Arkansas Department of Health and Human Services

Division of Medical Services

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

DATE: **March 1, 2006**

SUBJECT: **Provider Manual Update Transmittal #55**

REMOVE		**INSERT**	
Section	**Date**	**Section**	**Date**
—	—	214.210	3-1-06
—	—	214.220	3-1-06
—	—	214.230	3-1-06
—	—	214.240	3-1-06
—	—	214.250	3-1-06
—	—	214.260	3-1-06
216.300	11-1-05	216.300	3-1-06
—	—	216.305	3-1-06
216.310	11-1-05	216.310	3-1-06
216.315	11-1-05	216.315	3-1-06
216.320	8-15-05	216.320	3-1-06
262.400	11-1-05	262.400	3-1-06

Explanation of Updates

Sections 214.210 through 214.260 are new sections. They are being added to comply with the Medicaid Fairness Act of 2005 and provide a detailed discussion on how Arkansas Foundation for Medical Care, Inc. conducts retrospective therapy reviews.

Section 216.300 contains a minor change in the wording.

Section 216.305 is a new section number for “Documentation Requirements”.

Section 216.310 is a new section titled “AFMC Extension of Benefits Review Process”. It is included to comply with the Medicaid Fairness Act of 2005. The old section 216.310 has been moved and assigned a new number.

Section 216.315 is a new section number and has been renamed as “Administrative Reconsideration”. The information in this section has been updated to comply with the Medicaid Fairness Act of 2005.

Section 216.320 has been renamed as “Appealing an Adverse Action”. The information in this section has been updated to comply with the Medicaid Fairness Act of 2005.

Section 262.400 is included because a section reference number 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 have already been incorporated.

If you need this material in an alternative format, such as large print, please contact our Americans with Disabilities Act Coordinator at (501) 682-6789 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

214.210 Retrospective Therapy Review Process 3-1-06

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

On a calendar quarterly basis, Arkansas Foundation for Medical Care, Inc. (AFMC) will select and review a percentage random sample of all the therapy services billed and paid during the past three months (previous quarter). The written request for record copies is mailed to each provider along with instructions for mailing of the records. The request asks for the child's parent/guardian name and address and lists the child's name, date of birth, Medicaid identification number, dates of services, type of therapy, date of request and a listing of the documentation required for review. The provider(s) must copy and mail the information to AFMC within 30 calendar days of the request date printed in the record request cover letter. If the requested information is not received within the 30 day timeframe, a medical necessity denial is issued.

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

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

Records will not be accepted via facsimile or email.

214.220 Medical Necessity Review 3-1-06

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

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

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

214.230 Utilization Review 3-1-06

When the billed services are determined to be medically necessary, the nurse reviewer proceeds to the utilization portion of the review. The computer review system lists all claims for services paid during the previous quarter for each beneficiary selected. This listing includes the procedure code and modifier, if required, dates of service billed and units paid. The nurse reviewer compares the paid claims data to the progress notes submitted. The previously mentioned screening guidelines are utilized to verify that the proper procedure code and modifier, if required, were billed, time in/out is documented, a specific description of the therapy services provided, activities rendered during the therapy session and some form of measurement is documented for each daily therapy session along with the providing therapist's signature (full name and credentials). If the documentation submitted supports the billed services, the nurse reviewer approves the utilization portion of the retrospective review. When documentation submitted does not support the billed services, the nurse reviewer refers the services not supported by documentation to an appropriate therapist for further review.

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

214.240 Denial/Due Process 3-1-06

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

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

214.250 Reconsideration Review 3-1-06

See section 216.315 for the deadline requirements to request an administrative reconsideration. If the request is received timely, the appropriate therapist reviews the additional information and determines if the services can be approved. If approved, the therapist reverses the previous denial. If the additional information submitted for reconsideration does not support medical necessity or the paid claims (utilization), the case is referred to a physician adviser for final determination. The therapist provides a written recommendation to the physician adviser.

The physician adviser may approve or deny all or part of the services. A written notification of the outcome of the reconsideration review is mailed to all parties. This notification includes a case specific rationale for upholding or overturning the denial.

All denial letters are available for inspection and approval by the Division of Medical Services (DMS).

214.260 Complaints 3-1-06

The Project Manager will respond in writing to DMS concerning complaints that are a direct result of an AFMC review determination. DMS may use the information provided by AFMC as needed.

216.300 Procedures for Obtaining Extension of Benefits for Therapy Services 3-1-06

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 a benefit is 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.

216.305 Documentation Requirements 3-1-06

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

216.310 AFMC Extension of Benefits Review Process 3-1-06

The following is a step-by-step outline of AFMC's extension of benefits review process:

A. Requests received via mail are screened for completeness and researched to determine the beneficiary's eligibility for Medicaid when the service was provided and to determine if the claim has already been paid.

B. The documentation submitted is reviewed by a nurse. If, in the judgment of the nurse, the documentation supports the medical necessity, he or she may approve the request. An approval letter is computer generated and mailed to the provider the following day.

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

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

E. Providers may request administrative reconsideration of an adverse decision or they can appeal as provided in section 190.003 of this manual.

F. If the denial is because of incomplete documentation, but complete documentation that supports medical necessity is submitted with the reconsideration request, the nurse may approve the extension of benefits without referral to a physician adviser.

G. If the denial is because there is no proof of medical necessity or the documentation does not allow for approval by the nurse, 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.

216.315 Administrative Reconsideration 3-1-06

A request for administrative reconsideration of the denial of services must be in writing and sent to AFMC within 35 calendar days of the denial. The request must include a copy of the denial letter and additional supporting documentation.

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

216.320 Appealing an Adverse Action 3-1-06

Please see section 190.003 for information regarding administrative appeals.

262.400 Special Billing Procedures 3-1-06

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