suspected type of speech production disorder, including all relevant scores, quotients and/or indexes, if applicable. (Review Section 214.410 — Accepted Tests for Speech-Language Therapy.)

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

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

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

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

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

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

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

6. ORAL MOTOR/SWALLOWING/FEEDING: To establish medical necessity, results from a comprehensive assessment in the suspected area of deficit must be reported. (Refer to Section 214.400, part D, paragraphs 9-12 for required frequency of re-evaluations.) A comprehensive assessment for Oral Motor/Swallowing/Feeding disorder must include:

   a. Date of evaluation.

   b. Child's name and date of birth.

   c. Diagnosis specific to therapy.

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

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

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

      7 months - [(12) / 4 weeks]

      7 months - [3]

      4 months

   e. Results from an assessment specific to the suspected type of oral motor/swallowing/feeding disorder, including all relevant scores, quotients and/or indexes, if applicable. (See Section 214.410 — Accepted Tests for Speech-Language Therapy.)

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

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

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

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

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

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

D. Interpretation and Eligibility: Ages Birth to 21

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

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

   b. For children age three to 21: criterion-referenced tests will not be accepted as a second measure when determining eligibility for language therapy. (When use of standardized instruments is not appropriate, see Section 214.400, part D,

paragraph 8).

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

d. Age three to 21: Eligibility for language therapy will be based upon 2 composite or quotient scores from 2 tests, with at least 1 composite or quotient score on each test that is -1.5 standard deviations (SD) below the mean or greater. When -1.5 SD or greater is not indicated by both of these tests, a third standardized test indicating a score -1.5 SD or greater is required to support the medical necessity of services.

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

   Eligibility for articulation and/or phonological therapy will be based upon standard scores (SS) of -1.5 SD or greater below the mean from two tests. When -1.5 SD or greater is not indicated by both of these tests, corroborating data derived from clinical analysis procedures can be used to support the medical necessity of services (review Section 214.410 — Accepted Tests for Speech-Language Therapy).

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

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

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

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

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

   Eligibility for fluency therapy will be based upon standard scores (SS) of -1.5 SD or greater below the mean from two tests. When -1.5 SD or greater is not indicated by both of these tests, descriptive data from an affect measure and/or accepted clinical procedures can be used to support the medical necessity of services. (Review Section 214.410 – Accepted Tests for Speech-Language Therapy.)

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

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

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

8. When administration of standardized, norm-referenced instruments is inappropriate, the provider must submit an in-depth functional profile of the child's communication

abilities. An in-depth functional profile is a detailed narrative or description of a child's communication behaviors that specifically explains and justifies the following:

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

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

c. The medical necessity of therapy.

d. A variety of supplemental tests and tools exist that may be useful in developing an in-depth functional profile.

9. Children (birth to age 21) receiving services outside of the schools and adults receiving services at an Adult Developmental Day Treatment (ADDT) program must be evaluated annually.

10. Children (age three to 21) receiving services within schools as part of an Individual Program Plan (IPP) or an Individual Education Plan (IEP) must have a full evaluation every three years; however, an annual update of progress is required. "School-related" means the child is of school age, attends public school and receives therapy provided by the school.

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

E. Progress Notes

1. Child's name.

2. Date of service.

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

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

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

6. Progress notes must be legible.

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

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

216.300 Process for Requesting Extended Therapy Services 7-1-18

A. Requests for extended therapy services for beneficiaries under age 21 and adults receiving services in an Adult Developmental Day Treatment (ADDT) must be sent to Arkansas Medicaid's Quality Improvement Vendor (QIO) View or print the QIO 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 the QIO 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. The QIO 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.

216.305 Documentation Requirements 7-1-18

A. To request extended therapy services, all applicable documentation that support 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

216.310 QIO Extended Therapy Services Review Process 7-1-18

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

A. Requests are screened for completeness and researched to determine the beneficiary's eligibility for Medicaid.

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 are 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 7-1-18

A request for administrative reconsideration of the denial of services must be in writing and sent to the QIO 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 The QIO within 35 calendar days of a denial will be deemed timely.

231.000 Prior Authorization Request Procedures for Augmentative Communication Device (ACD) Evaluation 7-1-18

To perform an evaluation for the augmentative communication device (ACD), the provider must request prior authorization from the Division of Medical Services, using the following procedures.

A. A primary care physician (PCP) written referral is required for prior authorization of the ACD evaluation. If the beneficiary is exempt from the PCP process, then the attending physician must make the referral.

B. The physical and intellectual capabilities (functional level) of the beneficiary must be documented in the referral. The referring physician must justify the medical reason the individual requires the ACD.

C. If the beneficiary is currently receiving speech therapy, the speech-language pathologist must document the prerequisite communication skills for the augmentative communication system and the cognitive level of the beneficiary.

D. A completed Request for Prior Authorization and Prescription Form (DMS-679) must be used to request prior authorization. View or print form DMS-679 and instructions for completion. Copies of form DMS-679 can be requested using the Medicaid Form Request, HP-MFR-001. View or print the Medicaid Form Request HP-MFR-001.

E. Submit the request to the Division of Medical Services. View or print the Division of Medical Services contact information.

F. For approved requests, a PA control number will be assigned and entered in item 10 on the DMS-679 and returned to the provider. For denied requests, a denial letter with the reason for denial will be mailed to the requesting provider and the Medicaid beneficiary.

NOTE: Prior authorization for therapy services only applies to the augmentative communication evaluation. Refer back to Section 215.000 for additional information.

262.400 Special Billing Procedures 7-1-18

Services must be billed according to the care provided and to the extent each procedure is provided.

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 Development & Quality Assurance

P.O. Box 1437, Slot S295 · Little Rock, AR 72203-1437
501-320-6428 · Fax: 501-404-4619
TDD/TTY: 501-682-6789

TO: Arkansas Medicaid Health Care Providers – All Providers

EFFECTIVE DATE: July 1, 2018

SUBJECT: Provider Manual Update Transmittal SecV-3-18

REMOVE		INSERT	
Section	**Effective Date**	**Section**	**Effective Date**
Section 500.000	—	Section 500.000	—
DMS-632	7/00	DMS-632	7/18
DMS-638	10/02	DMS-638	7/18

Explanation of Updates

Section 500.000 is updated to revise form titles DMS-632, DMS-638 and DMS-640.

Form DMS-632 titled DDTCS (Developmental Day Treatment Clinic Services) Transportation Survey has been changed to EIDT (Early Intervention Day Treatment)/ADDT (Adults Developmental Day Treatment) Transportation Survey.

Form DMS-638 titled DDTCS Transportation Log has been changed to EIDT/ADDT Transportation Log.

Form DMS-640 has been updated to add programs EIDT/ADDT to the Occupational, Physical and Speech Therapy for Medicaid Eligible Beneficiaries Prescription/Referral.

This transmittal and the enclosed forms are for informational purposes only. **Please do not complete the enclosed forms.**

The paper version of this update transmittal includes revised pages that may be filed 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 have questions regarding this transmittal, please contact the Provider Assistance Center at 1-800-457-4454 (Toll-Free) within Arkansas or locally and Out-of-State at (501) 376-2211.

If you need this material in an alternative format, such as large print, please contact the Program Development and Quality Assurance Unit at (501) 320-6429.

Arkansas Medicaid provider manuals (including update transmittals), official notices, notices of rule making and remittance advice (RA) messages are available for downloading from the Arkansas Medicaid website: medicaid.mmis.arkansas.gov.

Thank you for your participation in the Arkansas Medicaid Program.

Rose M. Naff
Director

SECTION V – FORMS
500.000

Claim Forms

Red-ink Claim Forms

The following is a list of the red-ink claim forms required by Arkansas Medicaid. The forms below cannot be printed from this manual for use. Information about where to get the forms and links to samples of the forms is available below. To view a sample form, click the form name.

Claim Type	Where To Get Them
Professional – CMS-1500	Business Form Supplier
Institutional – CMS-1450*	Business Form Supplier

* For dates of service after 11/30/07 – ALL HOSPICE PROVIDERS USE ONLY FORM CMS-1450 (formerly UB-04) for billing.

Claim Forms

The following is a list of the non-red-ink claim forms required by Arkansas Medicaid. Information about where to get a supply of the forms and links to samples of the forms is available below. To view a sample form, click the form name.

Claim Type	Where To Get Them
Alternatives Attendant Care Provider Claim Form – AAS-9559	Client Employer
Dental – ADA-J430	Business Form Supplier

Arkansas Medicaid Forms

The forms below can be printed from this manual for use.

In order by form name:

Form Name	Form Link
Acknowledgement of Hysterectomy Information	DMS-2606
Address/Email Change Form	DMS-673
Adjustment Request Form – Medicaid XIX	HP-AR-004
Adjustment Request Form – Medicaid XIX – Pharmacy Program	DMS-802
Adverse Effects Form	DMS-2704
AFMC Prescription & Prior Authorization Request for Medical Equipment Excluding Wheelchairs & Wheelchair Components	DMS-679A
Amplification/Assistive Technology Recommendation Form	DMS-686
Application for WebRA Hardship Waiver	DMS-7736

Form Name	Form Link
Approval/Denial Codes for Inpatient Psychiatric Services	DMS-2687
Arkansas Early Intervention Infant & Toddler Program Intake/Referral/Application for Services	DDS/FS#0001.a
Arkansas Medicaid Patient-Centered Medical Home Program Practice Participation Agreement	DMS-844
Arkansas Medicaid Patient-Centered Medical Home Program Pooling Request Form	DMS-845
Arkansas Medicaid Patient-Centered Medical Home Program Practice Withdrawal Form	DMS-846
ARKids First Behavioral Health Services Provider Qualification Form	DMS-612
Authorization for Electronic Funds Transfer (Automatic Deposit)	autodeposit
Authorization for Payment for Services Provided	MAP-8
Certification of Need – Medicaid Inpatient Psychiatric Services for Under Age 21	DMS-2633
Certification of Schools to Provide Comprehensive EPSDT Services	CSPC-EPSDT
Certification Statement for Abortion	DMS-2698
Change of Ownership Information	DMS-0688
Child Health Management Services Enrollment Orders	DMS-201
Child Health Management Services Discharge Notification Form	DMS-202
CHMS Benefit Extension for Diagnosis/Evaluation Procedures	DMS-699A
CHMS Request for Prior Authorization	DMS-102
Claim Correction Request	DMS-2647
CMS 1500/UB04 Medicare EOMB Information (Crossover Cover Sheet)	DMS-600
Consent for Release of Information	DMS-619
Contact Lens Prior Authorization Request Form	DMS-0101
Contract to Participate in the Arkansas Medical Assistance Program	DMS-653
EIDT/ADDT Transportation Log	DMS-638
EIDT/ADDT Transportation Survey	DMS-632
Dental Treatment Additional Information	DMS-32-A
Disclosure of Significant Business Transactions	DMS-689
Disproportionate Share Questionnaire	DMS-628
Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Prescription/Referral For Medically Necessary Services/Items Not Specifically Included in the Medicaid State Plan	DMS-693
Early Childhood Special Education Referral Form	ECSE-R
EPSDT Provider Agreement	DMS-831

Form Name	Form Link
Evaluation for Wheelchair and Wheelchair Seating	DMS-0843
Explanation of Check Refund	HP-CR-002
Gait Analysis Full Body	DMS-647
Home Health Certification and Plan of Care	CMS-485
Hospital/Physician/Certified Nurse-Midwife Referral for Newborn Infant Medicaid Coverage	DCO-645
Inpatient Psychiatric Medicaid Agency Review Team Transmittal Sheet	DMS-2685
Individual Renewal Form for School-Based Audiologists	DMS-7782
Lower-Limb Prosthetic Evaluation	DMS-650
Lower-Limb Prosthetic Prescription	DMS-651
Media Selection/Email Address Change Form	HP-MS-005
Medicaid Claim Inquiry Form	HP-CI-003
Medicaid Form Request	HP-MFR-001
Medical Equipment Request for Prior Authorization & Prescription	DMS-679
Medical Transportation and Personal Assistant Verification	DMS-616
Mental Health Services Provider Qualification Form for LCSW, LMFT and LPC	DMS-633
Notice Of Noncompliance	DMS-635
NPI Reporting Form	DMS-683
Occupational, Physical and Speech Therapy for Medicaid Eligible Beneficiaries Under Age 21 Prescription/Referral	DMS-640
Ownership and Conviction Disclosure	DMS-675
Personal Care Assessment and Service Plan	DMS-618 English DMS-618 Spanish
Practitioner Identification Number Request Form	DMS-7708
Prescription & Prior Authorization Request For Nutrition Therapy & Supplies	DMS-2615
Primary Care Physician Managed Care Program Referral Form	DMS-2610
Primary Care Physician Participation Agreement	DMS-2608
Primary Care Physician Selection and Change Form	DMS-2609
Procedure Code/NDC Detail Attachment Form	DMS-664
Provider Application	DMS-652
Provider Communication Form	AAS-9502
Provider Data Sharing Agreement – Medicare Parts C & D	DMS-652-A
Provider Enrollment Application and Contract Package	Application Packet
Quarterly Monitoring Form	AAS-9506

Form Name	Form Link
Referral for Audiology Services – School-Based Setting	DMS-7783
Referral for Certification of Need Medicaid Inpatient Psychiatric Services for Under Age 21	DMS-2634
Referral for Medical Assistance	DMS-630
Request for Appeal	DMS-840
Request for Extension of Benefits	DMS-699
Request for Extension of Benefits for Clinical, Outpatient, Laboratory and X-Ray Services	DMS-671
Request for Extension of Benefits for Medical Supplies for Medicaid Beneficiaries Under Age 21	DMS-602
Request for Molecular Pathology Laboratory Services	DMS-841
Request for Orthodontic Treatment	DMS-32-0
Request for Prior Approval for the Special Pharmacy Therapeutic Agents and Treatments	DMS-6
Request for Private Duty Nursing Services Prior Authorization and Prescription – Initial Request or Recertification	DMS-2692
Request for Targeted Case Management Prior Authorization for Beneficiaries Under Age 21	DMS-601
Research Request Form	HP-0288
Service Log – Personal Care Delivery and Aides Notes	DMS-873
Sterilization Consent Form	DMS-615 English DMS-615 Spanish
Sterilization Consent Form – Information for Men	PUB-020
Sterilization Consent Form – Information for Women	PUB-019
Targeted Case Management Contact Monitoring Form	DMS-690
Upper-Limb Prosthetic Evaluation	DMS-648
Upper-Limb Prosthetic Prescription	DMS-649
Vendor Performance Report	Vendorperformreport
Verification of Medical Services	DMS-2618

In order by form number:

AAS-9502
AAS-9506
AAS-9559
Address Change
Autodeposit
CMS-485
CSPC-EPSDT
DCO-645
DDS/FS#0001.a
DMS-0101
DMS-0688
DMS-0843
DMS-102
DMS-201
DMS-202
DMS-2606
DMS-2608
DMS-2609
DMS-2610
DMS-2615
DMS-2618
DMS-2633
DMS-2634
DMS-2647
DMS-2685
DMS-2687
DMS-2692
DMS-2698
DMS-2704
DMS-32-A
DMS-32-0
DMS-6
DMS-600
DMS-601
DMS-602
DMS-612
DMS-615 English
DMS-615 Spanish
DMS-616
DMS-618 English
DMS-618 Spanish
DMS-619
DMS-628
DMS-630
DMS-632
DMS-633
DMS-635
DMS-638
DMS-640
DMS-647
DMS-648
DMS-649
DMS-650
DMS-651
DMS-652
DMS-652-A
DMS-653
DMS-664
DMS-671
DMS-675
DMS-673
DMS-679
DMS-679A
DMS-683
DMS-686
DMS-689
DMS-690
DMS-693
DMS-699
DMS-699A
DMS-7708
DMS-7736
DMS-7782
DMS-7783
DMS-802
DMS-831
DMS-840
DMS-841
DMS-844
DMS-845
DMS-846
DMS-873
ECSE-R
HP-0288
HP-AR-004
HP-CI-003
HP-CR-002
HP-MFR-001
HP-MS-005
MAP-8
Performance Report
Provider Enrollment Application and Contract Package
PUB-019
PUB-020

Arkansas Medicaid Contacts and Links

Click the link to view the information.

American Hospital Association
Americans with Disabilities Act Coordinator
Arkansas Department of Education, Health and Nursing Services Specialist
Arkansas Department of Education, Special Education
Arkansas Department of Finance Administration, Sales and Tax Use Unit
Arkansas Department of Human Services, Division of Aging and Adult Services
Arkansas Department of Human Services, Appeals and Hearings Section
Arkansas Department of Human Services, Division of Behavioral Health Services
Arkansas Department of Human Services, Division of Child Care and Early Childhood Education, Child Care Licensing Unit

Arkansas Department of Human Services, Division of Children and Family Services, Contracts Management Unit

Arkansas Department of Human Services, Children's Services

Arkansas Department of Human Services, Division of County Operations, Customer Assistance Section

Arkansas Department of Human Services, Division of Medical Services

Arkansas DHS, Division of Medical Services Director

Arkansas DHS, Division of Medical Services, Benefit Extension Requests, UR Section

Arkansas DHS, Division of Medical Services, Dental Care Unit

Arkansas DHS, Division of Medical Services, DXC Technology Provider Enrollment Unit

Arkansas DHS, Division of Medical Services, Financial Activities Unit

Arkansas DHS, Division of Medical Services, Hearing Aid Consultant

Arkansas DHS, Division of Medical Services, Medical Assistance Unit

Arkansas DHS, Division of Medical Services, Medical Director for Clinical Affairs

Arkansas DHS, Division of Medical Services, Pharmacy Unit

Arkansas DHS, Division of Medical Services, Program Communications Unit

Arkansas DHS, Division of Medical Services, Provider Reimbursement Unit

Arkansas DHS, Division of Medical Services, Third-Party Liability Unit

Arkansas DHS, Division of Medical Services, UR/Home Health Extensions

Arkansas DHS, Division of Medical Services, Utilization Review Section

Arkansas DHS, Division of Medical Services, Visual Care Coordinator

Arkansas Department of Health

Arkansas Department of Health, Health Facility Services

Arkansas Department of Human Services, Accounts Receivable

Arkansas Foundation for Medical Care

Arkansas Foundation for Medical Care, Retrospective Review for Therapy and Prior Authorization for Personal Care for Under Age 21

Arkansas Foundation for Medical Care, Provider Relations Representative

Arkansas Hospital Association

Arkansas Office of Medicaid Inspector General (OMIG)

ARKids First-B

ARKids First-B ID Card Example

Beacon Health Options (Formerly ValueOptions)

Central Child Health Services Office (EPSDT)

ConnectCare Helpline

County Codes

Dental Contractor

DXC Technology Claims Department

DXC Technology EDI Support Center (formerly AEVCS Help Desk)

DXC Technology Inquiry Unit

DXC Technology Manual Order

DXC Technology Provider Assistance Center (PAC)

DXC Technology Supplied Forms

Example of Beneficiary Notification of Denied ARKids First-B Claim

Example of Beneficiary Notification of Denied Medicaid Claim

First Connections Infant & Toddler Program, Developmental Disabilities Services

First Connections Infant & Toddler Program, Developmental Disabilities Services, Appeals

Flow Chart of Intake and Prior Authorization Process For Intervention/Treatment

Health Care Declarations

Immunizations Registry Help Desk

Magellan Pharmacy Call Center

Medicaid ID Card Example

Medicaid Managed Care Services (MMCS)

Medicaid Reimbursement Unit Communications Hotline

Medicaid Tooth Numbering System

National Supplier Clearinghouse

Partners Provider Certification

Primary Care Physician (PCP) Enrollment Voice Response System

Provider Qualifications, Division of Behavioral Health Services

Select Optical

Standard Register

Table of Desirable Weights

U.S. Government Printing Office

Vendor Performance Report

Arkansas Division of Medical Services
EIDT/ADDT Transportation Survey

EIDT or ADDT Transportation Provider Name_____
Medicaid EIDT or ADDT Transportation Provider Number_____
Fiscal Reporting Period_____ **through**_____
(Information not required if less than 6 months)

Total EIDT or ADDT "Loaded" Miles_____
Total EIDT or ADDT "Unloaded" Miles_____
Total EIDT or ADDT Miles_____

Unduplicated Count of Medicaid EIDT or ADDT Clients Transported_____
Unduplicated Count of Non-Medicaid EDIT or ADDT Clients Transported_____

Medicaid EIDT or ADDT Transportation Revenue_____
Non-Medicaid EIDT or ADDT Transportation Revenue_____
Total EIDT or ADDT Transportation Revenue_____

Direct Costs – EIDT or ADDT Transportation

Drivers Salaries	$_____
Drivers Fringes/Payroll Taxes	$_____
Escorts Salaries	$_____
Escorts Fringes/Payroll Taxes	$_____
Other Salaries	$_____
Other Fringes/Payroll Taxes	$_____
Program Supplies	$_____
Vehicle Repairs/Maint.	$_____
Gas and Oil	$_____
Vehicle Rent	$_____
Vehicle Insurance	$_____
Vehicle Depreciation	$_____
Vehicle Interest	$_____
Training	$_____
Direct Utilities	$_____
Direct Telephone	$_____
Direct Building Rent	$_____
Direct Building Utilities	$_____
Direct Building Depreciation	$_____
Direct Building Interest	$_____
Other - _____	$_____
Other - _____	$_____
Other - _____	$_____

Total Direct Costs – EIDT or ADDT Transportation $_____

Indirect/Overhead Costs – EIDT or ADDT Transportation $_____

Total EIDT or ADDT Transportation Costs $_____

(Report Cost in Dollars Only, No Cents)

DMS-632 (Rev. 7-1-18)

EIDT/ADDT Transportation Log

Pickup or Delivery
(Circle One)

Provider Name _____ Date _____

Medicaid Provider Number _____

Vehicle Description _____

Vehicle Identification Number _____

Vehicle License Plate Number _____

Driver's Name _____

Attendant's Name _____

Order of Pickup or Delivery	Time of Pickup or Delivery	Odometer Reading **In Field (a), Report Beginning Odometer Reading Before Leaving the Facility (a)**	Transported Client's Name If the pickup or delivery address is different from the address in the client's file, list the address on the log. (Reasons for different address pickup and/ or deliveries must be documented in the client's file).	Medicaid Client	Non-Medicaid Client
				(Check One)	
#1					
#2					
#3					
#4					
#5					
#6					
#7					
#8					
#9					
#10					
#11					
#12					
#13					
#14					
#15					
#16					
#17					
#18					
#19					
#20					
#21					
#22					
#23					
#24					
In Field (b), Report Ending Odometer Reading After Returning to the EIDT or ADDT Facility.		**(b)**			

*Total Unloaded Miles per Trip (Enter Tenths of Mile)_____

*Total Loaded Miles Per Trip (Enter Tenths of Mile)_____

*Total Loaded Medicaid Miles per Trip (Enter Tenths of Mile)_____

**Total Loaded Medicaid Billable Miles per Trip (Rounded to Whole Miles)_____

*Report all odometer readings (except Medicaid Billable Miles) in tenths of miles.

**To compute the "Total Loaded Medicaid Billable Miles", round the "Total Loaded Medicaid Miles" in whole miles by rounding up if 0.5 or greater and rounding down if 0.4 or less.

Arkansas Division of Medical Services

Therapy and Habilitation Services for Medicaid Eligible Beneficiaries
PRESCRIPTION/REFERRAL

The **Primary Care Physician** (PCP) or attending physician must use this form to make a referral for evaluation or prescribe medically necessary Medicaid therapy services. The PCP or attending physician must check the appropriate box or boxes indicating the modality. Providers of therapy services are responsible for obtaining renewed PCP referrals at least once per year in compliance with Section I 171.400 and Section II 214.00 of the Arkansas Medicaid Therapy services provider manual.

Referral (check all that apply) ☐ OT ☐ PT ☐ ST ☐ ABA ☐ Day Hab (can ONLY be in EIDT or ADDT, NOT both

☐ Treatment ☐ Therapy Not Medically Necessary

EVALUATE/TREAT IS NOT A VALID PRESCRIPTION

Patient Name: _____ Medicaid ID #: _____

Date Beneficiary Was Last Seen In Office: _____

Diagnosis as Related to Prescribed Therapy: _____

_____

Complete this block if this form is a prescription for 90 minutes or less per week					
Setting	**Occupational Therapy (OT)**	**Physical Therapy (PT)**	**Speech Therapy (ST)**	**Applied Behavior Analysis (ABA)**	**EIDT Day Hab (EIDT or ADDT)**
Early Intervention Day Treatment (EIDT)	_____minutes/ week	_____minutes/ week	_____minutes/ week	_____minutes/ week	_____hours/ week
Adult Developmental Day Treatment (ADDT)	_____minutes/ week	_____minutes/ week	_____minutes/ week	_____minutes/ week	_____hours/week
School-Based	_____minutes/ week	_____minutes/ week	_____minutes/ week	_____minutes/ week	N/A
Private Clinic	_____minutes/ week	_____minutes/ week	_____minutes/ week	_____minutes/ week	N/A
Specialized Clinic (i.e., equine assisted therapy)	_____minutes/ week	_____minutes/ week	_____minutes/ week	_____minutes/ week	N/A
TOTAL	_____Minutes/ week _____Duration (months) Date Expires: _____	_____Minutes/ week _____Duration (months) Date Expires: _____	_____Minutes/ week _____Duration (months) Date Expires: _____	_____Minutes/ week _____Duration (months) Date Expires: _____	_____Hours/week _____Duration (months) Date Expires: _____

Other Information/Medical necessity justification for more than 90 minutes per week: _____

_____

Primary Care Physician (PCP) Name *(Please Print)* _____ Provider ID Number/Taxonomy Code _____

Attending Physician Name *(Please Print)* _____ Provider ID Number/Taxonomy Code _____

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

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

Return To (name of provider(s)): _____

DMS-640 (Rev. 7/18)

Instructions for Completion

Form DMS-640 –Therapy and Habilitation Services for Medicaid Eligible Beneficiaries PRESCRIPTION/REFERRAL

- If the DMS-640 is used to make an initial referral for evaluation, check the box to indicate the appropriate therapy for the referral. After receiving the evaluation results and determining that therapy is necessary, you must use a separate DMS-640 form to prescribe the therapy. Check the treatment box for prescription and complete the form following the instructions below. If the referral and prescription are for previously prescribed services, you may check both boxes.
- Patient Name – Enter the patient's full name.
- Medicaid ID # – Enter the patient's Medicaid ID number.
- Return To – To be completed by requesting provider(s) to include providers' address/fax/secure email.

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

- Date Beneficiary Was Last Seen In Office – Enter the date of the last time you saw this beneficiary. (This could be either for a complete physical examination, a routine check-up or an office visit for other reasons requiring your personal attention.)
- Diagnosis as Related to Prescribed Therapy – Enter the diagnosis that indicates or establishes medical necessity for prescribed therapy.
- Prescription block – If the form is used for a prescription, enter the prescribed number of minutes per week and the prescribed duration (in months) of therapy.
- If therapy is not medically necessary at this time, check the box.
- Settings and Duration—Indicate the settings where therapy should occur and the duration of therapy expected to occur in that setting per week.
- Other Information/Medical necessity justification for more than 90 minutes per week – Any other information pertinent to the beneficiary's medical condition, plan of treatment, etc., may be entered. If you are requesting a prior authorization for more than 90 minutes per week, please include any written justification here.
- Primary Care Physician (PCP) Name and Provider ID Number and/or Taxonomy Code – Print the name of the prescribing PCP and his or her provider identification number and/or taxonomy code.
- Attending Physician Name and Provider ID Number and/or Taxonomy Code – If the Medicaid-eligible beneficiary is exempt from PCP requirements, print the name of the prescribing attending physician and his or her provider identification number and/or taxonomy code.
- Physician Signature and Date – The prescribing physician must sign and date the prescription for therapy in his or her original signature.
- Arkansas Medicaid's criteria for electronic signatures as stated in Arkansas Code 25-31-103 must be met. For vendor's EHR systems that are not configurable to meet the signature criteria, the provider should print, date and sign the DMS-640 form. Providers will be in compliance if a scanned copy of the original document is kept in a format that can be retrieved for a specific beneficiary. Most electronic health record systems allow this type of functionality.

- When an electronic version of the DMS 640 becomes part of the physician~~/~~ **or** providers' electronic health record, the inclusion of extraneous patient and clinic information does not alter the form.

- When the prescription needs to be amended for one service type or setting, a new DMS-640 must be submitted. This DMS-640 must contain the services to be received by that beneficiary in all settings. Only the amended service expiration date may change.

- Only the services listed on the most recent DMS-640 will be authorized to be provided.

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

11. Physical Therapy and Related Services

Speech-Language Pathology services and qualified Speech-Language Pathologists meet the requirements set forth in 42 CFR 440.110. Speech-Language Pathology Assistants work under the supervision of the Speech-Language Pathologist in accordance with the State's licensing and supervisory requirements.

Physical Therapy services and qualified Physical Therapists meet the requirements set forth in 42 CFR 440.110. Physical Therapy assistants work under the supervision of the Physical Therapist in accordance with the State's licensing and supervisory requirements.

Occupational Therapy services and qualified Occupational Therapists meet the requirements set forth in 42 CFR 440.110. Occupational Therapy assistants work under the supervision of the Occupational Therapist in accordance with the State's licensing and supervisory requirements.

Audiology services and qualified Audiologists meet the requirements set forth in 42 CFR 440.110.

A. Occupational, Physical and Speech Therapy

1. Refer to Attachment 3.1-A, Item 4.b. (15) for therapy services for recipients under age 21.

2. For recipients over age 21, effective for dates of services on or after **July 1, 2017**, individual and group therapy are limited to **six (6)** units per **week per discipline**. One unit equals 15 minutes. Evaluations are limited to four (4) units per State Fiscal Year (July 1 through June 30). One unit equals 30 minutes. **Extensions of the benefit limit will be provided if medically necessary.**

B. Speech Therapy

Augmentative Communication Device (ACD) Evaluation - Effective for dates of service on or after September 1, 1999, Augmentative Communication Device (ACD) evaluation is covered for eligible Medicaid recipients of all ages. One ACD evaluation may be performed every three years based on medical necessity. The benefit limit may be extended for individuals under age 21.

11. Physical Therapy and Related Services

Speech-Language Pathology services and qualified Speech-Language Pathologists meet the requirements set forth in 42 CFR 440.110. Speech-Language Pathology Assistants work under the supervision of the Speech-Language Pathologist in accordance with the State's licensing and supervisory requirements.

Physical Therapy services and qualified Physical Therapists meet the requirements set forth in 42 CFR 440.110. Physical Therapy assistants work under the supervision of the Physical Therapist in accordance with the State's licensing and supervisory requirements.

Occupational Therapy services and qualified Occupational Therapists meet the requirements set forth in 42 CFR 440.110. Occupational Therapy assistants work under the supervision of the Occupational Therapist in accordance with the State's licensing and supervisory requirements.

Audiology services and qualified Audiologists meet the requirements set forth in 42 CFR 440.110.

A. Occupational, Physical and Speech Therapy

1. Refer to Attachment 3.1-B, Item 4.b. (15) for therapy services for recipients under age 21.

3. For recipients over age 21, effective for dates of services on or after **July 1, 2017**, individual and group therapy are limited to **six (6)** units per **week per discipline**. One unit equals 15 minutes. Evaluations are limited to four (4) units per State Fiscal Year (July 1 through June 30). One unit equals 30 minutes. **Extensions of the benefit limit will be provided if medically necessary.**

B. Speech Therapy

Augmentative Communication Device (ACD) Evaluation - Effective for dates of service on or after September 1, 1999, Augmentative Communication Device (ACD) evaluation is covered for eligible Medicaid recipients of all ages. One ACD evaluation may be performed every three years based on medical necessity. The benefit limit may be extended for individuals under age 21.