ARKANSAS REGISTER

Proposed Rule Cover Sheet

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Other Subdivision or Department, If Applicable N/A

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SECTION II - DEVELOPMENTAL ~~REHABILITATION~~ THERAPY SERVICES

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200.000 DEVELOPMENTAL ~~REHABILITATION~~ THERAPY SERVICES GENERAL INFORMATION

201.000 Arkansas Medicaid Participation Requirements for Developmental ~~Rehabilitation~~ Therapy Services ~~12-1-14~~7-1-22

A ~~Developmental Rehabilitation Services~~ provider~~s~~ must meet the following ~~Provider P~~participation ~~and enrollment~~ requirements ~~contained within Section 140.000 of this manual as well as the following criteria to be eligible to participate in~~to qualify as a developmental therapy Service Provider under the Arkansas Medicaid Program:

A. Complete the Provider Participation and enrollment requirements contained within Section 140.000 of the Arkansas Medicaid Provider Manual; and

~~A~~B. ~~Providers must be certified~~ Obtain certification as a~~DDS~~ First Connections Developmental Therapy Service Provider from~~Program participants by~~ the Arkansas Department of Human Services, Division of Developmental Disabilities Services (DDS) ~~to provide early intervention services~~.

~~B. Verification of current certification from DDS must accompany the provider application and the Medicaid contract.~~

201.100 Providers of Developmental ~~Rehabilitation~~ Therapy Services in Arkansas and Bordering States ~~10-13-03~~7-1-22

~~Only p~~Providers of developmental ~~rehabilitation~~ therapy services in Arkansas and within fifty (50) miles of the state line in the six (6) bordering states (Louisiana, Mississippi, Missouri, Oklahoma, Tennessee, and Texas) may be enrolled as ~~**routine services providers**~~ Developmental Therapy Service Providers if they meet all Arkansas Medicaid Program participation requirements ~~outlined above~~.

~~**Routine services providers** may furnish and claim reimbursement for developmental rehabilitation services covered by Arkansas Medicaid. Services are subject to benefit limitations and coverage restrictions set forth in this manual. Claims must be filed according to Section 260.000 of this manual.~~

202.000 ~~Required~~ Developmental Therapy Service Documentation ~~12-1-14~~7-1-22

A. ~~Providers of d~~Developmental ~~rehabilitation~~ Therapy Providers ~~services~~ must ~~establish and~~ maintain records for each client that include sufficient, contemporaneous, written documentation demonstrating the medical necessity of the developmental therapy services provided.

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

~~C. Upon request, providers must furnish records to authorized representatives of the Arkansas Division of Medical Services, state Medicaid Fraud Unit, Office of Medicaid Inspector General (OMIG) and representatives of the U.S. Department of Health and Human Services Centers for Medicare and Medicaid Services (CMS).~~

~~1. Medicaid providers must make available all required records for audit and inspection by the Department of Human Services, or their authorized representatives, during normal business hours.~~

~~2. All records must be kept for a period of five (5) years from the ending date of service or until all audit questions, appeal hearings, investigations or court cases are resolved, whichever is longer. Failure to furnish medical records upon request may result in sanctions being imposed. (See Section I of this manual.)~~

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

B. Service documentation must include the following items:

~~E. Providers of developmental rehabilitation services are required to maintain copies of the following documentation in each child's file.~~

~~1. A written prescription and referral for DDS First Connections early intervention services signed by the child's primary care physician (PCP).~~

~~2. DDS First Connection eligibility verification.~~

~~3. Program Participation Authorization Form signed by the child's parent(s) or legal guardian(s).~~

~~4. A current (within a year) Individual Family Service Plan (IFSP) developed by an interdisciplinary team of professionals, the assigned service coordinator and the parent(s) or guardian(s).~~

~~5. The provider of a service must maintain documentation of the service provided as required by IDEA, Part C. This includes, but is not limited to: the specific service; the length, duration, frequency, intensity and method of the service; the date, times, activities and location where activities were conducted; outcomes or objectives worked on; progress made and recommendations (if appropriate).~~

~~6. Evaluations that meet the requirements of the DDS First Connections Program.~~1. The date and beginning and ending time for each developmental therapy service;

2. The name(s) and credential(s) of the person(s) providing the developmental therapy services;

3. The name(s) of the Parent(s) or caregiver(s) present and participating in the developmental therapy service;

4. The relationship of the developmental therapy service to the goals and objectives described in the client's individual family service plan (IFSP); and

5. Written progress notes signed or initialed by the person(s) providing the developmental therapy service describing the client's status with respect to their IFSP goals and objectives.

202.100 Electronic Signatures ~~10-8-10~~7-1-22

The Arkansas Medicaid Program will accept electronic signatures ~~provided the electronic signatures comply with~~in compliance with Arkansas Code § 25-31-103 et seq.

211.000 Introduction 3-15-12 7-1-22

The Medical Assistance (Arkansas Medicaid) Program is designed to assists eligible Medicaid beneficiaries individuals into obtaining medical care in accordance with in the guidelines specified in Section I of this mManual. All The Arkansas Medicaid benefits are based upon medical necessity. See the Glossary of this manual for the definition of "medical necessity."Program will reimburse enrolled DDS certified First Connections Developmental Therapy Service Providers for medically necessary covered developmental therapy services when such services are provided to an eligible client pursuant to the requirements in this manual.

212.000 Establishing Program EligibilityScope 12-1-14 7-1-22

Part C of the Individuals with Disabilities Education Act (IDEA) requires each state to provide mandated early intervention services. The Arkansas Department of Human Services (DHS) Division of Developmental Disabilities Services (DDS) is the lead agency for the Part C early intervention program in Arkansas. DDS First Connections is the name of the early intervention program.

Arkansas Medicaid's Developmental Rehabilitation Services Program provides coverage for the following DDS First Connections early intervention services that are medically necessary for Medicaid eligible beneficiaries under three years of age:

A. Developmental testing.

B. Therapeutic activities.

Developmental rehabilitation services require a primary care physician (PCP) referral.

212.100 Age Requirement 7-1-22

A client must be under three (3) years of age to receive covered developmental therapy services under the Arkansas Medicaid Program.

212.200 Prescription 7-1-22

Covered developmental therapy services require a written prescription signed and dated by the client's primary care or attending physician or advanced practice registered nurse (APRN) holding a certificate of prescriptive authority.

A. The prescription must identify the client's medical needs and demonstrate the medical necessity for the developmental therapy services.

B. A prescription for developmental therapy services is valid for the shorter of the length of time specified on the prescription or one (1) year.

212.300 Qualifying Diagnosis or Developmental Delay 7-1-22

A. A client must meet one (1) of the following to be eligible to receive covered developmental therapy services:

1. A score on both an age- appropriate standardized norm and criterion referenced developmental evaluation that indicates a developmental delay of twenty-five percent (25%) of the client's chronological age or greater in one (1) or more of the five (5) development domains: motor, social, cognitive, self-help or adaptive, or communication;

2. A written informed clinical opinion from the individual family service plan (IFSP) team that details the specific developmental concern or condition that forms the basis of

the informed clinical opinion. The informed clinical opinion must describe the rationale, contributing factors, and specific developmental evaluation results that indicate the client qualifies for First Connections, including without limitation why developmental evaluations do not clearly reflect the client's functional ability. It must also explain why developmental therapy services are medically necessary to prevent further developmental delay; or

3. A documented developmental diagnosis of a condition that has a high probability of developmental delay, including without limitation:

   i. Down's syndrome and other chromosomal abnormalities associated with intellectual disability;

   ii. Congenital syndromes and conditions associated with delays in development such as fetal alcohol syndrome, intra-uterine drug exposure, prenatal rubella, and severe macrocephaly and microcephaly;

   iii. Metabolic disorders;

   iv. Intra-cranial hemorrhage;

   v. Malignancy or congenital anomaly of brain or spinal cord;

   vi. Spina bifida;

   vii. Seizure disorder, asphyxia, respiratory distress syndrome, neurological disorder, and sensory impairments; and

   viii. Maternal Acquired Immune Deficiency Syndrome.

213.000 **Non-covered Services~~Exclusions~~** ~~12-1-14~~7-1-22

~~The following services are excluded from coverage in this program.~~

A. ~~Services that are not included in the Individualized Family Service Plan (IFSP)~~The Arkansas Medicaid Program will only reimburse for those services listed in Section 214.000. Additionally, the Arkansas Medicaid Program will only reimburse when such services are provided to a Medicaid client meeting the eligibility requirements in Section 212.000 by a DDS First Connections Developmental Therapy Provider meeting all the requirements of this Manual.

B. ~~Services furnished that are not within the scope of practice of the professional performing them or supervising the activity~~Arkansas Medicaid ARKids First-B coverage does not reimburse for developmental therapy services.

~~C. Services for individuals who are not Medicaid eligible.~~

~~D. Services provided in the Developmental Day Treatment Clinic Services (DDTCS) Medicaid Program.~~

~~E. Services provided in the Child Health Management Services (CHMS) Medicaid Program.~~

~~F. Services furnished that are not in compliance with the policies and procedures established by the DDS First Connections Program.~~

~~G. Services that are not provided in the natural environment as defined by the DDS First Connections Program.~~

~~Evaluations that are completed prior to the referral being made to the DDS First Connections Service Coordinator are excluded from coverage in this program.~~

214.000 **Cover~~age~~ed Developmental Therapy Services** ~~3-15-12~~7-1-22

Coverageed of developmental rehabilitation therapy services under the Arkansas Medicaid Program include the following:is limited to two basic services for Medicaid eligible beneficiaries who meet the eligibility requirements. Refer to Section 214.100 for beneficiary eligibility criteria and Sections 214.200 through 214.220 for information on the services covered.

A. Developmental evaluation and individualized family service plan (IFSP) development services; and

B. Developmental Therapeutic activities.

214.100 **Beneficiary EligibilityDevelopmental Evaluation and IFSP Development Services** 3-15-127-1-22

Beneficiaries eligible for these services must meet the following criteria:

A. The beneficiary must be Medicaid eligible and be under three years of age.A Developmental Therapy Provider may be reimbursed by the Arkansas Medicaid Program for medically necessary developmental testing evaluation and IFSP development services.

1. Medical necessity for developmental evaluation and IFSP development services is demonstrated by a written prescription from the client's physician or advanced practice registered nurse (APRN) holding a certificate of prescriptive authority.

2. A Developmental Therapy Provider may not be reimbursed for developmental evaluation and IFSP development services if, within the previous six (6) months, the Arkansas Medicaid Program has reimbursed an Early Intervention Day Treatment Provider for providing EIDT evaluation and treatment planning services to the client. See Section 214.100 of the Early Intervention Day Treatment Medicaid Manual.

B. The beneficiary must have an Individualized Family Service Plan (IFSP) developed by a multidisciplinary team that meets the requirements of Part C of IDEA.Developmental evaluation and IFSP development services include the administration of all necessary diagnostic instruments and tests, interviews, and other information gathering sessions that are required to complete the comprehensive multi-disciplinary developmental evaluation used to determine a client's eligibility for developmental therapy services and develop the client's individualized family service plan.

1. Any evaluation instrument used as part of the comprehensive multi-disciplinary developmental evaluation must be age appropriate and administered by an evaluator with the required qualifications and credentials.

2. Each evaluator must document that they were qualified to administer each evaluation instrument and that the test protocols for each instrument were followed.

C. The beneficiary must have been diagnosed by a multidisciplinary team as having a delay of 25% or more in one or more areas of development (physical, cognitive, communication, social or emotional and adaptive).

OR

The beneficiary must have a diagnosed physical or mental condition that has a high probability of developmental delay. These diagnosed conditions may include but are not limited to:

1. Down's syndrome and other chromosomal abnormalities associated with mental retardation;

2. Congenital syndromes and conditions associated with delays in development such as fetal alcohol syndrome, intra-uterine drug exposure, prenatal rubella, severe macro and microcephaly;

3. Metabolic disorders;

4. Intra-cranial hemorrhage;

5. Malignancy or congenital anomaly of brain or spinal cord;

6. Spina bifida;

7. Seizure disorder, asphyxia, respiratory distress syndrome, neurological disorder, sensory impairments and

8. Maternal Acquired Immune Deficiency Syndrome.Developmental evaluation and IFSP development services must be performed in a Natural Environment setting unless DDS has determined that developmental evaluation and IFSP treatment planning cannot be performed satisfactorily in a Natural Environment setting. A "Natural Environment" setting is any typical home or community setting for a similarly aged infant or toddler without a disability or delay that the client and their family frequent, such as the client's home, neighborhood playground, park, or childcare program the client attends with typically developing peers.

D. Developmental evaluation and IFSP development services must include the participation of one (1) or more Parents, family members, or other caregivers.

E. Developmental evaluation and IFSP development services are reimbursed on a per unit basis. The billable unit includes time spent administering an evaluation, scoring an evaluation, and writing an Evaluation Report along with time spent developing the IFSP with the family and Service Coordinator. **View or print the billable developmental evaluation and IFSP development services codes.**

Field Code Changed

214.200 Developmental ~~Rehabilitation Services~~Therapeutic Activities ~~12-1-14~~7-1-22

~~Developmental rehabilitation services are early intervention services. This program covers two basic services: developmental testing and therapeutic activities. The DDS certified provider must ensure that an individual providing developmental testing services and therapeutic activities services meets the qualifications as outlined in Part C of IDEA and the DDS First Connections services guidelines.~~

~~Developmental rehabilitation services must be provided in the natural environment as defined by the DDS First Connections Program. Natural environments include: in the beneficiary's home, in the community (e.g., day care center) or in a clinical setting (with justification approved by the DDS First Connections Program).~~

~~Refer to Section 260.000 of this manual for billing instructions and procedure codes for services covered in this program.~~A. A Developmental Therapy Provider may be reimbursed by the Arkansas Medicaid Program for medically necessary developmental therapeutic activities. Medical necessity for developmental therapeutic activities is demonstrated by a written prescription from the client's physician or advanced practice registered nurse (APRN) holding a certificate of prescriptive authority.

B. Developmental therapeutic activities must involve providing direct one-on-one instruction to a client, with the Parent or a parent-identified caregiver present and involved. The developmental therapeutic activities must be based on a need identified in the individual family service plan (IFSP).

C. Developmental therapeutic activities must be performed in a Natural Environment setting.

1. A "Natural Environment" is any typical home or community setting for a similarly aged infant or toddler without a disability or delay that the client and their family frequent, such as the client's home, neighborhood playground, park, or childcare program the client attends with typically developing peers.

2. Developmental therapeutic activities may be performed in settings other than Natural Environment only with developmental justification of need approved by DDS that documents the developmental therapeutic activities provided in a Natural Environment setting failed to support the client in reaching IFSP goals and objectives.

D. Developmental therapeutic activities must include the participation of one (1) or more Parents, family members, or other parent-identified caregivers.

E. Developmental therapeutic activities are reimbursed on a per unit basis. **View or print the billable developmental therapeutic activities codes**.

Field Code Changed

~~**214.210 Developmental Testing** 10-13-03~~

~~Developmental testing is a battery of diagnostic tests for the purpose of determining a child's developmental status and need for early intervention services. This may include, but is not limited to, psychological and behavioral developmental profiles. The profiles are required to determine a person's eligibility for services and the development of the Individualized Family Service Plan (IFSP).~~

~~Developmental testing includes two instruments and a narrative report with interpretation.~~

~~Developmental testing is not covered through Developmental Rehabilitation Services if developmental testing has been provided and covered through a DDTCS program or a CHMS program within the last six months.~~

~~**214.220 Therapeutic Activities** 10-13-03~~

~~Therapeutic activities are services that provide direct instruction to a child, or both the parent or caregiver and the child, to promote the child's acquisition of skills in a variety of developmental areas.~~

~~A. Therapeutic activities must be based on an identified need as documented in the IFSP and must be the direct result of the level of delay(s) determined by the inter-disciplinary assessment.~~

~~B. Therapeutic activities **may not** be provided on the same day a Developmental Day Treatment Clinic Services (DDTCS) core service is provided, or on the same day that services are provided in a Child Health Management Services (CHMS) pediatric day program/intervention setting.~~

~~C. Therapeutic activities must include direct one-on-one instruction to the child, or to the child and parent or caregiver.~~

215.000 ~~Benefit Limits~~Individual Family Service Plan (IFSP) ~~3-15-12~~7-1-21

~~Benefit limits are the limits on the *quantity* of covered services Medicaid eligible beneficiaries may receive.~~

A. ~~Developmental testing is limited to a maximum of four (4) one-hour units of service per calendar year.~~Each client receiving developmental therapy services must have an individual family service plan (IFSP). The IFSP is a written, individualized plan to improve the client's condition that must contain, at a minimum:

1. The client's present level of development stated in months with the percentage of client's chronological age delay in each of the five (5) developmental domains, based on professionally acceptable objective criteria;

2. The family's resources, priorities, and concerns related to the development of the client;
3. One (1) or more family outcomes stating what the Parent(s) and family will accomplish;
4. A list of the client's functional outcomes, which must be:
   i. Specific, functional, family-driven;
   ii. Linked to client and family activities and routines; and
   iii. Measurable in a range of months, not to exceed six (6);
5. The action steps that will be taken to reach each functional outcome;
6. The accompanying developmental therapeutic activity service delivery information, which must include:
   i. The location for each developmental therapeutic activity session;
   ii. A schedule of developmental therapeutic activity sessions that includes the frequency and intensity of each developmental therapeutic activity session;
   iii. The name of the Developmental Therapy Service Provider;
   iv. The specific date by which the client will be expected to achieve the outcome tied to the developmental therapeutic activities; and
   v. The funding source for the developmental therapeutic activities;
7. A list of other services that the client or family will need or receive in order to achieve the client's outcomes;
8. The comprehensive multi-disciplinary developmental evaluation results; and
9. The original signature and date signed of all parties participating in an IFSP meeting.

B. ~~Therapeutic activities are limited to a maximum of four (4) 15-minute units of service per week.~~The IFSP must be re-evaluated and updated at least every six (6) months by an interdisciplinary team that includes, at a minimum, the Developmental Therapy Provider, the Service Coordinator, and the client's Parent or /guardian. All parties participating in an IFSP update meeting must sign and date the updated IFSP.

~~**215.100 Extension of Benefits** **12-1-14**~~

~~Providers may request benefit extensions for **medically necessary** services by submitting the appropriate DDS First Connections forms for a benefit extension along with supporting documentation to the DDS First Connections Infant & Toddler Program Developmental Disabilities Services. **View or print DDS First Connections contact information**.~~

~~DDS First Connections Infant & Toddler Program staff is responsible for approval or denial of benefit extension requests. The requesting provider will be notified of approval or denial of the request. The approval notification will list the procedure codes approved for benefit extension, the approved dates or date-of-service range and the number of units of service authorized.~~

~~Providers are to file the claims electronically, entering the assigned control number in the Prior Authorization (PA) number field of the CMS-1500 claim format. Subsequent benefit extension requests will be necessary only when the extension expires or when a beneficiary's need for services unexpectedly exceeds the amount or number of services granted under the benefit extension.~~

~~Providers may obtain the appropriate forms for requesting benefit extensions from the DDS First Connections Service Coordinator or from the DDS First Connections Program in the DDS central office as listed above.~~

~~Refer to Section 262.100 of this manual for a listing of the procedure codes.~~

240.000 PRIOR AUTHORIZATION

241.000 Prior Authorization (PA) Request Procedures 12-1-14

A. Developmental rehabilitation services procedures require prior authorization. The DDS First Connections Program Prior Authorization Unit staff is responsible for the review of and approval or denial of all prior authorization requests.

B. The DDS certified initial or ongoing service coordinator must submit all requests for prior authorization of Developmental Rehabilitation Services to the DDS First Connections Program. **View or print the DDS First Connections contact information**.

C. Each request for prior authorization must be submitted through the DDS First Connections Comprehensive Data System (CDS).

D. For prior authorization approval, the documentation submitted must substantiate the following:

1. Medical necessity for the service requested.
2. Eligibility for the DDS First Connections Program.
3. Needed service(s) determined by a multi-disciplinary team.
4. IFSP completed within the last year.

E. A PA request is processed by the DDS First Connections program staff within 15 working days of the receipt of request.

F. DDS First Connections staff will verify information submitted. A prior authorization (PA) control number will be assigned and the PA number will be entered into the Medicaid system.

G. Notification of the prior authorization approval will be sent to the service provider through the CDS system.

H. The PA control number must be entered on the CMS-1500 claim format when filing claims for reimbursement. Refer to Section 260.000 of this manual for billing instructions and procedure codes.

I. If a PA request is denied, the beneficiary may request a fair hearing. (Refer to Section 242.000)

241.100 Quality Assurance 12-1-14

The DDS First Connections Program staff will review all PA requests. The Individual Family Service Plan (IFSP) will be reviewed and the parent or legal guardian will be contacted to assess successful outcomes for the child and family.

242.000 Appeal Process 12-1-14

When coverage of services or a prior authorization request for services is denied, the beneficiary may request a fair hearing of the denial of services from DDS First Connections Appeals.

The appeal request must be in writing and received by DDS First Connections Appeals within thirty (30) days of the date of the denial notification.

Submit appeal requests to DDS First Connections Appeals. **View or print DDS First Connections Appeals contact information.**

230.000 REIMBURSEMENT

231.000 Method of Reimbursement 7-1-22

A. Developmental therapy services use "fee schedule" reimbursement methodology. Under the fee schedule methodology, reimbursement is made at the lower of the billed charge or the maximum allowable reimbursement for the procedure under the Arkansas Medicaid Program. The maximum allowable reimbursement for a procedure is the same for all Developmental Therapy Service Providers.

B. A full unit of service must be rendered to bill a unit of service.

C. Partial units of service may not be rounded up and are not reimbursable.

232.000 Fee Schedules 7-1-22

The Arkansas Medicaid Program provides fee schedules on the DHS website. **View or print the developmental therapy services fee schedule**. Fee schedules do not address coverage limitations or special instructions applied by the Arkansas Medicaid Program before final payment is determined. Fee schedules and procedure codes do not guarantee payment, coverage, or the reimbursement amount. Fee schedule and procedure code information may be changed or updated at any time to correct a discrepancy or error.

~~250.000 REIMBURSEMENT~~

~~251.000 Method of Reimbursement~~ ~~10-13-03~~

~~The reimbursement methodology for developmental rehabilitation services is a "fee schedule" methodology. Under the fee schedule methodology, reimbursement is based on the lesser of the billed amount or the Title XIX (Medicaid) maximum allowed for each procedure. The maximum allowable fee for a procedure is the same for all Developmental Rehabilitation Services Program providers.~~

~~252.000 Rate Appeal Process~~ ~~10-13-03~~

~~A provider may request reconsideration of a Program decision by writing to the Assistant Director, Division of Medical Services. This request must be received within 20 calendar days following the application of policy and/or procedure or the notification of the provider of its rate. Upon receipt of the request for review the Assistant Director will determine the need for a Program/Provider conference and will contact the provider to arrange a conference if needed. Regardless of the Program decision the provider will be afforded the opportunity for a conference, if he or she so wishes, for a full explanation of the factors involved and the Program decision. Following review of the matter, the Assistant Director will notify the provider of the action to be taken by the division within 20 calendar days of receipt of the request for review or the date of the Program/Provider conference.~~

~~If the decision of the Assistant Director, Division of Medical Services, is unsatisfactory, the provider may then appeal the question to the standing Rate Review Panel established by the Director of the Division of Medical Services. This panel will include one member of the Division of Medical Services, a representative of the provider association and a member of the Department of Human Services Management Staff, who will serve as chairman.~~

~~The request for review by the Rate Review Panel must be postmarked within 15 calendar days following the notification of the initial decision by the Assistant Director, Division of Medical Services. The Rate Review Panel will meet to consider the question(s) within 15 calendar days after receipt of a request for such appeal. The question(s) will be heard by the panel and a recommendation will be submitted to the Director of the Division of Medical Services.~~

260.000 BILLING PROCEDURES

261.000 Introduction to Billing 7-1-20

Developmental Rehabilitation Services Program providers use the CMS-1500 form to bill the Arkansas Medicaid Program on paper for services provided to eligible Medicaid beneficiaries. Each claim may contain charges for only one (1) beneficiary.

Section III of this manual contains information about available options for electronic claim submission.

262.000 CMS-1500 Billing Procedures

262.100 Procedure Codes 10-13-03

The following is a listing of Developmental Rehabilitation Services Program procedure codes. It is imperative to use the Medicaid code listed for the services provided.

Procedure Codes	
96111	97530

262.200 National Place of Service Codes 12-1-14

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

Place of Service	Place of Service Codes
Office	11
Home*	12
Clinic	49
Day Care Center or Other Natural Environment**	99

* Home (12) is defined as a location where the beneficiary receives care in a private residence. This code is appropriate when services are delivered in the child's home, a relative's home or a caregiver's home.

** Other Natural Environment (99) settings are community settings as defined by DDS First Connections.

262.300 Billing Instructions – Paper Only 11-1-17

Bill Medicaid for professional services with form CMS-1500. The numbered items in the following instructions correspond to the numbered fields on the claim form. **View a sample form CMS-1500.**

Carefully follow these instructions to help the Arkansas Medicaid fiscal agent efficiently process claims. Accuracy, completeness, and clarity are essential. Claims cannot be processed if necessary information is omitted.

Forward completed claim forms to the Claims Department. **View or print the Claims Department contact information.**

NOTE: A provider delivering services without verifying beneficiary eligibility for each date of service does so at the risk of not being reimbursed for the services.

262.310 Completion of CMS-1500 Claim Form 9-1-14

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.
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.

Field Name and Number	Instructions for Completion
b. RESERVED	Reserved for NUCC use.
SEX	Not required.
c. RESERVED	Reserved for NUCC use.
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?	Required when an auto accident is related to the services. Check YES or NO.
PLACE (State)	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	Not required.
SEX	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.
13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE	Enter "Signature on File," "SOF" or legal signature.

Field Name and Number	Instructions for Completion
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	Name and title of referral source, whether an individual (such as a PCP) or a clinic or other facility.
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	Identifies additional information about the beneficiary's condition or the claim. Enter the appropriate qualifiers describing the identifier. See **www.nucc.org** for qualifiers.
20. OUTSIDE LAB?	Not required.
$ CHARGES	Not required.

Field Name and Number	Instructions for Completion
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY	Enter the applicable ICD indicator to identify which version of ICD codes is being reported. Use "9" for ICD-9-CM. Use "0" for ICD-10-CM. Enter the indicator between the vertical, dotted lines in the upper right-hand portion of the field. Diagnosis code for the primary medical condition for which services are being billed. Use the appropriate International Classification of Diseases (ICD). 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.
22. RESUBMISSION CODE ORIGINAL REF. NO.	Reserved for future use. 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.
23. PRIOR AUTHORIZATION NUMBER	The prior authorization or benefit extension control number if applicable.
24A. DATE(S) OF SERVICE	The "from" and "to" dates of service for each billed service. Format: MM/DD/YY. 1. On a single claim detail (one charge on one line), bill only for services provided within a single calendar month. 2. Some 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.
C. EMG	Enter "Y" for "Yes" or leave blank if "No." EMG identifies if the service was an emergency.
D. PROCEDURES, SERVICES, OR SUPPLIES	
CPT/HCPCS	One CPT or HCPCS procedure code for each detail.
MODIFIER	Modifier(s) if applicable.

Field Name and Number	Instructions for Completion
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.

262.400 Special Billing Procedures 10-13-03

Not applicable to this program.

FINANCIAL IMPACT STATEMENT

PLEASE ANSWER ALL QUESTIONS COMPLETELY

DEPARTMENT Department of Human Services

DIVISION Division of Developmental Disabilities Services

PERSON COMPLETING THIS STATEMENT Jason Callan

TELEPHONE (501) 320-6540 **FAX** _____ **EMAIL:** Jason.callan@dhs.arkansas.gov

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

SHORT TITLE OF THIS RULE Developmental Therapy Services Medicaid Manual Section II

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

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

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

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

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

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

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

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

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

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

Current Fiscal Year		**Next Fiscal Year**	
General Revenue	$0.00	General Revenue	$0.00
Federal Funds	$0.00	Federal Funds	$0.00
Cash Funds		Cash Funds	
Special Revenue		Special Revenue	

Other (Identify)		Other (Identify)	
Total	$0.00	Total	$0.00

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

Current Fiscal Year		**Next Fiscal Year**	
General Revenue	$0.00	General Revenue	$0.00
Federal Funds	$0.00	Federal Funds	$0.00
Cash Funds		Cash Funds	
Special Revenue		Special Revenue	
Other (Identify)		Other (Identify)	
Total	$ 0.00	Total	$ 0.00

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

Current Fiscal Year	**Next Fiscal Year**
$ 0.00	$ 0.00

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

Current Fiscal Year	**Next Fiscal Year**
$ 0.00	$ 0.00

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

Yes ☐ No ☒

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

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

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

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

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

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

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

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

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

Statement of Necessity and Rule Summary
Section II of Developmental Therapy Services Medicaid Manual

Why is this change necessary? Please provide the circumstances that necessitate the change.

The Division of Developmental Disabilities Services amends the Developmental Therapy Services Medicaid Manual to conform to other division Medicaid manuals and create a clearer and more readable manual. It also aligns the requirements with existing federal regulations under Part C of Individuals with Disabilities Education Act.

What is the change? Please provide a summary of the change.

The proposed rule:

- Changes the name of services from "rehabilitation therapy" to "developmental therapy";
- Reorganizes the manual into sections mirroring other Division of Developmental Disabilities Services Medicaid manuals;
- Updates the table of contents to reflect new document organization;
- Directs that therapeutic activities must include the parent, family member, or other designated care giver;
- Removes billing procedures that are covered in other Medicaid manuals; and
- Provides clarification concerning minimum requirements for:
    - Service documentation;
    - Prescription for developmental therapy services;
    - Qualifying diagnosis or developmental delay criteria; and
    - Individual service plan content.

Please attach additional documents if necessary

NOTICE OF RULE MAKING

The Director of the Division of Developmental Disabilities Services of the Department of Human Services announces for a public comment period of thirty (30) calendar days a notice of rulemaking for the following proposed rule under one or more of the following chapters, subchapters, or sections of the Arkansas Code: §§ 20-76-201, 20-77-107, and 25-10-129.

Effective July 1, 2022:

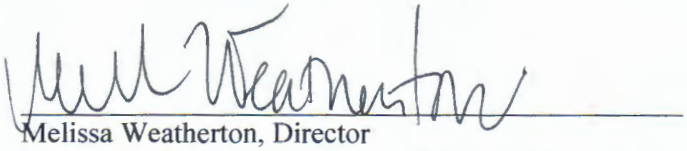
The Director of the Division of Developmental Disabilities Services (DDS) amends Section II of the Developmental Therapy Services Medicaid Manual. DDS changes the term Rehabilitation Therapy to Developmental Therapy, to align with industry language. DDS removes billing procedures that are covered in Section I of all manuals. Also, DDS removes duplicative language including language concerning retention and furnishing records for audit and inspection purposes. The manual changes provide clarification concerning minimum requirements for service documentation, prescriptions for developmental therapy services, qualifying diagnosis or developmental delay criteria, and individual family service plan content. DDS directs that development therapeutic activities must include the parent, family member, or other designated caregiver.

The proposed rule is available for review at the Department of Human Services (DHS) Office of Rules Promulgation, 2nd floor Donaghey Plaza South Building, 7th and Main Streets, P. O. Box 1437, Slot S295, Little Rock, Arkansas 72203-1437. You may also access and download the proposed rule at https://humanservices.arkansas.gov/do-business-with-dhs/proposed-rules/. Public comments must be submitted in writing at the above address or at the following email address: ORP@dhs.arkansas.gov. All public comments must be received by DHS no later than May 09, 2022. Please note that public comments submitted in response to this notice are considered public documents. A public comment, including the commenter's name and any personal information contained within the public comment, will be made publicly available and may be seen by various people.

A public hearing by remote access only through a Zoom webinar will be held on April 28, 2022, at 10:00 a.m. and public comments may be submitted at the hearing. Individuals can access this public hearing at https://us02web.zoom.us/j/82893363038. The webinar ID is 828 9336 3038. If you would like the electronic link, "one-tap" mobile information, listening only dial-in phone numbers, or international phone numbers, please contact ORP at ORP@dhs.arkansas.gov.

If you need this material in a different format, such as large print, contact the Office of Rules Promulgation at 501-396-6428.

The Arkansas Department of Human Services is in compliance with Titles VI and VII of the Civil Rights Act and is operated, managed and delivers services without regard to religion, disability, political affiliation, veteran status, age, race, color or national origin. 4502035775



Melissa Weatherton, Director
Division of Developmental Disabilities Services