ARKANSAS DEPARTMENT OF HUMAN SERVICES

Division of Medical Services
Program Planning & Development
P.O. Box 1437, Slot S-295 · Little Rock, AR 72203-1437
501-682-8368 · Fax: 501-682-2480 · TDD: 501-682-6789

TO: **Arkansas Medicaid Health Care Providers-Child Health Management Services**

DATE: **December 1, 2007**

SUBJECT: **Provider Manual Update Transmittal No. 97**

REMOVE		**INSERT**	
Section	**Date**	**Section**	**Date**
217.110	01-01-07	217.110	12-01-07
245.100	11-01-05	245.100	12-01-07
245.200	11-01-05	245.200	12-01-07

Explanation of Updates

Section 217.110 is revised to clarify the definition of prematurity.

Sections 245.100 and 245.200 are revised to instruct how to adjust standardized testing results for prematurity. 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 (TDD only).

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

TOC not required

217.110 Medical Diagnosis Only 12-1-07

A. Listing of Medical Diagnoses

The presence of a significant medical diagnosis may be adequate to identify a child in need of Child Health Management Services. The following, though not a complete list, are examples of diagnoses that may indicate a child in need of care. The current clinical medical records relied upon to substantiate or support the diagnosis that establishes the need for services must accompany all requests for prior authorization or extension of benefits.

AIDS

Cerebral Degeneration

Child Maltreatment Syndrome (abuse or neglect) – must provide documentation of when and what events occurred and evidence of involvement of DHHS in current social situation.

Chronic Renal Failure

CMV

Congenital Heart Disease

Congenital Hypothyroidism

Cystic Fibrosis

Down's Syndrome

Encepholomalacia

Esophageal Atresia

Failure to Thrive – must provide documentation and detailed history, medical evaluation, nutritional evaluation and up-to-date growth chart.

Gastroschisis

HIV – must provide documentation of medical treatments and necessity of daily medical care.

Hydrocephaly with Shunt

Hypopituitarism

Hypoxic Hemmorraghic Encephalopathy

Lead Poisoning – must document lead level and extent of injury

Macrocephaly – must have documented head circumference on growth chart and medical evaluation with results of MRI, CT, etc.

Metabolic Disorder

Microcephaly – must have documented head circumference on growth chart and medical evaluation with results of MRI, CT, etc.

Neuroblastoma

Newborn Intraventricular Hemorrhage – document degree of hemorrhage

Periventricular Leukomalacia

Prematurity (less than 37 weeks gestation) – must include documentation of neonatal course and any additional significant medical problems for a child less than 12 months of age.

Prenatal Drug/Alcohol Exposure – documentation of extent of exposure and medical effects of exposure.

Seizure Disorder – does not include febrile seizures. Documentation to include medications, type and frequency of seizures.

Sickle Cell Disease – documentation of actual disease, not trait. Documentation should include history of treatment for the disease.

Spina Bifida

Tracheomalacia

Tuberous Sclerosis and Other Neurodermatoses

Various Syndromes/Severity Determined by Physician

B. Mechanism for Establishing Need for Care (Medical Only)

A medical diagnosis alone will not adequately document the necessity for CHMS. Documentation must include a complete medical evaluation by a pediatrician or pediatric specialist to include a history and physical. There must be documentation to support the need for ongoing intervention by a medical multi-disciplinary diagnosis and treatment team within a CHMS clinic.

245.100 Occupational and Physical Therapy Guidelines for Retrospective Review 12-1-07

A. Occupational and physical therapy services are medically prescribed services for the diagnosis and treatment of movement dysfunction that results in functional disabilities.

Occupational and physical therapy services must be medically necessary for the treatment of the individual's illness or injury. To be considered medically necessary, the following conditions must be met:

1. The service must be considered under accepted standards of practice to be a specific and effective treatment for the patient's condition.
2. The service must be of such a level of complexity or the patient's condition must be such that the services required can be safely and effectively performed only by or under the supervision of a qualified physical or occupational therapist.
3. There must be reasonable expectation that therapy will result in a meaningful improvement or a reasonable expectation that therapy will prevent a worsening of the condition. (See the medical necessity definition in the Glossary of this manual.)

A diagnosis alone is not sufficient documentation to support the medical necessity of therapy. Assessment for physical and/or occupational therapy includes a comprehensive evaluation of the patient's physical deficits and functional limitations, treatment planned and goals to address each identified problem.

B. Evaluations:

In order to determine that therapy services are medically necessary, an annual evaluation must contain the following:

1. Date of evaluation.
2. Child's name and date of birth.
3. Diagnosis applicable to specific therapy.
4. Background information including pertinent medical history and gestational age.
5. Standardized test results, including all subtest scores, if applicable. Test results, if applicable, should be adjusted for prematurity (less than 37 weeks gestation) if the child is 12 months of age or younger. The test results should be noted in the evaluation.
6. Objective information describing the child's gross/fine motor abilities/deficits, e.g., range of motion measurements, manual muscle testing, muscle tone or a narrative description of the child's functional mobility skills.
7. Assessment of the results of the evaluation, including recommendations for frequency and intensity of treatment.
8. Signature and credentials of the therapist performing the evaluation.

C. Standardized Testing:

1. Tests used must be norm-referenced, standardized tests specific to the therapy provided.
2. Tests must be age appropriate for the child being tested.
3. Test results must be reported as standard scores, Z scores, T scores or percentiles. Age equivalent scores and percentage of delay cannot be used to qualify for services.
4. A score of -1.50 standard deviations or more from the mean in at least one subtest area or composite score is required to qualify for services.
5. If the child cannot be tested with a norm-referenced, standardized test, criterion-based testing or a functional description of the child's gross/fine motor deficits may be used. Documentation of the reason why a standardized test could not be used must be included in the evaluation.
6. The Mental Measurement Yearbook (MMY) is the standard reference to determine reliability and validity.

Refer to sections 245.110 and 245.120 for a list of standardized tests accepted by the Arkansas Foundation for Medical Care, Inc. (AFMC) for retrospective review.

D. Other Objective Tests and Measures:

1. Range of Motion: A limitation of greater than ten degrees and/or documentation of how deficit limits function.
2. Muscle Tone: Modified Ashworth Scale.
3. Manual Muscle Test: A deficit is a muscle strength grade of fair (3/5) or below that impedes functional skills. With increased muscle tone, as in cerebral palsy, testing is unreliable.
4. Transfer Skills: Documented as amount of assistance required to perform transfer, i.e., maximum, moderate, minimal assistance. A deficit is defined as the inability to perform a transfer safely and independently.

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

Frequency, intensity and duration of therapy services should always be medically necessary and realistic for the age of the child and the severity of the deficit or

disorder. Therapy is indicated if improvement will occur as a direct result of these services and if there is a potential for improvement in the form of functional gain.

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

F. Progress Notes:

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

245.200 Speech-Language Therapy Guidelines for Retrospective Review 12-1-07

A. Speech-language therapy services must be medically necessary for the treatment of the individual's illness or injury. 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 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.)

A diagnosis alone is not sufficient documentation to support the medical necessity of therapy. Assessment for speech-language therapy includes a comprehensive

evaluation of the patient's speech language deficits and functional limitations, treatment planned and goals to address each identified problem.

B. Evaluations:

In order to determine that speech-language therapy services are medically necessary, an evaluation must contain the following information:

1. Date of evaluation.
2. Child's name and date of birth.
3. Diagnosis specific to therapy
4. Background information including pertinent medical history and gestational age.
5. Standardized test results, including all subtest scores, if applicable. Test results, if applicable, should be adjusted for prematurity (less than 37 weeks gestation) if the child is 12 months old or younger and this should be noted in the evaluation.
6. An assessment of the results of the evaluation including recommendations for frequency and intensity of treatment.
7. The child should be tested in his or her native language; if not, an explanation must be provided in the evaluation.
8. Signature and credentials of the therapist performing the evaluation.

C. Feeding/Swallowing/Oral Motor:

1. Can be formally or informally assessed.
2. Must have in-depth functional profile on oral motor structures and function. An in-depth functional profile of oral motor structure and function is a description of a child's oral motor structure that specifically notes how such structure is impaired in its function and justifies the medical necessity of feeding/swallowing/oral motor therapy services. Standardized forms are available for the completion of an in-depth functional profile of oral motor structure and function, but a standardized form is not required.

D. Voice

A medical evaluation is a prerequisite for voice therapy.

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 entry with a full signature and credentials.
8. Graduate students must have the supervising speech-language pathologist co-sign progress notes.

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

DATE: **December 1, 2007**

SUBJECT: **Provider Manual Update Transmittal No. 89**

REMOVE		**INSERT**	
Section	**Date**	**Section**	**Date**
214.300	06-01-06	214.300	12-01-07
214.400	11-01-05	214.400	12-01-07

Explanation of Updates

Sections 214.300 and 214.400 are revised to clarify the definition of prematurity.

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 (TDD only).

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.

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Thank you for your participation in the Arkansas Medicaid Program.

Roy Jeffus, Director

TOC not required

214.300 Occupational and Physical Therapy Guidelines for Retrospective Review 12-1-07

A. Occupational and physical therapy services are medically prescribed services for the diagnosis and treatment of movement dysfunction, which results in functional disabilities.

Occupational and physical therapy services must be medically necessary to the treatment of the individual's illness or injury. To be considered medically necessary, the following conditions must be met:

1 The services must be considered under accepted standards of practice to be a specific and effective treatment for the patient's condition.

2. The services must be of such a level of complexity or the patient's condition must be such that the services required can be safely and effectively performed only by or under the supervision of a qualified physical or occupational therapist.

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

A diagnosis alone is not sufficient documentation to support the medical necessity of therapy. Assessment for physical and/or occupational therapy includes a comprehensive evaluation of the patient's physical deficits and functional limitations, treatment planned and goals to address each identified problem.

B. Evaluations:

In order to determine that therapy services are medically necessary, an annual evaluation must contain the following information:

1. Date of evaluation.
2. Child's name and date of birth.
3. Diagnosis applicable to specific therapy.
4. Background information including pertinent medical history and gestational age.
5. Standardized test results, including all subtest scores, if applicable. Test results, if applicable, should be adjusted for prematurity (less than 37 weeks gestation) if the child is 12 months of age or younger. The test results should be noted in the evaluation.
6. Objective information describing the child's gross/fine motor abilities/deficits, e.g., range of motion measurements, manual muscle testing, muscle tone or a narrative description of the child's functional mobility skills.
7. Assessment of the results of the evaluation including recommendations for frequency and intensity of treatment.
8. Signature and credentials of the therapist performing the evaluation.
9. Non-school age children must be evaluated annually.
10. School-age children must have a full evaluation every three years (a yearly update is required) if therapy is school related; outside of school, annual evaluations are required. "School related" means the child is of school age, attends public school and receives therapy provided by the school.

C. Standardized Testing:

1. Test used must be norm referenced, standardized and specific to the therapy provided.
2. Test must be age appropriate for the child being tested.
3. Test results must be reported as standard scores, Z scores, T scores or percentiles. Age-equivalent scores and percentage of delay cannot be used to qualify for services.
4. A score of -1.50 standard deviations or more from the mean in at least one subtest area or composite score is required to qualify for services.
5. If the child cannot be tested with a norm-referenced, standardized test, criterion-based testing or a functional description of the child's gross/fine motor deficits may be used. Documentation of the reason a standardized test could not be used must be included in the evaluation.
6. The Mental Measurement Yearbook (MMY) is the standard reference to determine reliability/validity. Refer to sections 214.310 and 214.320 for a list of standardized tests accepted by the Arkansas Foundation for Medical Care, Inc. (AFMC), for retrospective reviews.

D. Other Objective Tests and Measures:

1. Range of Motion: A limitation of greater than ten degrees and/or documentation of how a deficit limits function.
2. Muscle Tone: Modified Ashworth Scale.
3. Manual Muscle Test: A deficit is a muscle strength grade of fair (3/5) or below that impedes functional skills. With increased muscle tone, as in cerebral palsy, testing is unreliable.
4. Transfer Skills: Documented as the amount of assistance required to perform transfer, i.e., maximum, moderate, or minimal assistance. A deficit is defined as the inability to perform a transfer safely and independently.

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

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

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

should be discontinued and monitoring or establishment of a home program should be implemented.

F. Progress Notes:

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

214.400 Speech-Language Therapy Guidelines for Retrospective Review 12-1-07

A. Speech-language therapy services must be medically necessary to the treatment of the individual's illness or injury. 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.)

A diagnosis alone is not sufficient documentation to support the medical necessity of therapy. Assessment for speech-language therapy includes a comprehensive evaluation of the patient's speech language deficits and functional limitations, treatment planned and goals to address each identified problem.

B. Evaluations:

In order to determine that speech-language therapy services are medically necessary, an evaluation must contain the following information:

1. Date of evaluation.
2. Child's name and date of birth.
3. Diagnosis specific to therapy.
4. Background information including pertinent medical history and gestational age.
5. Standardized test results, including all subtest scores, if applicable. Test results, if applicable, 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.
6. An assessment of the results of the evaluation including recommendations for frequency and intensity of treatment.

7. The child should be tested in his or her native language; if not, an explanation must be provided in the evaluation.
8. Signature and credentials of the therapist performing the evaluation.

C. Feeding/Swallowing/Oral Motor:

1. Can be formally or informally assessed.
2. Must have an in-depth functional profile on oral motor structures and function. An in-depth functional profile of oral motor structure and function is a description of a child's oral motor structure that specifically notes how such structure is impaired in its function and justifies the medical necessity of feeding/swallowing/oral motor therapy services. Standardized forms are available for the completion of an in-depth functional profile of oral motor structure and function, but a standardized form is not required.
3. If swallowing problems and/or signs of aspiration are noted, then a formal medical swallow study must be submitted.

D. Voice:

A medical evaluation is a prerequisite to voice therapy.

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 entry with a full signature and credentials.
8. Graduate students must have the supervising speech-language pathologist co-sign progress notes.

ARKANSAS DEPARTMENT OF HUMAN SERVICES

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Program Planning & Development

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TO: **Arkansas Medicaid Health Care Providers-Developmental Day Treatment Clinic Services**

DATE: **December 1, 2007**

SUBJECT: **Provider Manual Update Transmittal No. 99**

REMOVE		**INSERT**	
Section	**Date**	**Section**	**Date**
220.100	11-01-05	220.100	12-01-07
220.200	11-01-05	220.200	12-01-07

Explanation of Updates

Sections 220.100 and 220.200 are revised to clarify the definition of prematurity.

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.

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Roy Jeffus, Director

TOC not required

220.100 Occupational and Physical Therapy Guidelines for Retrospective Review 12-1-07

A. Occupational and physical therapy services are medically prescribed services for the diagnosis and treatment of movement dysfunction, which results in functional disabilities.

Occupational and physical therapy services must be medically necessary for the treatment of the individual's illness or injury. To be considered medically necessary, the following conditions must be met:

1. The services must be considered under accepted standards of practice to be a specific and effective treatment for the patient's condition.
2. The services must be of such a level of complexity or the patient's condition must be such that the services required can be safely and effectively performed only by or under the supervision of a qualified physical or occupational therapist.
3. There must be reasonable expectation that therapy will result in a meaningful improvement or a reasonable expectation that therapy will prevent a worsening of the condition (See the *medical necessity* definition in the Glossary of this manual).

A diagnosis alone is not sufficient documentation to support the medical necessity of therapy. Assessment for physical and/or occupational therapy includes a comprehensive evaluation of the patient's physical deficits and functional limitations, treatment planned and goals to address each identified problem.

B. Evaluations:

In order to determine that therapy services are medically necessary, an annual evaluation must contain the following:

1. Date of evaluation.
2. Child's name and date of birth.
3. Diagnosis applicable to specific therapy.
4. Background information including pertinent medical history and gestational age.
5. Standardized test results, including all subtest scores, if applicable. Test results, if applicable, should be adjusted for prematurity (less than 37 weeks gestation) if the child is 12 months of age or younger. The test results should be noted in the evaluation.
6. Objective information describing the child's gross/fine motor abilities/deficits, e.g., range of motion measurements, manual muscle testing, muscle tone or a narrative description of the child's functional mobility skills.
7. Assessment of the results of the evaluation, including recommendations for frequency and intensity of treatment.
8. Signature and credentials of the therapist performing the evaluation.

C. Standardized Testing:

1. Tests used must be norm-referenced, standardized tests specific to the therapy provided.
2. Tests must be age appropriate for the child being tested.

3. Test results must be reported as standard scores, Z scores, T scores or percentiles. Age equivalent scores and percentage of delay cannot be used to qualify for services.
4. A score of -1.5 standard deviations or more from the mean in at least one subtest area or composite score is required to qualify for services.
5. If the child cannot be tested with a norm-referenced standardized test, criterion-based testing or a functional description of the child's gross/fine motor deficits may be used. Documentation of the reason why a standardized test could not be used must be included in the evaluation.
6. The Mental Measurement Yearbook (MMY) is the standard reference to determine reliability and validity.

   Refer to sections 220.110 and 220.120 for a list of standardized tests accepted by AFMC for retrospective reviews of occupational and physical therapy services.

D. Other Objective Tests and Measures:

1. Range of Motion: A limitation of greater than ten degrees and/or documentation of how deficit limits function.
2. Muscle Tone: Modified Ashworth Scale.
3. Manual Muscle Test: A deficit is a muscle strength grade of fair (3/5) or below that impedes functional skills. With increased muscle tone, as in cerebral palsy, testing is unreliable.
4. Transfer Skills: Documented as amount of assistance required to perform transfer, e.g., maximum, moderate or minimal assistance. A deficit is defined as the inability to perform a transfer safely and independently.

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

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

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

F. Progress Notes:

1. Child's name.

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

220.200 Speech-Language Therapy Guidelines for Retrospective Review 12-1-07

A. Speech-language therapy services must be medically necessary for the treatment of the individual's illness or injury. 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 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).

A diagnosis alone is not sufficient documentation to support the medical necessity of therapy. Assessment for speech-language therapy includes a comprehensive evaluation of the patient's speech language deficits and functional limitations, treatment planned and goals to address each identified problem.

B. Evaluations:

In order to determine that speech-language therapy services are medically necessary, an evaluation must contain the following information:

1. Date of evaluation.
2. Child's name and date of birth.
3. Diagnosis specific to therapy.
4. Background information including pertinent medical history and gestational age.
5. Standardized test results, including all subtest scores, if applicable. Test results should be adjusted for prematurity (less than 37 weeks gestation) if the child is age 12 months or younger, and this should be noted in the evaluation.
6. An assessment of the results of the evaluation, including recommendations for frequency and intensity of treatment.
7. The child should be tested in his or her native language; if not, an explanation must be provided in the evaluation.
8. Signature and credentials of the therapist performing the evaluation.

C. Feeding/Swallowing/Oral Motor:

1. Can be formally or informally assessed.
2. Must have an in-depth functional profile on oral motor structures and function. This profile is a description of a child's oral motor structure that specifically notes how the structure is impaired and justifies the medical necessity of feeding/swallowing/oral motor therapy services. Standardized forms are available for the completion of an in-depth functional profile of oral motor structure and function, but a standardized form is not required.
3. If swallowing problems and/or signs of aspiration are noted, a formal medical swallow study must be submitted.

D. Voice

A medical evaluation is a prerequisite for voice therapy.

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 entry with a full signature and credentials.
8. Graduate students must have the supervising SLP co-sign progress notes.

ARKANSAS DEPARTMENT OF HUMAN SERVICES

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TO: **Arkansas Medicaid Health Care Providers-Hospital/CAH/End-Stage Renal Disease**

DATE: **December 1, 2007**

SUBJECT: **Provider Manual Update Transmittal No. 128**

REMOVE		**INSERT**	
Section	**Date**	**Section**	**Date**
218.101	11-01-05	218.101	12-01-07
218.202	11-01-05	218.202	12-01-07

Explanation of Updates

Sections 218.101 and 218.202 are revised to clarify the definition of prematurity.

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Roy Jeffus, Director

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TO: **Arkansas Medicaid Health Care Providers-Physician/Independent Laboratory/CRNA/Radiation Therapy Center**

DATE: **December 1, 2007**

SUBJECT: **Provider Manual Update Transmittal No. 144**

REMOVE		**INSERT**	
Section	**Date**	**Section**	**Date**
227.200	11-01-05	227.200	12-01-07
227.300	11-01-05	227.300	12-01-07

Explanation of Updates

Sections 227.200 and 227.300 are revised to clarify the definition of prematurity.

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Roy Jeffus, Director

TOC not required

227.200 Occupational and Physical Therapy Guidelines for Retrospective Review 12-1-07

A. Occupational and physical therapy services are medically prescribed services for the diagnosis and treatment of movement dysfunction, which results in functional disabilities.

Occupational and physical therapy services must be medically necessary to the treatment of the individual's illness or injury. To be considered medically necessary, the following conditions must be met:

1. The services must be considered under accepted standards of practice to be a specific and effective treatment for the patient's condition.
2. The services must be of such a level of complexity, or the patient's condition must be such that the services required can be safely and effectively performed only by or under the supervision of a qualified physical or occupational therapist.
3. There must be reasonable expectation that therapy will result in a meaningful improvement or a reasonable expectation that therapy will prevent a worsening of the condition (See medical necessity definition in the Glossary of this manual.)

A diagnosis alone is not sufficient documentation to support the medical necessity of therapy. Assessment for physical and/or occupational therapy includes a comprehensive evaluation of the patient's physical deficits and functional limitations, treatment planned and goals to address each identified problem.

B. Evaluations:

In order to determine that therapy services are medically necessary, an annual evaluation must contain the following:

1. Date of evaluation.
2. Child's name and date of birth.
3. Diagnosis applicable to specific therapy.
4. Background information including pertinent medical history and gestational age.
5. Standardized test results, including all subtest scores, if applicable. Test results, if applicable, should be adjusted for prematurity (less than 37 weeks gestation) if the child is 12 months of age or younger. The test results should be noted in the evaluation.
6. Objective information describing the child's gross/fine motor abilities/deficits, e.g., range of motion measurements, manual muscle testing, muscle tone or a narrative description of the child's functional mobility skills.
7. Assessment of the results of the evaluation, including recommendations for frequency and intensity of treatment.
8. Signature and credentials of the therapist performing the evaluation.

C. Standardized Testing:

1. Tests used must be norm-referenced, standardized tests specific to the therapy provided.
2. Tests must be age appropriate for the child being tested.

3. Test results must be reported as standard scores, Z scores, T scores or percentiles. Age equivalent scores and percentage of delay cannot be used to qualify for services.
4. A score of -1.5 standard deviations or more from the mean in at least one subtest area or composite score is required to qualify for services.
5. If the child cannot be tested with a norm-referenced standardized test, criterion-based testing or a functional description of the child's gross/fine motor deficits may be used. Documentation of the reason why a standardized test could not be used must be included in the evaluation.
6. The Mental Measurement Yearbook (MMY) is the standard reference to determine reliability and validity. Refer to sections 227.210 and 227.220 for a list of standardized tests recognized by the Arkansas Foundation for Medical Care, Inc. (AFMC) for retrospective reviews.

D. Other Objective Tests and Measures:

1. Range of Motion: A limitation of greater than ten degrees and/or documentation of how deficit limits function.
2. Muscle Tone: Modified Ashworth Scale.
3. Manual Muscle Test: A deficit is a muscle strength grade of fair (3/5) or below that impedes functional skills. With increased muscle tone, as in cerebral palsy, testing is unreliable.
4. Transfer Skills: Documented as amount of assistance required to perform transfer, e.g., maximum, moderate, or minimal assistance. A deficit is defined as the inability to perform a transfer safely and independently.

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

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

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

F. Progress Notes:

1. Child's name.
2. Date of service.

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

227.300 Speech-Language Therapy Guidelines for Retrospective Review 12-1-07

A. Speech-language therapy services must be medically necessary to the treatment of the individual's illness or injury. 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 reasonable expectation that therapy will result in meaningful improvement or a reasonable expectation that therapy will prevent a worsening of the condition. (See medical necessity definition in the Glossary of the Arkansas Medicaid manual.)

A diagnosis alone is not sufficient documentation to support the medical necessity of therapy. Assessment for speech-language therapy includes a comprehensive evaluation of the patient's speech language deficits and functional limitations, treatment planned and goals to address each identified problem.

B. Evaluations:

In order to determine that speech-language therapy services are medically necessary, an evaluation must contain the following information:

1. Date of evaluation.
2. Child's name and date of birth.
3. Diagnosis specific to therapy.
4. Background information including pertinent medical history and gestational age.
5. Standardized test results, including all subtest scores, 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.
6. An assessment of the results of the evaluation, including recommendations for frequency and intensity of treatment.
7. The child should be tested in their native language; if not, an explanation must be provided in the evaluation.
8. Signature and credentials of the therapist performing the evaluation.

C. Feeding/Swallowing/Oral Motor:

1. Can be formally or informally assessed.

2. Must have an in-depth functional profile on oral motor structures and function. An in-depth functional profile of oral motor structure and function is a description of a child's oral motor structure that specifically notes how such structure is impaired in its function and justifies the medical necessity of feeding/swallowing/oral motor therapy services. Standardized forms are available for the completion of an in-depth functional profile of oral motor structure and function, but a standardized form is not required.
3. If swallowing problems and/or signs of aspiration are noted, a formal medical swallow study must be submitted.

D. Voice:

A medical evaluation is a prerequisite to voice therapy.

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 entry with a full signature and credentials.

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TO: **Arkansas Medicaid Health Care Providers-Rehabilitative Hospital**

DATE: **December 1, 2007**

SUBJECT: **Provider Manual Update Transmittal No. 91**

REMOVE		**INSERT**	
Section	**Date**	**Section**	**Date**
216.101	11-01-05	216.101	12-01-07
216.202	11-01-05	216.202	12-01-07

Explanation of Updates

Sections 216.101 and 216.202 are revised to clarify the definition of prematurity.

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Roy Jeffus, Director

TOC not required

216.101 Documenting Evaluations 12-1-07

Documentation of an annual evaluation must contain the following:

A. Date of evaluation

B. Patient's name and date of birth

C. Diagnosis applicable to specific therapy

D. Background information including pertinent medical history (and gestational age when applicable)

E. Standardized test results, including all subtest scores, when applicable

F. Test results adjusted for prematurity (less than 37 weeks gestation), when applicable, when the child is less than 12 months of age or younger

G. Objective information describing the child's gross/fine motor abilities/deficits, e.g., range of motion measurements, manual muscle testing, muscle tone or a narrative description of the patient's functional mobility skills.

H. Assessment of the results of the evaluation, including recommendations for frequency and intensity of treatment.

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

216.202 Documenting Evaluations 12-1-07

Documentation of a speech-language evaluation must include the following information:

A. Patient's name and date of birth

B. Diagnosis specific to therapy

C. Background information including pertinent medical history and gestational age

D. Standardized test results, including all subtest scores when applicable

E. Adjustment of test results for prematurity (less than 37 weeks gestation), when applicable, when the child is 12 months of age or younger

F. An assessment of the results of the evaluation, including recommendations for frequency and intensity of treatment

G. An explanation why the child was not tested in his or her native language, when such is the case

H. Signature and credentials of the therapist performing the evaluation

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TO: **Arkansas Medicaid Health Care Providers-Rehabilitative Services for Persons with Mental Illness**

DATE: **December 1, 2007**

SUBJECT: **Provider Manual Update Transmittal No. 92**

REMOVE		**INSERT**	
Section	**Date**	**Section**	**Date**
228.411	11-01-05	228.411	12-01-07

Explanation of Updates

Section 228.411 is revised to clarify the definition of prematurity.

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Roy Jeffus, Director

228.411 Evaluations 12-1-07

In order to determine that speech-language therapy services are medically necessary, an evaluation must contain the following information:

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 gestational age

E. Standardized test results, including all subtest scores, if applicable. Test results, if applicable, 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

F. An assessment of the results of the evaluation, including recommendations for frequency and intensity of treatment

G. An explanation why the child was not tested in his or her native language, when such is the case

H. Signature and credentials of the therapist performing the evaluation

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TO: **Arkansas Medicaid Health Care Providers-Home Health**

DATE: **December 1, 2007**

SUBJECT: **Provider Manual Update Transmittal No. 106**

REMOVE		**INSERT**	
Section	**Date**	**Section**	**Date**
218.110	11-01-05	218.110	12-01-07

Explanation of Updates

Sections 218.110 is revised to clarify the definition of prematurity.

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Roy Jeffus, Director

TOC not required

218.110 Retrospective Review of Physical Therapy Evaluations for Beneficiaries Under the Age of 21 12-01-07

A physical therapy evaluation must contain:

A. The date of evaluation.

B. The patient's name and date of birth.

C. The diagnosis or diagnoses specifically applicable to the proposed therapy.

D. Background information, including pertinent medical history.

E. Standardized test results, including all subtest scores, if applicable. Test results, if applicable, should be adjusted for prematurity (less than 37 weeks gestation) if the patient is a child 12 months of age or younger. The test results must be noted in the evaluation.

F. Objective information describing the patient's gross and fine motor abilities and deficits, which shall include range of motion measurements, manual muscle testing results and a narrative description of the patient's functional mobility skills.

G. An assessment of the results of the evaluation, including recommendations for frequency and intensity of treatment.

H. The signature and credentials of the qualified physical therapist or physician performing the evaluation.

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TO: **Arkansas Medicaid Health Care Providers-Nurse Practitioner**

DATE: **December 1, 2007**

SUBJECT: **Provider Manual Update Transmittal No. 87**

REMOVE		**INSERT**	
Section	**Date**	**Section**	**Date**
214.812	03-1-05	214.812	12-01-07

Explanation of Updates

Section 214.812 is revised to clarify the definition of prematurity.

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Roy Jeffus, Director

TOC not required

214.812 Speech-Language Therapy Retrospective Review Guidelines 12-1-07

A. Speech-language therapy services must be medically necessary to the treatment of the individual's illness or injury. 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 reasonable expectation that therapy will result in meaningful improvement or a reasonable expectation that therapy will prevent a worsening of the condition. (See medical necessity in glossary of the Arkansas Medicaid manual.)

A diagnosis alone is not sufficient documentation to support the medical necessity of therapy. Assessment for speech-language therapy includes a comprehensive evaluation of the patient's speech language deficits and functional limitations, treatment planned and goals to address each identified problem.

B. Evaluations:

In order to determine that speech-language therapy services are medically necessary, an evaluation must contain the following information:

1. Date of evaluation.
2. Child's name and date of birth.
3. Diagnosis specific to therapy.
4. Background information including pertinent medical history and gestational age.
5. Standardized test results, including all subtest scores, if applicable. Test results, if applicable, should be adjusted for prematurity (when less than 37 weeks gestation) if the child is 12 months of age or younger this should be noted in the evaluation.
6. An assessment of the results of the evaluation including recommendations for frequency and intensity of treatment.
7. The child should be tested in their native language; if not, an explanation must be provided in the evaluation.
8. Signature and credentials of the therapist performing the evaluation.

The mental measurement yearbook is the standard reference to determine good reliability/validity of the test(s) administered in the evaluation.

C. Birth to Three:

1. — (minus) 1.5 SD (standard score of 77) below the mean in two areas (expressive, receptive) or a — (minus) 2.0 SD (standard score of 70) below the mean in one area to qualify for language therapy.
2. Two language tests must be reported with at least one of these being a global norm-referenced standardized test with good reliability/validity. The second test may be criterion referenced.