Arkansas Department of Human Services
Division of Medical Services
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TO: **Arkansas Medicaid Health Care Providers - Occupational, Physical, Speech Therapy Services**

DATE: **November 1, 2005**

SUBJECT: **Provider Manual Update Transmittal #49**

REMOVE		**INSERT**	
Section	**Date**	**Section**	**Date**
201.000 – 201.100	7-1-05	201.000 – 201.100	11-1-05
216.300	8-15-05	216.300 – 216.315	11-1-05
220.200	4-15-05		
262.400	8-15-05	262.400	11-1-05

Explanation of Updates

Section 201.000: This section contains a change in the wording of one of the provider participation requirements listed and other minor corrections.

Section 201.100: This section contains a change in the wording of one of the provider participation requirements listed.

Section 216.300: The title of this section has been changed to "Procedures for Obtaining Extension of Benefits for Therapy Services." The section contains new instructions that outline the process providers should follow to request an extension of benefits of therapy services for a beneficiary.

Section 216.310: This is a new section titled "Reconsideration of Extension of Benefits Denial." It advises providers of their right to request a reconsideration if their benefit extension request is denied and lists the type of information the Arkansas Foundation for Medical Care, Inc. (AFMC), requires for this review.

Section 216.315: This is a new section titled "Documentation Requirements." It outlines the required documentation to be submitted with providers' requests for extension of benefits for therapy services.

Section 220.200: This section has been deleted because it is no longer applicable.

Section 262.400: This section is included because a section number reference shown in the policy has been updated.

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

If you need this material in an alternative format, such as large print, please contact our Americans with Disabilities Act Coordinator at (501) 682-6789 or 1-877-708-8191. Both telephone numbers are voice and TDD.

If you have questions regarding this transmittal, please contact the EDS Provider Assistance Center at 1-800-457-4454 (toll free) within Arkansas or locally and out of state at (501) 376-2211.

Arkansas Medicaid provider manuals (including update transmittals), official notices and remittance advice (RA) messages are available for downloading from the Arkansas Medicaid website: www.medicaid.state.ar.us.

Thank you for your participation in the Arkansas Medicaid Program.

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Roy Jeffus, Director

SECTION II OCCUPATIONAL, PHYSICAL, SPEECH THERAPY CONTENTS

260.000 BILLING PROCEDURES

201.000 Arkansas Medicaid Participation Requirements 11-1-05

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

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

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

C. The provider must complete and submit to the Medicaid Provider Enrollment Unit a provider application (form DMS-652), a Medicaid contract (form DMS-653) and a Request for Taxpayer Identification Number and Certification (Form W-9). **View or print a provider application (form DMS-652), Medicaid contract (form DMS-653) and Request for Taxpayer Identification Number and Certification (Form W-9).**

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

1. A copy of all certifications and licenses verifying compliance with enrollment criteria for the therapy discipline to be practiced. (See section 202.000 of this manual.)
2. If enrolled in the Title XVIII (Medicare) Program, an out-of-state provider must submit a copy of verification that reflects current enrollment in that program.

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

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

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

201.100 Group Providers of Therapy Services 11-1-05

Group providers of therapy services must meet the following criteria to be eligible for participation in the Arkansas Medicaid Program.

A. In situations where a therapist, a therapy assistant, a speech-language pathologist or a speech-language pathology assistant is a member of a group of therapy service providers, each individual therapist, speech-language pathologist, or assistant **and the group must both enroll.**

1. Each individual in the group must enroll following the participation requirements in section 201.000 and by meeting the enrollment criteria established in section 202.000 for the applicable therapy disciplines.

2. The group must also enroll in the Arkansas Medicaid Program by completing and submitting to the Medicaid Provider Enrollment Unit a provider application (form DMS-652), a Medicaid contract (form DMS-653) and a Request for Taxpayer Identification Number and Certification (Form W-9). **View or print a provider application (form DMS-652), Medicaid contract (form DMS-653) and Request for Taxpayer Identification Number and Certification (Form W-9).**

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

3. The group has the option of enrolling in the Title XVIII (Medicare) program. (See subpart B of section 201.000 of this manual.)

4. The group must also comply with subsequent certifications and license renewals as outlined in section 201.000, subparts F and G.

B. Group providers are “pay to” providers *only*. The service must be performed and billed by the performing licensed and Medicaid-enrolled therapist, speech-language pathologist, therapy assistant or speech-language pathology assistant with the group.

216.300 Procedures for Obtaining Extension of Benefits for Therapy Services 11-1-05

A. Requests for extension of benefits for therapy services for beneficiaries under age 21 must be mailed to the Arkansas Foundation for Medical Care, Inc. (AFMC). **View or print the Arkansas Foundation for Medical Care, Inc., contact information**. A request for extension of benefits must meet the medical necessity requirement, and adequate documentation must be provided to support this request.

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

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

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

216.310 Reconsideration of Extension of Benefits Denial 11-1-05

A request for reconsideration of an extension of benefits denial must be in writing and must include a copy of the denial letter as well as additional supporting documentation. The written reconsideration request must be received by AFMC within 31 calendar days from the next business day following the date of the postmark on the denial notice envelope.

216.315 Documentation Requirements 11-1-05

A. To request an extension of benefits for any benefit-limited service, all applicable records that support the medical necessity of extended benefits are required.

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

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

262.400 Special Billing Procedures 11-1-05

Services may be billed according to the care provided and to the extent each procedure is provided. Occupational, physical and speech therapy services do not require prior authorization.

Extension of benefits may be provided for all therapy services if medically necessary for beneficiaries under age 21. Refer to sections 216.000 through 216.315 of this manual for more information.