

ARKANSAS REGISTER

Transmittal Sheet

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



Secretary of State

John Thurston

500 Woodlane, Suite 026

Little Rock, Arkansas 72201-1094

(501) 682-5070

www.sos.arkansas.gov



For Office

Use Only:

Effective Date _____ Code Number _____

Name of Agency Department of Human Services

Department Division of Developmental Disabilities Services

Contact Mac E. Golden E-mail Mac.E.Golden@dhs.arkansas.gov Phone 501-563-7634

Statutory Authority for Promulgating Rules Arkansas Code Annotated 20-76-201

Rule Title: SPA #2020-0021 Therapy Amend. to the OPS Therapy Services Medicaid Provider Manual, with Related Changes to ARKids, Hospital, Rehab Hospital, Prosthetics, Home Health, Physician, and Nurse Practitioner Provider Manuals

Intended Effective Date
(Check One)

Date

☐ Emergency (ACA 25-15-204)

Legal Notice Published 10/04/2020

☐ 10 Days After Filing (ACA 25-15-204)

Final Date for Public Comment 11/02/2020

☒ Other 01/01/2021
(Must be more than 10 days after filing date.)

Reviewed by Legislative Council 12/18/2020

Adopted by State Agency 01/01/2021

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

Jack Tiner jack.tiner@dhs.arkansas.gov

12/18/2020

Contact Person

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.)

Signature

501-682-8662

melissa.stone@dhs.arkansas.gov

Phone Number

E-mail Address

Director

Title

December 18, 2020

Date

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
MEDICAL ASSISTANCE PROGRAM
STATE ARKANSAS

ATTACHMENT 3.1-A
Page 1o

AMOUNT, DURATION AND SCOPE OF
SERVICES PROVIDED

Revised: January 1, 2021

CATEGORICALLY NEEDY

4.b. Early and Periodic Screening and Diagnosis of Individuals Under 21 Years of Age, and Treatment of Conditions Found. (Continued)

(14) RESERVED

(15) Physical Therapy and Related Services

a. Physical Therapy

- (1) Services are limited to eligible Medicaid recipients in the Child Health Services (EPSDT) Program.
- (2) Effective for dates on or after **January 1, 2021**, evaluations are limited to **two (2)** units per State Fiscal Year (July 1 through June 30). Extensions of the benefit limit will be provided if medically necessary.
- (3) Services must be prescribed by a physician and provided by or under the supervision of a qualified physical therapist.

A qualified physical therapist assistant may provide services under the supervision of a licensed physical therapist.

All therapies' service definitions and providers must meet the requirements of 42 C.F.R. § 440.110.

- (4) Effective for dates of service on or after July 1, 2017, individual and group therapy are limited to six (6) units per week. Extensions of the benefit limit will be provided if medically necessary.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
MEDICAL ASSISTANCE PROGRAM
STATE ARKANSAS

ATTACHMENT 3.1-A
Page 1h

AMOUNT, DURATION AND SCOPE OF
SERVICES PROVIDED

Revised: January 1, 2021

CATEGORICALLY NEEDY

4.b Early and Periodic Screening and Diagnosis of Individuals Under 21 Years of Age, and Treatment of Conditions Found.

- (1) No limitation on services within the scope of the program (except for consultations, home health services and personal care services) if services are EPSDT related. Extension of the benefit limit for consultations (2 per State Fiscal Year), home health services (50 visits per State Fiscal Year), personal care services (64 hours per calendar month), personal care transportation (50 units per date of service per recipient), physical therapy evaluations (2 per State Fiscal Year), occupational therapy evaluations (2 per State Fiscal Year), speech-**language** therapy evaluations (4 units per State Fiscal Year), and chiropractor X-ray services (2 per State Fiscal Year) will be provided if medically necessary for recipients in the Child Health Services (EPSDT) Program.

Medical Screens are provided based on the recommendations of the American Academy of Pediatrics. Childhood immunizations are provided based on the Advisory Committee on Immunization Practices (ACIP).

The State will provide other health care described in Section 1905(a) of the Social Security Act that is found to be medically necessary to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services, even when such health care is not otherwise covered under the State Plan.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
MEDICAL ASSISTANCE PROGRAM
STATE ARKANSAS

ATTACHMENT 3.1-A
Page 1o

AMOUNT, DURATION AND SCOPE OF
SERVICES PROVIDED

Revised: January 1, 2021

CATEGORICALLY NEEDY

4.b. Early and Periodic Screening and Diagnosis of Individuals Under 21 Years of Age, and Treatment of Conditions Found. (Continued)

(14) RESERVED

(15) Physical Therapy and Related Services

a. Physical Therapy

- (1) Services are limited to eligible Medicaid recipients in the Child Health Services (EPSDT) Program.
- (2) Effective for dates on or after **January 1, 2021**, evaluations are limited to **two (2)** units per State Fiscal Year (July 1 through June 30). Extensions of the benefit limit will be provided if medically necessary.
- (3) Services must be prescribed by a physician and provided by or under the supervision of a qualified physical therapist.

A qualified physical therapist assistant may provide services under the supervision of a licensed physical therapist.

All therapies' service definitions and providers must meet the requirements of 42 C.F.R. § 440.110.

- (4) Effective for dates of service on or after July 1, 2017, individual and group therapy are limited to six (6) units per week. Extensions of the benefit limit will be provided if medically necessary.

AMOUNT, DURATION AND SCOPE OF
SERVICES PROVIDED

Revised: January 1, 2021

CATEGORICALLY NEEDY

4.b. Early and Periodic Screening and Diagnosis of Individuals Under 21 Years of Age, and Treatment of Conditions Found.
(Continued)

(15) Physical Therapy and Related Services (Continued)

b. Occupational Therapy

(1) Services are limited to eligible Medicaid recipients in the Child Health Services (EPSDT) Program.

(2) Services must be prescribed by a physician and provided by or under the supervision of a qualified occupational therapist.

A qualified occupational therapist assistant may provide services under the supervision of a licensed occupational therapist.

All therapies' service definitions and providers must meet the requirements of 42 C.F.R. § 440.110.

(3) Effective for dates on or after **January 1, 2021**, evaluations are limited to **two (2)** units per State Fiscal Year (July 1 through June 30). Extensions of the benefit limit will be provided if medically necessary.

(4) Effective for dates of service on or after July 1, 2017, individual and group occupational therapy are limited to six (6) units per week. Extensions of the benefit limit will be provided if medically necessary.

c. Services for individuals with speech, hearing and language disorders (provided by or under the supervision of a speech pathologist or audiologist)

(1) Speech-language pathology services are limited to Medicaid recipients in the Child Health Services (EPSDT) Program.

(2) Speech-**language** pathology services must be referred by a physician and provided by or under the supervision of a qualified speech-**language** pathologist.

A qualified speech-**language** therapist assistant may provide services under the supervision of a licensed speech-**language** therapist.

All therapies' service definitions and providers must meet the requirements of 42 C.F.R. § 440.110.

(3) Evaluations are limited to four (4) units per State Fiscal Year (July 1 through June 30). Extensions of the benefit limit will be provided if medically necessary.

(4) Effective for dates of service on or after July 1, 2017, individual and group speech-language pathology services are limited to six (6) units per week. Extensions of the benefit limit will be provided if medically necessary.

AMOUNT, DURATION AND SCOPE OF
SERVICES PROVIDED

Revised: January 1, 2021

CATEGORICALLY NEEDY

7. Home Health Services (Continued)

7.c. Medical supplies, equipment, and appliances suitable for use in the home. (Continued)

(5) Diapers/Underpads

Diapers/underpads are limited to \$130.00 per month, per beneficiary. The \$130.00 benefit limit is a combined limit for diapers/underpads provided through the Prosthetics Program and Home Health Program. The benefit limit may be extended with proper documentation. Only patients with a medical diagnosis other than infancy which results in incontinence of the bladder and/or bowel may receive diapers. This coverage does not apply to infants who would otherwise be in diapers regardless of their medical condition. Providers cannot bill for underpads/diapers if a beneficiary is under the age of three years.

7.d. Physical therapy, occupational therapy, or speech-**language** pathology and audiology services provided by a home health agency or medical rehabilitative facility.

Physical therapists must meet the requirements outlined in 42 CFR 440.110(a).

Services under this item are limited to physical therapy when provided by a home health agency and prescribed by a physician. Effective for dates of service on or after **July 1, 2017**, individual and group physical therapy are limited to six (6) units per week. **Effective for dates on or after January 1, 2021, physical therapy** evaluations are limited to **two (2)** units per State Fiscal Year (July 1 through June 30). Extensions of the benefit limits will be provided if medically necessary for eligible Medicaid recipients.

8. Private Duty Nursing to enhance the effectiveness of treatment for ventilator-dependent beneficiaries or non-ventilator dependent tracheotomy beneficiaries

Enrolled providers are Private Duty Nursing Agencies licensed by Arkansas Department of Health. Services are provided by Registered Nurses or Licensed Practical Nurses licensed by the Arkansas State Board of Nursing.

Services are covered for Medicaid-eligible beneficiaries age 21 and over when determined medically necessary and prescribed by a physician.

Beneficiaries 21 and over to receive PDN Nursing Services must require constant supervision, visual assessment and monitoring of both equipment and patient. In addition the beneficiary must be:

- A. Ventilator dependent (invasive) or
- B. Have a functioning trach
 - 1. requiring suctioning and
 - 2. oxygen supplementation and
 - 3. receiving Nebulizer treatments or require Cough Assist / inextufflator devices.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
MEDICAL ASSISTANCE PROGRAM
STATE ARKANSAS

ATTACHMENT 3.1-B
Page 2g

AMOUNT, DURATION AND SCOPE OF
SERVICES PROVIDED

Revised: January 1, 2021

MEDICALLY NEEDY

4.b Early and Periodic Screening and Diagnosis of Individuals Under 21 Years of Age, and Treatment of Conditions Found.

- (1) No limitation on services within the scope of the program, except for consultations, home health services if services are EPSDT related. Extension of the benefit limit for consultations (2 per State Fiscal Year), home health services (50 visits per State Fiscal Year), physical therapy evaluations (2 per State Fiscal Year), occupational therapy evaluations (2 per State Fiscal Year), speech-**language** therapy evaluations (4 units per State Fiscal Year), and chiropractor X-ray services (2 per State Fiscal Year) will be provided if medically necessary for recipients in the Child Health Services (EPSDT) Program.

Medical Screens are provided based on the recommendations of the American Academy of Pediatrics. Childhood immunizations are provided based on the Advisory Committee on Immunization Practices (ACIP).

The State will provide other health care described in Section 1905(a) of the Social Security Act that is found to be medically necessary to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services, even when such health care is not otherwise covered under the State Plan.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
MEDICAL ASSISTANCE PROGRAM
STATE ARKANSAS

ATTACHMENT 3.1-B
Page 2n

AMOUNT, DURATION AND SCOPE OF
SERVICES PROVIDED

Revised: January 1, 2021

MEDICALLY NEEDY

4.b. Early and Periodic Screening and Diagnosis of Individuals Under 21 Years of Age, and Treatment of Conditions Found. (Continued)

(14) RESERVED

(15) Physical Therapy and Related Services

a. Physical Therapy

(1) Services are limited to eligible Medicaid recipients in the Child Health Services (EPSDT) Program.

(2) **Effective** for dates on or after **January 1, 2021**, evaluations are limited to **two (2)** units per State Fiscal Year (July 1 through June 30). Extensions of the benefit limit will be provided if medically necessary.

(3) Services must be prescribed by a physician and provided by or under the supervision of a qualified physical therapist.

A qualified physical therapist assistant may provide services under the supervision of a licensed physical therapist.

All therapies' service definitions and providers must meet the requirements of 42 C.F.R. § 440.110.

(4) Effective for dates of service on or after July 1, 2017, individual and group therapy are limited to six (6) units per week. Extensions of the benefit limit will be provided if medically necessary.

AMOUNT, DURATION AND SCOPE OF
SERVICES PROVIDED

Revised: January 1, 2021

MEDICALLY NEEDY

4.b. Early and Periodic Screening and Diagnosis of Individuals Under 21 Years of Age, and Treatment of Conditions Found. (Continued)

(15) Physical Therapy and Related Services (Continued)

b. Occupational Therapy

- (1) Services are limited to eligible Medicaid recipients in the Child Health Services (EPSDT) Program.
- (2) Services must be prescribed by a physician and provided by or under the supervision of a qualified occupational therapist.

A qualified occupational therapist assistant may provide services under the supervision of a licensed occupational therapist.

All therapies' service definitions and providers must meet the requirements of 42 C.F.R. § 440.110.

- (3) Effective for dates on or after **January 1, 2021**, evaluations are limited to **two (2)** units per State Fiscal Year (July 1 through June 30). Extensions of the benefit limit will be provided if medically necessary.
- (4) Effective for dates of service on or after July 1, 2017, individual and group occupational therapy are limited to six (6) units per week. Extensions of the benefit limit will be provided if medically necessary.

c. Services for individuals with speech, hearing and language disorders (provided by or under the supervision of a speech-**language** pathologist or audiologist)

- (1) Speech-language pathology services are limited to Medicaid recipients in the Child Health Services (EPSDT) Program.
- (2) Speech-**language** pathology services must be referred by a physician and provided by or under the supervision of a qualified speech-**language** pathologist.

A qualified speech-**language** therapist assistant may provide services under the supervision of a licensed speech-**language** therapist.

All therapies' service definitions and providers must meet the requirements of 42 C.F.R. § 440.110.

- (3) Evaluations are limited to four (4) units per State Fiscal Year (July 1 through June 30). Extensions of the benefit limit for the evaluation will be provided if medically necessary.
- (4) Effective for dates of service on or after July 1, 2017, individual and group speech-language pathology services are limited to six (6) units per week. Extensions of the benefit limit will be provided if medically necessary.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
MEDICAL ASSISTANCE PROGRAM
STATE ARKANSAS

ATTACHMENT 3.1-B
Page 3f

AMOUNT, DURATION AND SCOPE OF
SERVICES PROVIDED

Revised: January 1, 2021

MEDICALLY NEEDY

7. Home Health Services (Continued)

7.c. Medical supplies, equipment, and appliances suitable for use in the home. (Continued)

(5) Diapers/Underpads

Diapers/underpads are limited to \$130.00 per month, per recipient. The \$130.00 benefit limit is a combined limit for diapers/underpads provided through the Prosthetics Program and Home Health Program. The benefit limit may be extended with proper documentation. Only patients with a medical diagnosis other than infancy which results in incontinence of the bladder and/or bowel may receive diapers. This coverage does not apply to infants who would otherwise be in diapers regardless of their medical condition. Providers **cannot** bill for underpads/diapers if a recipient is under the age of three years.

7.d. Physical therapy, occupational therapy, or speech-**language** pathology and audiology services provided by a home health agency or medical rehabilitative facility.

Services under this item are limited to physical therapy when provided by a home health agency and prescribed by a physician. Effective for dates of service on or after **July 1, 2017**, individual and group physical therapy are limited to **six (6)** units per **week**. **Effective for dates of service on or after January 1, 2021, physical therapy** evaluations are limited to **two (2)** units per State Fiscal Year (July 1 through June 30). Extensions of the benefit limit will be provided if medically necessary for eligible Medicaid recipients.

AMOUNT, DURATION AND SCOPE OF
SERVICES PROVIDED

Revised: January 1, 2021

MEDICALLY NEEDY

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-Language 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. **For recipients over age 21, speech-language therapy evaluations are limited to four (4) units per State Fiscal Year (July 1 through June 30). Extensions of the benefit limit will be provided if medically necessary.**
- 3 **For recipients over age 21, effective for dates on or after January 1, 2021, physical therapy evaluations are limited to two (2) units per State Fiscal Year (July 1 through June 30). For recipients over age 21, effective for dates on or after January 1, 2021, Occupational therapy evaluations are limited to two (2) units per State Fiscal Year (July 1 through June 30).**

A. Speech-Language Therapy

Speech Generating Device (SGD) Evaluation - Effective for dates of service on or after September 1, 1999, **Speech Generating Device (SGD)** evaluation is covered for eligible Medicaid recipients of all ages. One **SGD** evaluation may be performed every three (3) years based on medical necessity. The benefit limit may be extended for individuals under age 21.

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES-
OTHER TYPES OF CARE

Revised: January 1, 2021

4.b. Early and Periodic Screening and Diagnosis of Individuals Under 21 Years of Age
and Treatment of Conditions Found (Continued)

(19) Physical Therapy and Related Services (Continued)

2. Occupational Therapy

Listed below are covered occupational therapy services:

Description

Evaluation for occupational therapy Individual
occupational therapy
Group occupational therapy
Individual occupational therapy by occupational therapy assistant
Occupational therapy by occupational therapy assistant

At the beginning of each calendar year, Medicaid officials and the Arkansas Occupational Therapy Association or its successor will arrive at mutually agreeable increase or decrease in reimbursement rates based on the market forces as they impact on access. Any agreed upon increase or decrease will be implemented at the beginning of the following state fiscal year, July 1 with any appropriate State Plan changes.

3. Speech-Language Therapy

Listed below are covered speech-language therapy services:

Description

Evaluation of speech language voice, communication, auditory processing
and/or aural rehabilitation status
Individual speech-language
therapy session
Group speech-language **therapy**
session
Individual speech-language therapy by speech-language pathology assistant
Group speech-language therapy by speech language pathology assistant

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES -
OTHER TYPES OF CARE

Revised: January 1, 2021

2.a. Outpatient Hospital Services (continued)

(3) Arkansas State Operated Teaching Hospitals

Effective for cost reporting periods ending June 30, 2000 or after, outpatient hospital services provided at an Arkansas State Operated Teaching Hospital will be reimbursed based on reasonable costs with interim payments in accordance with 2.a.(1) and a year-end cost settlement.

Arkansas Medicaid will use the lesser of the reasonable costs or customary charges to establish cost settlements. Except for graduate medical education costs, the cost settlements will be calculated using the methods and standards used by the Medicare Program. Graduate medical education costs are reimbursed as described in Attachment 4.19-A, Page 8a for inpatient hospital services.

(4) Speech Generating Device Evaluation

Effective for dates of service on or after September 1, 1999, reimbursement for a **Speech Generating Device (SGD)** Evaluation is based on the lesser of the provider's actual charge for the service or the Title XIX (Medicaid) maximum. The XIX (Medicaid) maximum is based on the current hourly rate for both disciplines of therapy involved in the evaluation process. The Medicaid maximum for speech-**language** therapy is \$25.36 per (20 mins.) unit x's 3 units per date of service (DOS) and occupational therapy is \$18.22 per (15 mins.) unit x's 4 units per DOS equals a total of \$148.96 per hour. Two (2) hours per DOS is allowed. This would provide a maximum reimbursement rate per DOS of \$297.92.

(5) Outpatient/Clinic-Indian Health Services

Effective for dates of service on or after November 1, 2002, covered outpatient/clinic services provided by Indian Health Services (IHS) and Tribal 638 Health Facilities will be reimbursed the IHS outpatient/clinic rate published by the Office of Management and Budget (OMB). Covered IHS outpatient/clinic services include only those services that are covered under other Arkansas Medicaid programs. This rate is an all-inclusive rate with no year-end cost settlement. The initial rate is the published IHS outpatient rate for calendar year 2002. The rate will be adjusted to the OMB published rate annually or for any other period identified by OMB.

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES -
OTHER TYPES OF CARE

Revised: January 1, 2021

- 4.b. Early and Periodic Screening and Diagnosis of Individuals Under 21 Years of Age and Treatment of Conditions Found (Continued)

(19) Physical Therapy, Occupational Therapy, and Speech-Language Therapy Services

Effective for dates of service on or after October 1, 1999, the Arkansas Medicaid maximum rates for physical therapy services, occupational therapy services and speech-**language** therapy services are based on court-ordered rates issued by the United States District Court, Eastern District of Arkansas, Western Division and agreed upon by the Division of Medical Services and representatives of the Arkansas Physical Therapy Association, the Arkansas Occupational Therapy Association and the Arkansas Speech-Language-Hearing Association.

The agency's therapy fee schedule rates were set as of January 1, 2008 and are effective for services on or after that date. All therapy fee schedule rates are published on the agency's website (www.medicaid.state.ar.us). A uniform rate for these services is paid to all governmental and non- governmental providers unless otherwise indicated in the state plan. The State assures that physical therapists, occupational therapists and speech-**language** therapists will meet the requirements contained in 42 CFR 440.110.

Therapy Assistants - Effective for dates of service on or after October 1, 1999, the Arkansas Medicaid maximum for the physical therapy assistant, occupational therapy assistant and the speech-**language** therapy assistant is based on 80% of the amount reimbursed to the licensed therapist.

Fee schedule service reimbursement is based on the lesser of the amount billed or the Arkansas Title XIX (Medicaid) maximum charge allowed.

1. Physical Therapy

Listed below are covered physical therapy services:

Description

Evaluation for physical therapy

Individual physical therapy Group

physical therapy

Individual physical therapy by physical therapy assistant Group

physical therapy by physical therapy assistant

At the beginning of each calendar year, Medicaid officials and the Arkansas Physical Therapy Association or its successor will arrive at mutually agreeable increase or decrease in reimbursement rates based on the market forces as they impact on access. Any agreed upon increase or decrease will be implemented at the beginning of the following state fiscal year, July 1 with any appropriate State Plan changes.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
MEDICAL ASSISTANCE PROGRAM
STATE ARKANSAS

ATTACHMENT 4.19-B
Page lrr

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES-
OTHER TYPES OF CARE

Revised: January 1, 2021

4.b. Early and Periodic Screening and Diagnosis of Individuals Under 21 Years of Age and
Treatment of Conditions Found (Continued)

(19) Speech-**Language** Therapy (Continued)

At the beginning of each calendar year, Medicaid officials and the Arkansas Speech-**Language** Therapy Association or its successor will arrive at mutually agreeable increase or decrease in reimbursement rates based on the market forces as they impact on access. Any agreed upon increase or decrease will be implemented at the beginning of the following state fiscal year, July 1 with any appropriate State Plan changes.

{20} Rehabilitative Services for Persons with **Physical** Disabilities (RSPD)

1. Residential Rehabilitation Centers

The per diem reimbursement for RSPD services provided by a Residential Rehabilitation center will be based on the provider's fiscal year end 1994 audited cost report as submitted by an independent auditor plus a percentage increase equal to the HCFA Market Basket Index published for the quarter ending in March. A cap has been established at \$395.00. This is a prospective rate with no cost settlement. Room and board is not an allowable program cost. The criteria utilized to exclude room and board is as follows: The total Medicaid ancillary cost was divided by total Medicaid inpatient days which equals the RSPD prospective per diem. The ancillary cost was determined based upon Medicare Principles of Reimbursement. There is no routine cost included.

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES –
OTHER TYPES OF CARE

Revised: January 1, 2021

4 Physical **Therapy** and Related Services

- a. Physical Therapy - Refer to Attachment 4.19-B, Item 4.b.(19).
- b. Occupational Therapy - Refer to Attachment 4.19-B, Item 4.b.(19).
- c. Speech-**Language** Pathology - Refer to Attachment 4.19-B, Item 4.b.(19).

1. **Speech Generating** Device Evaluation

Effective for dates of service on or after September 1, 1999, reimbursement for an **Speech Generating Device (SGD)** Evaluation is based on the lesser of the provider's actual charge for the service or the Title XIX (Medicaid) maximum. The XIX (Medicaid) maximum is based on the current hourly rate for both disciplines of therapy involved in the evaluation process. The Medicaid maximum for speech-**language** therapy is \$25.36 per (20 mins.) unit x's 3 units per date of service (DOS) and occupational therapy is \$18.22 per (15 mins.) unit x's 4 units per DOS equals a total of \$148.96 per hour. Two (2) hours per DOS is allowed. This would provide a maximum reimbursement rate per DOS of \$297.92.

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES –
OTHER TYPES OF CARE

Revised: January 1, 2021

11. Physical Therapy and Related Services (Continued)

- c. Speech-**Language** Pathology - Reimbursement Is based on the lesser of the amount billed or the Title XIX (Medicaid) maximum.

The Title XIX (Medicaid) maximum was established based on a 1985 survey conducted by the Division of Developmental Disabilities of private therapy providers, hospital providers and nursing home providers of their 1985 billed charges. The mean (arithmetic average) rate for therapy services established the Title XIX maximum. The rates include the professional and administrative components. Effective for dates of service on or after 7-1-91, rates were increased by 4%.

SECTION II - OCCUPATIONAL, PHYSICAL, SPEECH-LANGUAGE THERAPY

CONTENTS

TOC required

200.000 OCCUPATIONAL, PHYSICAL, SPEECH-LANGUAGE THERAPY SERVICES GENERAL INFORMATION

201.110 School Districts, Education Service Cooperatives, and Early Intervention Day Treatment, or Adult Developmental Day Treatment 1-1-21

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-Language 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.

202.000 Enrollment Criteria for Providers of Occupational, Physical, and Speech-Language Therapy Services

203.000 Supervision

1-1-21

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

- A. The person who is performing supervision must be a paid employee of the enrolled Medicaid provider of therapy or speech-language pathology services who is filing claims for services.
- B. The qualified therapist or speech-language pathologist must monitor and be responsible for the quality of work performed by the individual under his or her supervision.
 - 1. The qualified therapist or speech-language pathologist must be immediately available to provide assistance and direction throughout the time the service is being performed. Availability by telecommunication is sufficient to meet this requirement.
 - 2. When therapy services are provided by a licensed therapy assistant or speech-language pathology assistant who is supervised by a licensed therapist or speech-language pathologist, the supervising therapist or speech-language pathologist must observe a therapy session with a child and review the treatment plan and progress notes at a minimum of every 30 calendar days.
- C. The qualified therapist or speech-language pathologist must review and approve all written documentation completed by the individual under his or her supervision prior to the filing of claims for the service provided.
 - 1. Each page of progress note entries must be signed by the supervising therapist with his or her full signature, credentials and date of review.
 - 2. The supervising therapist must document approval of progress made and any recommended changes in the treatment plan.
 - 3. The services must be documented and available for review in the beneficiary's medical record.
- D. The qualified therapist or speech-language pathologist may not be responsible for the supervision of more than 5 individuals.

203.100**Speech-Language Pathologist/Speech-Language Therapist Supervision****1-1-21**

Individuals **must** be under the supervision of a qualified speech-language pathologist if the following conditions exist.

- A. The individual is employed by an Arkansas school district or educational service and meets **one** of the following:
 - 1. Holds a current Arkansas teaching certificate as a Speech Therapist,
 - 2. Holds a current Arkansas teaching certificate as a Speech Pathologist I,
 - 3. Holds a current Arkansas teaching certificate as a Speech Pathologist II and does not meet any one of the Medicaid federally mandated requirements for a qualified speech-language pathologist. (See Section 202.300 of this manual.)
- B. The individual is **not** employed by an Arkansas school district, an education service cooperative, a regular group provider of therapy services or the Division of Developmental Disabilities Services and:
 - 1. Is licensed by the Arkansas Board of Examiners in Speech-Language Pathology and Audiology (ABESPA) as a speech-language pathologist, but
 - 2. Does not meet any one of the Medicaid federally mandated requirements for qualified speech-language pathologist (See Section 202.300 of this manual.)

- C. In the six bordering states (Louisiana, Mississippi, Missouri, Oklahoma, Tennessee and Texas) an individual provider of speech-language pathology services:
1. Does not meet any one of the Medicaid federally mandated requirements for a qualified speech-language pathologist (see Section 202.300 of this manual) but
 2. The individual provider of speech-language pathology services must be licensed as a speech-language pathology assistant in his or her state.

205.000 The Physician's Role in the Occupational, Physical, Speech-Language Therapy Program

1-1-21

All occupational, physical, and speech-language therapy services must be medically necessary. Medicaid accepts a physician's diagnosis that clearly establishes and supports medical necessity for therapy treatment. These services require a referral from the beneficiary's primary care physician (PCP) or the attending physician if the beneficiary is exempt from PCP Managed Care Program requirements. (See Section I of this manual.) Therapy treatment services also require a prescription written by the physician who refers the beneficiary to the therapist for services.

208.000 Referral to LEA, pursuant to Part B of the Individuals with Disabilities Education Act (IDEA)

1-1-21

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.

Each therapist must, within two (2) working days of first contact, refer children ages three (3) until entry into Kindergarten for whom there is a diagnosis or suspicion of a developmental delay or disability. For children who are turning three years of age while receiving services at the center, the referral must be made at least 90 days prior to the child's third birthday. If the child begins services less than 90 days prior to their third birthday, the referral should be made in accordance with the late referral requirements of the IDEA.

The referral must be made to the LEA where that child resides. Each therapist is responsible for maintaining documentation evidencing that a proper and timely referral to has been made.

211.000 Introduction

1-1-21

The Arkansas Medicaid Occupational, Physical, and Speech-Language 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

1-1-21

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-language therapy services when provided to eligible Medicaid beneficiaries under age 21 in the Child Health Services (EPSDT) Program by qualified occupational, physical, or speech-language therapy providers.
- F. 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-Language Therapy Services

1-1-21

- A. Occupational, physical, and speech-language 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-Language Therapy for Medicaid Eligible Beneficiaries Under Age 21" form DMS-640.
- B. Occupational, physical, and speech-language 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 even if the prescription for therapy is for one year.
 - 2. A prescription for therapy services is valid for the length of time specified by the prescribing physician, up to one year.
- C. When a school district is providing therapy services in accordance with a child's Individualized Education Program (IEP), a PCP referral is required at the beginning of each school year. The PCP referral for the therapy services related to the IEP can be for the 9-month school year.
- 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. ([View ICD codes.](#))
- E. Therapy services providers must use form DMS-640 – “Occupational, Physical and Speech-Language 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.

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-language therapy services is required for beneficiaries under age 21 who are receiving 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.

Retrospective review of occupational, physical, and speech-language evaluations is required for beneficiaries under age 21 who receive an evaluation less than six months from the previous evaluation when the provider is utilizing a complexity code rather than a timed code.

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-language therapy retrospective reviews. These guidelines may be found in Sections 214.300 and 214.400.

214.400 Speech-Language Therapy Guidelines for Review

1-1-21

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:

$$7 \text{ months} - [(40 \text{ weeks}) - 28 \text{ weeks}] / 4 \text{ weeks}]$$

$$7 \text{ months} - [(12) / 4 \text{ weeks}]$$

$$7 \text{ months} - [3]$$

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 Fluarty-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:

$$7 \text{ months} - [(40 \text{ weeks}) - 28 \text{ weeks}] / 4 \text{ weeks}]$$

$$7 \text{ months} - [(12) / 4 \text{ weeks}]$$

$$7 \text{ months} - [3]$$

$$4 \text{ months}$$

- 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:

$$7 \text{ months} - [(40 \text{ weeks}) - 28 \text{ weeks}] / 4 \text{ weeks}]$$

$$7 \text{ months} - [(12) / 4 \text{ weeks}]$$

$$7 \text{ months} - [3]$$

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:

$$7 \text{ months} - [(40 \text{ weeks}) - 28 \text{ weeks}] / 4 \text{ weeks}]$$

$$7 \text{ months} - [(12) / 4 \text{ weeks}]$$

$$7 \text{ months} - [3]$$

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 must be evaluated annually, and adults receiving services in an Adult Developmental Day Treatment (ADDT) program.
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.

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.

215.000 Speech Generating Device (SGD) Evaluation**1-1-21**

Arkansas Medicaid covers evaluations for speech generating devices (SGDs) under the following conditions.

- A. Prior authorization by the Division of Medical Services Utilization Review Section is required for approval of the SGD evaluation. (See Section 231.000 of this manual for prior authorization procedures for SGD evaluations.)
- B. A multidisciplinary team must conduct the SGD evaluation. The evaluation team must meet the following requirements:
 - 1. A speech-language pathologist must lead the team. The speech-language pathologist must be licensed by the Arkansas Board of Examiners for Speech-Language Pathology and Audiology and have a Certification of Clinical Competence from the American Speech-Language and Hearing Association.
 - 2. The team must also include an occupational therapist. The occupational therapist must be licensed by the Arkansas State Medical Board. A physical therapist should be added to the team if it is determined that there is a need for assistance in the evaluation as it relates to the positioning and seating in utilizing specific SGD equipment. The physical therapist must be licensed by the Arkansas State Board of Physical Therapy.
 - 3. The speech-language pathologist, occupational therapist, and physical therapist must have verifiable training and experience in the use and evaluation of SGD equipment. Their knowledge must include, but not be limited to, the equipment's use and its working capabilities, access and mounting requirements, and information on training, warranties, and maintenance.
 - 4. The team may also include regular and special educators, caregivers and parents, vocational rehabilitation counselors, behavior analysts, and others.
 - 5. The team must use an interdisciplinary approach in the evaluation, incorporating the goals, objectives, skills, and knowledge of various disciplines.
 - 6. Team members must disclose any financial relationship they have with device manufacturers and must certify that their recommendations are based on a comprehensive evaluation and preferred practice patterns and are not due to any financial or personal incentive.
 - 7. The team must use at least three SGDs with different language/storage systems during the evaluation and these devices must not be from the same manufacturer or product line.
 - 8. The recommended SGD is prior authorized for purchase only after the client has completed a minimum of a four-week trial period that includes extensive experience with the requested system. Data must be collected during the trial period and document that the client can successfully use the recommended device. If the client cannot demonstrate successful use of the recommended device, subsequent trial periods with different devices shall occur until a device is identified that the client can successfully use. Information about the trial period must be documented in the evaluation report.

A trial period is not required when replacing an existing SGD unless the client's needs have changed, the current device is no longer available, and/or another device or method of access is being considered as more appropriate.

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

The evaluation report must meet the following requirements.

1. The report must indicate the medical reason for the SGD and pertinent background information.
2. The report must include information about the client's current speech/language and communication abilities. Information from speech-language diagnostic testing must be current within one year.
3. The report must indicate limitations of the client's current communication abilities, systems and devices used, and current communication needs.
4. The report must include information on sensory functioning, including vision and hearing, as related to the SGD.
5. The report must include information regarding the client's postural and motor abilities. The report must include optimal access/selection technique needed for independent use of SGD. It may include a description of the control interfaces needed between the SGD and other devices such as power mobility.
6. The report must include a description of the functional placement of the SGD such as mounting devices, carrying cases, straps, etc.
7. The report must indicate the client's ability to use various graphic and auditory symbol forms.
8. The report must include information on vocabulary storage/rate enhancement techniques considered and justification for those deemed most appropriate.
9. The report must summarize the client's required device features and delineate features of devices presented.
10. The report must give specific recommendations of the system and justify why one system is more appropriate than the others presented.
11. The report must include information about the trial period documenting that the client could successfully use the recommended device. This documentation must include information on length of trial, frequency of use of SGD, environments, activities and communication partners involved, access method(s) used, portability of the device, symbolic language system and rate enhancement used, number of symbols and layout of overlay used, a sample of language expressed, client's level of independence (prompting strategies) using the device and expressing various language functions, and a summary of baseline and end of trial data.
12. The report must include a description of the recommended device and all components and accessories.
13. The report must include an initial treatment plan for implementing use of the device. The plan shall identify who will be responsible for delivering and programming the SGD; who will develop initial goals and objectives for functional use of SGD; and who will train the client's team members and communication partners in the proper use, programming, care and maintenance of the SGD.
14. The speech-language pathologist and all other professionals directly involved in the evaluation must sign the SGD evaluation report. All professionals involved must also sign a non-conflict disclosure stating that they do not have financial relationship or other affiliation with a SGD manufacturer.

Refer to Section 215.100 of this manual for SGD evaluation benefits and Section 260.000 for billing procedures.

215.100 Speech Generating Devices (SGD) Evaluation Benefit

1-1-21

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

216.100 Extended Therapy Services**1-1-21**

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

- A. Medicaid will reimburse for annual occupational, physical, and speech-language therapy evaluations in accordance with the attached procedure codes sheet. [View or print the procedure codes for therapy services.](#)
- B. Medicaid will reimburse up to 90 minutes of occupational, physical, and speech-language therapy weekly, per discipline, without authorization. Additional therapy units will require an extended therapy request.
- C. All requests for extended therapy services must comply with Sections 216.300 through 216.315.

216.310 QIO Extended Therapy Services Review Process**1-1-21**

The following is a step-by-step outline of the extended therapy 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 an appropriate clinician reviewer. If, in the judgment of the clinician reviewer, the documentation supports the medical necessity, the clinician reviewer may approve the request. An approval letter is generated and mailed to the provider the following day.
- C. If the clinician reviewer determines the documentation does not justify the service or it appears that the service is not medically necessary, the reviewer 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 clinician reviewer 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 clinician reviewer, 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.

231.000 Prior Authorization Request Procedures for Speech Generating Device (SGD) Evaluation 1-1-21

To perform an evaluation for the speech generating device (SGD), the provider must request prior authorization from the QIO, using the following procedures.

- A. A primary care physician (PCP) written referral is required for prior authorization of the SGD 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 SGD.
- C. If the beneficiary is currently receiving speech-language therapy, the speech-language pathologist must document the prerequisite communication skills for the speech generating 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 speech generating evaluation. Refer back to Section 215.000 for additional information.

231.100 Reconsideration of Prior Authorization Determination 1-1-21

Reconsideration of a denial may be requested within thirty (30) calendar days of the denial date. Requests must be made in writing and must include additional documentation to substantiate the medical necessity of the SGD evaluation.

262.100 Occupational, Physical, Speech-Language Therapy Procedure Codes 1-1-21

Occupational, physical, and speech-language therapy procedure codes can be found by following this link: [View or print the procedure codes for therapy services.](#)

262.200 National Place of Service Codes 1-1-21

Electronic and paper claims now require the same National Place of Service Code.

Place of Service	Place of Service Code
Doctor's Office	11
Patient's Home	12
Independent Clinic (EIDT/ADDT)	49
Day Care Facility	52

Place of Service	Place of Service Code
Night Care Facility	52
Other Locations	99
Residential Treatment Center	56

262.310 Completion of the CMS-1500 Claim Form

1-1-21

Field Name and Number	Instructions for Completion
1. (type of coverage)	Not required.
1a. INSURED'S I.D. NUMBER (For Program in Item 1)	Beneficiary's or participant's 10-digit Medicaid or ARKids First-A or ARKids First-B identification number.
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)	Beneficiary's or participant's last name and first name.
3. PATIENT'S BIRTH DATE	Beneficiary's or participant's date of birth as given on the individual's Medicaid or ARKids First-A or ARKids First-B identification card. Format: MM/DD/YY.
SEX	Check M for male or F for female.
4. INSURED'S NAME (Last Name, First Name, Middle Initial)	Required if insurance affects this claim. Insured's last name, first name, and middle initial.
5. PATIENT'S ADDRESS (No., Street)	Optional. Beneficiary's or participant's complete mailing address (street address or post office box).
CITY	Name of the city in which the beneficiary or participant resides.
STATE	Two-letter postal code for the state in which the beneficiary or participant resides.
ZIP CODE	Five-digit zip code; nine digits for post office box.
TELEPHONE (Include Area Code)	The beneficiary's or participant's telephone number or the number of a reliable message/contact/emergency telephone.
6. PATIENT RELATIONSHIP TO INSURED	If insurance affects this claim, check the box indicating the patient's relationship to the insured.
7. INSURED'S ADDRESS (No., Street)	Required if insured's address is different from the patient's address.
CITY	
STATE	
ZIP CODE	
TELEPHONE (Include Area Code)	
8. RESERVED	Reserved for NUCC use.

Field Name and Number	Instructions for Completion
9. OTHER INSURED'S NAME (Last name, First Name, Middle Initial)	If patient has other insurance coverage as indicated in Field 11d, the other insured's last name, first name, and middle initial.
a. OTHER INSURED'S POLICY OR GROUP NUMBER	Policy and/or group number of the insured individual.
b. RESERVED SEX	Reserved for NUCC use. Not required.
c. EMPLOYER'S NAME OR SCHOOL NAME	Required when items 9 a-d are required. Name of the insured individual's employer and/or school.
d. INSURANCE PLAN NAME OR PROGRAM NAME	Name of the insurance company.
10. IS PATIENT'S CONDITION RELATED TO:	
a. EMPLOYMENT? (Current or Previous)	Check YES or NO.
b. AUTO ACCIDENT? PLACE (State)	Required when an auto accident is related to the services. Check YES or NO. If 10b is YES, the two-letter postal abbreviation for the state in which the automobile accident took place.
c. OTHER ACCIDENT?	Required when an accident other than automobile is related to the services. Check YES or NO.
d. CLAIM CODES	The "Claim Codes" identify additional information about the beneficiary's condition or the claim. When applicable, use the Claim Code to report appropriate claim codes as designated by the NUCC. When required to provide the subset of Condition Codes, enter the condition code in this field. The subset of approved Condition Codes is found at www.nucc.org under Code Sets.
11. INSURED'S POLICY GROUP OR FECA NUMBER	Not required when Medicaid is the only payer.
a. INSURED'S DATE OF BIRTH SEX	Not required. Not required.
b. OTHER CLAIM ID NUMBER	Not required.
c. INSURANCE PLAN NAME OR PROGRAM NAME	Not required.
d. IS THERE ANOTHER HEALTH BENEFIT PLAN?	When private or other insurance may or will cover any of the services, check YES and complete items 9, 9a and 9d. Only one box can be marked.
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE	Enter "Signature on File," "SOF" or legal signature.

Field Name and Number	Instructions for Completion
13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE	Enter "Signature on File," "SOF" or legal signature.
14. DATE OF CURRENT: ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)	Required when services furnished are related to an accident, whether the accident is recent or in the past. Date of the accident. Enter the qualifier to the right of the vertical dotted line. Use Qualifier 431 Onset of Current Symptoms or Illness; 484 Last Menstrual Period.
15. OTHER DATE	Enter another date related to the beneficiary's condition or treatment. Enter the qualifier between the left-hand set of vertical, dotted lines. The "Other Date" identifies additional date information about the beneficiary's condition or treatment. Use qualifiers: 454 Initial Treatment 304 Latest Visit or Consultation, 453 Acute Manifestation of a Chronic Condition 439 Accident 455 Last X-Ray 471 Prescription 090 Report Start (Assumed Care Date) 091 Report End (Relinquished Care Date) 444 First Visit or Consultation
16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION	Not required.
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	Primary Care Physician (PCP) referral is required for Occupational, Physical, and Speech-Language Therapy Services. Enter the referring physician's name.
17a. (blank)	Not required.
17b. NPI	Enter NPI of the referring physician.
18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES	When the serving/billing provider's services charged on this claim are related to a beneficiary's or participant's inpatient hospitalization, enter the individual's admission and discharge dates. Format: MM/DD/YY.
19. ADDITIONAL CLAIM INFORMATION	For tracking purposes, occupational, physical, and speech-language therapy providers are required to enter one of the following therapy codes:
<u>Code</u>	<u>Category</u>

Field Name and Number	Instructions for Completion
A	Individuals from birth through 2 years who are receiving therapy services under an Individualized Family Services Plan (IFSP) through the Division of Developmental Disabilities Services.
B	Individuals ages 0 to 6 years who are receiving therapy services under an Individualized Plan (IP) through the Division of Developmental Disabilities Services. NOTE: This code is to be used only when all three of the following conditions are in place: 1) The individual receiving services has not attained the age of 6. 2) The individual receiving services is receiving the services under an Individualized Plan. 3) The Individualized Plan is through the Division of Developmental Disabilities Services.
When using code C or D, providers must also include the 4-digit LEA (local education agency) code assigned to each school district. For example: C1234	
C (and 4-digit LEA code)	Individuals ages 3 to 5 years who are receiving therapy services under an Individualized Education Program (IEP) through a school district or education service cooperative. NOTE: This code set is to be used only when all three of the following conditions are in place: 1) The individual receiving services is 3 years old and is not yet 5 years old. 2) The individual is receiving the services under an IEP maintained by a school district or education service cooperative. 3) Therapy services are being furnished by a) the school district or an ESC, which is an enrolled Medicaid therapy provider, or by b) a Medicaid-enrolled therapist or therapy group provider.
D (and 4-digit LEA code)	Individuals ages 5 to 21 years who are receiving therapy services under an IEP through a school district or an education service cooperative. NOTE: This code set is to be used only when all three of the following conditions are in place: 1) The individual receiving services is 5 years old and is not yet 21 years old. 2) The individual is receiving the services under an IEP. 3) The IEP is through a school district or an education service cooperative.
E	Individuals ages 18 through 20 years who are receiving therapy services through the Division of Developmental Disabilities Services.

Field Name and Number	Instructions for Completion
F	Individuals ages 18 through 20 years who are receiving therapy services from individual or group providers not included in any of the previous categories (A-E).
G	Individuals ages birth through 17 years who are receiving therapy/pathology services from individual or group providers not included in any of the previous categories (A-F).
20. OUTSIDE LAB? \$ CHARGES	Not required. Not required.
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY	<p>Enter the applicable ICD indicator to identify which version of ICD codes is being reported.</p> <p>Use "9" for ICD-9-CM.</p> <p>Use "0" for ICD-10-CM.</p> <p>Enter the indicator between the vertical, dotted lines in the upper right-hand portion of the field.</p> <p>Diagnosis code for the primary medical condition for which services are being billed. Use the appropriate International Classification of Diseases until further notice. List no more than 12 diagnosis codes. Relate lines A-L to the lines of service in 24E by the letter of the line. Use the highest level of specificity.</p>
22. RESUBMISSION CODE ORIGINAL REF. NO.	<p>Reserved for future use.</p> <p>Any data or other information listed in this field does not/will not adjust, void or otherwise modify any previous payment or denial of a claim. Claim payment adjustments, voids, and refunds must follow previously established processes in policy.</p>
23. PRIOR AUTHORIZATION NUMBER	The prior authorization or benefit extension control number if applicable.
24A. DATE(S) OF SERVICE	<p>The "from" and "to" dates of service for each billed service. Format: MM/DD/YY.</p> <ol style="list-style-type: none"> On a single claim detail (one charge on one line), bill only for services provided within a single calendar month. Providers may bill on the same claim detail for two or more sequential dates of service within the same calendar month when the provider furnished equal amounts of the service on each day of the date sequence.
B. PLACE OF SERVICE	Two-digit national standard place of service code. See Section 262.200 for codes.
C. EMG	Enter "Y" for "Yes" or leave blank if "No." EMG identifies if the service was an emergency.
D. PROCEDURES, SERVICES, OR SUPPLIES	

Field Name and Number	Instructions for Completion
CPT/HCPCS	Enter the correct CPT or HCPCS procedure code from Sections 262.100 through 262.120.
MODIFIER	Modifier(s) if applicable.
E. DIAGNOSIS POINTER	Enter the diagnosis code reference letter (pointer) as shown in Item Number 21 to relate to the date of service and the procedures performed to the primary diagnosis. When multiple services are performed, the primary reference letter for each service should be listed first; other applicable services should follow. The reference letter(s) should be A-L or multiple letters as applicable. The "Diagnosis Pointer" is the line letter from Item Number 21 that relates to the reason the service(s) was performed.
F. \$ CHARGES	The full charge for the service(s) totaled in the detail. This charge must be the usual charge to any client, patient, or other beneficiary of the provider's services.
G. DAYS OR UNITS	The units (in whole numbers) of service(s) provided during the period indicated in Field 24A of the detail.
H. EPSDT/Family Plan	Enter E if the services resulted from a Child Health Services (EPSDT) screening/referral.
I. ID QUAL	Not required.
J. RENDERING PROVIDER ID #	Enter the 9-digit Arkansas Medicaid provider ID number of the individual who furnished the services billed for in the detail or
NPI	Enter NPI of the individual who furnished the services billed for in the detail.
25. FEDERAL TAX I.D. NUMBER	Not required. This information is carried in the provider's Medicaid file. If it changes, please contact Provider Enrollment.
26. PATIENT'S ACCOUNT NO.	Optional entry that may be used for accounting purposes; use up to 16 numeric or alphabetic characters. This number appears on the Remittance Advice as "MRN."
27. ACCEPT ASSIGNMENT?	Not required. Assignment is automatically accepted by the provider when billing Medicaid.
28. TOTAL CHARGE	Total of Column 24F—the sum all charges on the claim.
29. AMOUNT PAID	Enter the total of payments previously received on this claim. Do not include amounts previously paid by Medicaid. *Do not include in this total the automatically deducted Medicaid or ARKids First-B co-payments.
30. RESERVED	Reserved for NUCC use.

Field Name and Number	Instructions for Completion
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS	The provider or designated authorized individual must sign and date the claim certifying that the services were personally rendered by the provider or under the provider's direction. "Provider's signature" is defined as the provider's actual signature, a rubber stamp of the provider's signature, an automated signature, a typewritten signature, or the signature of an individual authorized by the provider rendering the service. The name of a clinic or group is not acceptable.
32. SERVICE FACILITY LOCATION INFORMATION	If other than home or office, enter the name and street, city, state, and zip code of the facility where services were performed.
a. (blank)	Not required.
b. (blank)	Not required.
33. BILLING PROVIDER INFO & PH #	Billing provider's name and complete address. Telephone number is requested but not required.
a. (blank)	Enter NPI of the billing provider or
b. (blank)	Enter the 9-digit Arkansas Medicaid provider ID number of the billing provider.

TOC required**221.100 ARKids First-B Medical Care Benefits****1-1-21**

Listed below are the covered services for the ARKids First-B program. This chart also includes benefits, whether Prior Authorization or a Primary Care Physician (PCP) referral is required, and specifies the cost-sharing requirements.

Program Services	Benefit Coverage and Restrictions	Prior Authorization/ PCP Referral*	Co-payment/ Coinsurance/ Cost Sharing Requirement**
Ambulance (Emergency Only)	Medical Necessity	None	\$10 per trip
Ambulatory Surgical Center	Medical Necessity	PCP Referral	\$10 per visit
Audiological Services (<u>only</u> Tympanometry, CPT procedure code 92567, when the diagnosis is within the ICD range (View ICD codes.))	Medical Necessity	None	None
Certified Nurse-Midwife	Medical Necessity	PCP Referral	\$10 per visit
Chiropractor	Medical Necessity	PCP Referral	\$10 per visit
Dental Care	Routine dental care and orthodontia services	None – PA for inter-periodic screens and orthodontia services	\$10 per visit
Durable Medical Equipment	Medical Necessity \$500 per state fiscal year (July 1 through June 30) minus the coinsurance/cost-share. Covered items are listed in Section 262.120	PCP Referral and Prescription	10% of Medicaid allowed amount per DME item cost-share
Emergency Dept. Services			
Emergency	Medical Necessity	None	\$10 per visit
Non-Emergency	Medical Necessity	PCP Referral	\$10 per visit
Assessment	Medical Necessity	None	\$10 per visit
Family Planning	Medical Necessity	None	None
Federally Qualified Health Center (FQHC)	Medical Necessity	PCP Referral	\$10 per visit

Program Services	Benefit Coverage and Restrictions	Prior Authorization/ PCP Referral*	Co-payment/ Coinsurance/ Cost Sharing Requirement**
Home Health	Medical Necessity (10 visits per state fiscal year (July 1 through June 30))	PCP Referral	\$10 per visit
Hospital, Inpatient	Medical Necessity	PA on stays over 4 days if age 1 or over	10% of first inpatient day
Hospital, Outpatient	Medical Necessity	PCP referral	\$10 per visit
Inpatient Psychiatric Hospital and Psychiatric Residential Treatment Facility	Medical Necessity	PA & Certification of Need is required prior to admittance	10% of first inpatient day
Immunizations	All per protocol	None	None
Laboratory & X-Ray	Medical Necessity	PCP Referral	\$10 per visit
Medical Supplies	Medical Necessity Benefit of \$125/mo. Covered supplies listed in Section 262.110	PCP Prescriptions PA required on supply amounts exceeding \$125/mo	None
Mental and Behavioral Health, Outpatient	Medical Necessity	PCP Referral PA on treatment services	\$10 per visit
School-Based Mental Health	Medical Necessity	PA Required (See Section 250.000 of the School-Based Mental Health provider manual.)	\$10 per visit
Nurse Practitioner	Medical Necessity	PCP Referral	\$10 per visit
Physician	Medical Necessity	PCP referral to specialist and inpatient professional services	\$10 per visit
Podiatry	Medical Necessity	PCP Referral	\$10 per visit
Prenatal Care	Medical Necessity	None	None
Prescription Drugs	Medical Necessity	Prescription	Up to \$5 per prescription (Must use generic, if available)***
Preventive Health Screenings	All per protocol	PCP Administration or PCP Referral	None
Rural Health Clinic	Medical Necessity	PCP Referral	\$10 per visit

Program Services	Benefit Coverage and Restrictions	Prior Authorization/ PCP Referral*	Co-payment/ Coinsurance/ Cost Sharing Requirement**
Speech-Language Therapy	Medical Necessity 4 evaluation units (1 unit =30 min) per state fiscal year 4 therapy units (1 unit=15 min) daily	PCP Referral Authorization required on extended benefit of services	\$10 per visit
Occupational Therapy	Medical Necessity 2 evaluation units per state fiscal year	PCP Referral Authorization required on extended benefit of services	\$10 per visit
Physical Therapy	Medical Necessity 2 evaluation units per state fiscal year	PCP Referral Authorization required on extended benefit of services	\$10 per visit
Vision Care			
Eye Exam	One (1) routine eye exam (refraction) every 12 months	None	\$10 per visit
Eyeglasses	One (1) pair every 12 months	None	None

*Refer to your Arkansas Medicaid specialty provider manual for prior authorization and PCP referral procedures.

**ARKids First-B beneficiary cost-sharing is capped at 5% of the family's gross annual income.

***ARKids First-B beneficiaries will pay a maximum of \$5.00 per prescription. The beneficiary will pay the provider the amount of co-payment that the provider charges non-Medicaid purchasers up to \$5.00 per prescription.

222.600 Occupational, Physical, and Speech-Language Therapy Benefits

1-1-21

Occupational, physical, and speech-language therapy services are available to beneficiaries in the ARKids First-B program and must be performed by a qualified, Medicaid participating Occupational, Physical, or Speech-Language Therapist. A referral for an occupational, physical, or speech-language therapy evaluation and prescribed treatment must be made by the beneficiary's PCP or attending physician if exempt from the PCP program. All therapy services for ARKids First-B beneficiaries require referrals and prescriptions be made utilizing the "Occupational, Physical and Speech Therapy for Medicaid Eligible Beneficiaries Under Age 21" form DMS-640. [View or print form DMS-640.](#)

Occupational, physical, and speech-language therapy referrals and covered services are further defined in the Physicians and in the Occupational, Physical, and Speech-Language Therapy Provider Manuals. Physicians and therapists must refer to those manuals for additional rules and regulations that apply to occupational, physical, or speech-language therapy services for ARKids First-B beneficiaries.

ARKids First-B has the same occupational, physical, and speech-language therapy services benefits as Arkansas Medicaid, which are found in the procedure codes for therapy services. [View or print the procedure codes for therapy services.](#)

All requests for extended therapy services must comply with the guidelines located within the Occupational, Physical, and Speech-Language Therapy Provider Manual.

262.140 **Speech-Language Pathology, Occupational, and Physical Therapy
Procedure Codes**

262.141 **Occupational, Physical, and Speech-Language Pathology Therapy** **1-1-21**
Procedure Codes

Occupational, physical, and speech-language therapy procedure codes can be found in the following link: [View or print the procedure codes for therapy services.](#)

TOC not required

213.200 Physical Therapy Services Benefits

1-1-21

Refer to the [Occupational, Physical, and Speech-Language Therapy Manual](#) for medically necessary home health physical therapy visits that a beneficiary may receive.

- A. Home health physical therapy must be prescribed by the beneficiary's PCP or authorized attending physician and established on a current home health plan of care.
- B. Home health physical therapy for beneficiaries under the age of 21 is subject to additional documentation requirements; see Sections 218.000 through 218.100 of this manual and Section 214.320 of the [Occupational, Physical, Speech-Language Therapy Services Manual](#) for more information.

TOC required**215.021 Benefit Limit for Occupational, Physical, and Speech-Language Therapies For Beneficiaries 21 Years of Age and Older 1-1-21**

- A. Occupational, physical, and speech-language therapies are subject to the benefit limit of 12 outpatient hospital visits per state fiscal year (SFY), as explained in Section 215.020, for beneficiaries age 21 and over.
 - 1. Outpatient therapy services furnished by acute care hospitals and rehabilitative hospitals are combined when tallying utilization of this benefit.
 - 2. This limit does not apply to eligible Medicaid beneficiaries under the age of 21.
 - 3. Outpatient occupational, physical, and speech-language therapy services for beneficiaries over age 21 require a referral from the beneficiary's primary care physician (PCP) unless the beneficiary is exempt from PCP Program requirements; if exempt from PCP, a referral from their attending physician is required.
- B. For range of benefits, see the following procedure codes: [View or print the procedure codes for therapy services.](#)
- C. All requests for benefit extensions for therapy services for beneficiaries over age 21 must comply with Sections 215.100 through 215.110.

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

Outpatient occupational, physical, and speech-language 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. A prescription for therapy services is valid for the length of time specified by the prescribing physician, up to one year. Providers of therapy services are responsible for obtaining renewed PCP referrals every twelve (12) months. The PCP or attending physician is responsible for determining medical necessity for therapy treatment. Outpatient treatment limits do not apply to eligible Medicaid beneficiaries under the age of 21.

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

- A. For range of benefits, see the following procedure codes: [View or print the procedure codes for therapy services.](#)
- B. All requests for extended therapy services for beneficiaries under age 21 must comply with Sections 218.250 through 218.180.

218.115 Speech-Language Therapy Services For Beneficiaries up to Age 19 In ARKids First – B 1-1-21

Arkansas Medicaid applies speech-language therapy benefits in the ARKids First-B program for children under age 19 as found in the therapy services procedure codes: [View or print the procedure codes for therapy services.](#)

All requests for extended speech-language therapy services for beneficiaries age 18 and under must comply with Sections 218.250 through 218.280.

TOC required**214.800 Occupational, Physical, and Speech-Language Therapy 1-1-21**

- A. Medicaid covers occupational, physical, and speech-language therapy services for eligible beneficiaries under age 21 in the Child Health Services (EPSDT) Program by qualified occupational, physical, or speech-language therapy providers. Therapy services are not covered as nurse practitioner services. The following is provided for the nurse practitioner's information.
- B. Occupational, Physical, and Speech-Language therapies are covered for beneficiaries in the ARKids A and ARKids -B program benefits.
- C. Therapy services for individuals age 21 and older 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.
- D. All therapy services for beneficiaries under age 21 require a referral for evaluation utilizing the form DMS-640 and a separate form DMS-640 for the written prescription from the patient's primary care physician (PCP) or attending physician if the beneficiary is exempt from PCP Managed Care Program requirements. A referral for therapy services must be renewed every twelve (12) months. After the initial referral using the form DMS-640 and initial prescription, utilizing a separate form DMS-640, subsequent referrals and prescriptions for continued therapy may be made at the same time using the same DMS-640. The prescription for treatment is valid for one year unless the prescribing physician specifies a shorter period.
- E. The PCP or attending physician must complete and sign the DMS-640 for beneficiaries under age 21. The PCP or attending physician must initiate a referral and prescription for beneficiaries over age 21. An original signature is required when making a referral or prescribing a therapy service. An electronic signature is acceptable on either document, provided it is in compliance with Arkansas Code 25-31-103. A copy of the prescription must be maintained in the beneficiary's records. The original prescription is to be maintained by the physician. [View or print form DMS-640](#) (for beneficiaries under age 21)
- F. For range of benefits, see the following procedure codes: [View or print the procedure codes for therapy services](#).

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

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

TOC required**227.000 Physical and Speech-Language Therapy Services 1-1-21**

- A. Arkansas Medicaid applies physical and speech-language therapy benefits for beneficiaries of all ages. For range of benefits, see the following procedure codes: [View or print the procedure codes for therapy services](#).
1. Speech-language therapy (individual and group sessions) are payable only to a qualified speech-language therapist.
 2. For beneficiaries under age 21, Arkansas Medicaid will reimburse the physician for make-up therapy sessions in the event a physical therapy session is canceled or missed. Make-up therapy sessions are covered when medically necessary and prescribed by the beneficiary's primary care physician (PCP) or attending physician, if the beneficiary is exempt from PCP Managed Care Program requirements. A new prescription, signed by the PCP, is required for each make-up therapy session.
- B. Extended therapy services may be provided for physical and speech-language therapy services based on medical necessity for Medicaid beneficiaries under age 21. Refer to Sections 229.200 through 229.240 of this manual for procedures for obtaining extended services.
- C. Benefit Extensions may be provided for physical therapy, based on medical necessity, for Medicaid beneficiaries 21 years of age and over when provided within a covered program in accordance with Sections 229.100 through 229.140 of this manual.

292.700 Physical and Speech-Language Therapy Services Billing 1-1-20

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

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

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

TOC required**211.000 Scope 1-1-21**

There are several broad areas of service provision in the Prosthetics manual. Services provided include durable medical equipment, which also encompasses specialized wheelchairs, wheelchair seating systems, specialized rehabilitation equipment and the speech generating device. Other programs covered in the Prosthetics manual include medical supplies, nutritional formulas, diapers and underpads, prosthetic devices and orthotic appliances.

211.800 Electronic Filing of Extension of Benefits 1-1-21

Form DMS-699, titled *Request for Extension of Benefits*, serves as both a request form and a notification of approval or denial of extension of benefits when requesting diapers and underpads for beneficiaries age 3 and older. If the benefit extension is approved, the form returned to the provider will contain a Benefit Extension Control Number. The approval notification will also list the procedure codes approved for benefit extension, the approved dates or date-of-service range and the number of units of service (or dollars, when applicable) authorized.

Upon notification of a benefit extension approval, providers may file the benefit extension claims electronically, entering the assigned Benefit Extension Control Number in the Prior Authorization (PA) number field. Subsequent benefit extension requests to the Utilization Review Section will be necessary only when the Benefit Extension Control Number expires or when a beneficiary's need for services unexpectedly exceeds the amount or number of services granted under the benefit extension.

Form DMS-679A, titled *Prescription and Prior Authorization Request for Medical Equipment Excluding Wheelchairs & Wheelchair Components* serves as a request form when requesting extension of benefits for the speech generating device. The QIO will notify providers of approval or denial by letter.

212.202 (DME) Speech Generating Device (SGD), All Ages 1-1-21

The speech generating device (SGD) is covered for beneficiaries of all ages. Coverage for beneficiaries under 21 years of age must result from an EPSDT screen. There is a \$7,500.00 lifetime benefit for speech generating devices. When a beneficiary who is under age 21 has met the lifetime benefit and it is determined that additional equipment is medically necessary, the provider may request an extension of benefits by submitting form DMS-679A. [View or print form DMS-679A.](#)

The SGD is also covered for Medicaid beneficiaries 21 years old and older. Prior authorization is required on the device and on repairs of the device. For beneficiaries who are age 21 and above, there is a \$7,500.00 lifetime benefit without benefit extensions.

The Arkansas Medicaid Program will not cover SGDs that are prescribed solely for social or educational development.

Training in the use of the device is not included and is not a covered cost.

Prior authorization **must** be requested for repairs of equipment or associated items after the expiration of the initial maintenance agreement.

The following information must be submitted when requesting prior authorization for SGDs for Medicaid beneficiaries.

Submit form DMS-679A, titled *Prescription & Prior Authorization Request for Medical Equipment Excluding Wheelchairs & Wheelchair Components*. [View or print form DMS-679A and instructions for completion.](#) The form should be accompanied by:

- A. A current speech generating device evaluation completed by a multidisciplinary team consisting of, at least, a speech/language pathologist and an occupational therapist. The team may consist of a physical therapist, regular and special educators, caregivers and parents. The speech-language pathologist must lead the team and sign the SGD evaluation report. (For the qualifications of the team members, see the Hospital/Critical Access Hospital/End Stage Renal Disease provider manual.)
 1. The team must use an interdisciplinary approach in the evaluation, incorporating the goals, objectives, skills and knowledge of various disciplines. The team must use at least three SGD systems, with written documentation of each usage included in the SGD assessment.
 2. The evaluation report must indicate the medical reason for the SGD. The report must give specific recommendations of the system and justification of why one system is more appropriate than another system.
 3. The evaluation report must be submitted to the prosthetics provider who will request prior authorization for the SGD.
- B. Written denial from the insurance company if the individual has other insurance.

This information **must** be submitted to the QIO. [View or print QIO contact information.](#)

Benefit Limit

There is a \$7500 lifetime benefit for speech generating devices. When the beneficiary under age 21 has met the limit and it is determined that additional equipment is necessary, the provider may request an extension of benefits.

In order to obtain an extension of the \$7,500.00 lifetime benefit for beneficiaries under 21 years of age, a medical necessity determination for additional equipment is required. The provider must submit a form DMS-679A, a completed Medicaid claim and medical records substantiating medical necessity that the beneficiary cannot function using his or her existing equipment and whether the equipment can be repaired or needs repair. The information must be sent to the QIO. [View or print form DMS-679A titled Prescription & Prior Authorization Request for Medical Equipment Excluding Wheelchairs & Wheelchair Components.](#) [View or print the QIO contact information.](#)

The provider will be notified in writing of the approval or denial of the request for extended benefits.

235.000 **Speech Generating Device Reimbursement for Repairs** 1-1-21

Reimbursement for repairs of speech generating device components will be manufacturer's invoice price for parts plus 10%. Labor will be reimbursed per unit of service (1 unit = 15 minutes limited to a maximum of 20 units per date of service allowed).

242.193 **Speech Generating Device for Beneficiaries of All Ages** 1-1-21

The speech generating device must be billed using the procedure code assigned to each component. The specific components will be reimbursed, as needed, for the procedure codes listed below and will count toward the lifetime limit of \$7,500 per beneficiary.

Procedure codes found in this section must be billed either electronically or on paper with modifier **EP** for beneficiaries under 21 years of age or modifier **NU** for beneficiaries age 21 and over. When a second modifier is listed, that modifier must be used in conjunction with either **EP** or **NU**.

Modifiers in this section are indicated by the headings M1 and M2. Prior authorization requirements are shown under the heading PA. If prior authorization is needed, that information is indicated with a “Y” in the column; if not, an “N” is shown.

NOTE: Attach a manufacturer’s invoice to the claim and indicate the item or parts billed on the invoice. A description and the amount billed for each item must be attached to the claim. If more than one item is billed under a procedure code, the description and billed amount of each item must be listed separately under each procedure code and attached to the claim. The total billed for each procedure code should be reflected in field 24F.

◆ Prior authorization is not required when other insurance pays at least 50% of the Medicaid maximum allowable reimbursement amount.

※(...) This symbol, along with text in parentheses, indicates the Arkansas Medicaid description of the product. When using a procedure code with this symbol, the product must meet the indicated Arkansas Medicaid description.

Speech Generating Device, All Ages (Section 242.193)

National Procedure Code	M1	M2	PA	Description	Payment Method
E2500	NU EP		Y◆	※(Light Technology Communication Aids - communication aids that do not have the memory component to store the information. They are often used in conjunction with higher tech devices as part of a multi-modal communication system.) Speech-generating device, digitized speech, using pre-recorded messages less than or equal to 8 minutes recording time	Purchase
E2502	NU EP		Y◆	※(Simple Voice Output Device - simple devices with limited storage capacity and voice output only.) Speech-generating device, digitized speech, using pre-recorded messages, greater than 8 minutes but less than or equal to 20 minutes recording time	Purchase
E2504	NU EP		Y◆	※(Simple Voice Output Device - simple devices with limited storage capacity and voice output only) Speech-generating device, digitized speech, using pre-recorded messages, greater than 20 minutes but less than or equal to 40 minutes recording time	Purchase
E2506	NU EP		Y◆	※(Simple Voice Output Device - simple devices with limited storage capacity and voice output only) Speech-generating device, digitized speech, using pre-recorded messages, greater than 40 minutes recording time.	Purchase

Speech Generating Device, All Ages (Section 242.193)

National Procedure Code	M1	M2	PA	Description	Payment Method
E2508	NU EP		Y ♦	** (More Advanced Voice Output Communication Aids - offer more storage capacity and often have other output methods in addition to voice output; e.g., LED display) Speech-generating device, synthesized speech, requiring message formulation by spelling and access by physical contact with the device	Purchase
E2510	NU EP		Y ♦	** (Higher Technology Voice Output Communication Aids - offer greater memory capabilities, various types of output, computer interface options, etc.) Speech-generating device synthesized speech, permitting multiple methods of message formulation and multiple methods of device access	Purchase
E2510	NU EP		Y ♦	** (State-of-the-Art Voice Output Communication Aids - represents state-of-the-art communication aid technology. Have extensive memory capabilities, various output methods, computer interface options; offer a variety of input methods in a single device and advanced functions such as auditory scanning, icon and word prediction, etc.) Speech-generating device synthesized speech, permitting multiple methods of message formulation and multiple methods of device access	Purchase
E2511	NU EP		Y ♦	** (Software - often recommended for speech generating device. Software may change as the child matures.) Speech-generating software program, for personal computer or personal digital assistant	Purchase
E2512	NU EP		Y	Accessory for speech generating device, mounting system	Manually Priced
E2599	NU EP		Y ♦	** (Switches - used with training aids and speech generating devices as a means of access) Accessory for speech generating device, not otherwise classified	Manually Priced
V5336	NU EP	RP RP	Y	** (Speech Generating Device Repair - parts only) Repair/modification of speech generating system or device (excludes adaptive hearing aid)	Manually Priced
V5336	NU EP		Y	** (Speech Generating Device Repair - labor only) Repair/modification of speech generating system or device (excludes adaptive hearing aid)	Manually Priced

Note: When repair charges for both parts and labor of the SGD is provided and/or billed on the same date of service, only one detail (parts only or labor only) of procedure code V5336 may be billed per beneficiary per date of service. Information must be specified on the paper claim to clarify the charges billed by the provider. Parts and labor charges must be itemized by narrative and documentation.

- A.** The charge for parts must be clearly documented. A manufacturer's invoice for the parts must be attached.
- B.** The labor charge and the time represented by the labor charge must be clearly documented.

TOC required**214.130 Benefit Limit for Occupational, Physical, and Speech-Language Therapies For Beneficiaries 21 Years of Age and Older 1-1-21**

- A. Occupational, physical, and speech-language therapies are subject to the benefit limit of 12 outpatient hospital visits per state fiscal year (SFY), as explained in Section 214.120, for beneficiaries age 21 and over.
 - 1. Outpatient therapy services, as well as other outpatient services, furnished by acute care hospitals and rehabilitative hospitals are combined when tallying utilization of this benefit.
 - 2. This limit does not apply to eligible Medicaid beneficiaries under the age of 21 (see Sections 216.110 – 216.111).
 - 3. Outpatient occupational, physical, and speech-language therapy services for beneficiaries over age 21 require a referral from the beneficiary's primary care physician (PCP) unless the beneficiary is exempt from PCP Program requirements; if exempt from PCP, a referral from their attending physician is required.
- B. For range of benefits see the following procedure codes: [View or print the procedure codes for therapy services](#).
- C. All requests for benefit extensions for therapy services for beneficiaries over age 21 must comply with Sections 215.120 through 215.130.

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

Outpatient occupational, physical, and speech-language 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. A prescription for therapy services is valid for the length of time specified by the prescribing physician, up to one year. Providers of therapy services are responsible for obtaining renewed PCP referrals every twelve (12) months. The PCP or attending physician is responsible for determining medical necessity for therapy treatment.

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

- A. For range of benefits, see the following procedure codes: [View or print the procedure codes for therapy services](#).
- B. All requests for extended therapy services for beneficiaries under age 21 must comply with Sections 216.112 through 216.116.

216.111 Occupational, Physical, and Speech-Language Therapy Services For Beneficiaries Age 18 and Under In ARKids First – B 1-1-21

Occupational, physical, and speech-language therapy services are covered for beneficiaries in the ARKids First-B program benefits at the same level as the Arkansas Medicaid.

For range of benefits, see the following procedure codes: [View or print the procedure codes for therapy services](#). All requests for extended therapy services must comply with the

guidelines located within the [Occupational, Physical, and Speech-Language Therapy Provider Manual](#).

242.122 Procedure Codes Requiring Modifiers

1-1-21

Treatment and therapy procedure codes may not be billed in conjunction with revenue code T1015. Medicaid reimbursement for a treatment/therapy room is included in the therapy reimbursement. [View or print the procedure codes for therapy services](#).