PUBLIC COMMENTS ON OCCUPATIONAL THERAPY,
PHYSICAL THERAPY, AND SPEECH THERAPY RULE AMENDMENTS

1. JODI KUSTURIN, PT, DPT, DIRECTOR, RECOVERY ZONE PEDIATRIC THERAPY

COMMENT: I am writing for public comment of the proposed DMS-640. It is my recommendation that the "Private Clinic" row will capture the patients who receive therapy in a specialized clinic and that we do not need an additional row for specialties.

For example: If the child receives OT at a sensory integration clinic/equine-assisted therapy clinic but that clinic also provides outpatient care as a private clinic and that same patient also receives OT (depending on the week) through the private clinic, there would be some confusion on which row is appropriate for the recommended treatment time.

Recommend deleting this row on the DMS 640:

Specialized Clinic (i.e., equine assisted therapy)	minutes/ week	minutes/ week	minutes/ week	minutes/ week	N/A

RESPONSE: The addition of this line is not to limit the therapy a child or adult can receive, but to capture all therapies a child or adult is receiving in <u>all</u> settings.

2. GABE FREYALDENHOVEN, PT, PRESIDENT, REHAB NET OF ARKANSAS RIVER VALLEY THERAPY AND SPORTS MEDICINE

COMMENT: In reference to the recently proposed revisions for the DM-640, there is some confusion regarding its intended use.
The instruction line for the grid where the number of minutes of therapy is to be entered reads "Complete this block if this form is a prescription for 90 minutes or less per week". Is the intended use that this grid would not be used if the request is over 90 minutes? Instead the two lines at the bottom only would be used if greater than 90 minutes were being ordered? This seems like a point of confusion if DHS intends for the grid to be used for the physician to order the number of therapy minutes greater than 90 minutes in the grid as well. If this is not the intended use, to have the number of minutes greater than 90 to only be listed on the bottom 2 lines seems like not enough room, when considering multiple discipline could be ordered.
Additionally, Medical necessity historically has come from the therapist doing the evaluation, not the physician. Is it the intention for DHS/AFMC to begin new requirements from the physician?

RESPONSE: We agree with your comments. We will convene a workgroup to rework the DMS 640 based on public comments.

3. DANA WARREN MSPT, ABC CHILDREN'S ACADEMY

COMMENT: Our ABCCA team of health professionals oppose proposed changes to the attached DMS 640 for the following reasons:

1. The 640 script does not allow for blended treatment locations for children
   a. For a 90-minute week session, a child may see an equine assisted location for 60 minutes that week but the other 30-minute session that week may be at an Outpatient clinic all under the same service provider.
   b. The multiple rows infer two different scripts would need to be obtained and flexibility of treatment locations be limited.
2. The 640 script will not line up for EIDT programs that integrate their children in each classroom.
   a. if a child is in a EIDT program yet their Medicaid expires and therapy has to be converted to outpatient therapy yet the child never leaves the classroom. This MICROMANGED script infers a new script will have to be obtained with each transition.
   b. Another example is if a child is attending preschool in the Arkansas Better Chance program with therapies but would be better served in the EIDT program – an unnecessary additional DMS640 would have to be obtained 2 months after another one – frustrating and confusing physician staff.
3. Lastly, the proposed DMS 640 is predicted to be overall frustrating to the physician staff. It is unfamiliar and over complicated to fill out.
   Our recommendation would be to allow physicians two row options on the new DMS640 script and leave the other changes as proposed:
   Pediatric therapy row
   Adult therapy row

The rest of the 640 changes are beneficial; however, the over specified locations will CREATE MUCH MORE WORK FOR OUR PHYSICIANS AND THERAPY PROVIDERS. Common knowledge lends to the concept that with increased work load comes increased cost of service provisions and with proposed Medicaid cuts, providers are expecting decreased revenues. So making changes that increase costs and confusion seems worthy to take a second look.

RESPONSE: Based on the 90 minute loose caps that were put in place on July 1, 2017, multiple issues arose showing a child having several DMS 640 and receiving multiple therapy units without each therapy provider knowing of the other. The goal of the new DMS 640 is to have one prescription that outlines all of the child or adult's needs. It is not intended to blend or limit treatment, nor is it intended to require two prescriptions. DDS will be doing outreach to PCP's to train on the new DMS 640. However, we will convene a workgroup to rework the DMS 640 based on public comments.

4. RENEE BENNETT, PT, PHYSICAL THERAPY TEAM LEADER, ACCESS GROUP, INC.
   SHELLY KELLER, MCD, CCC-SLP, CEO/OWNER, MIRACLE KIDS
   STEPHANIE SMITH, COO, EASTER SEALS
   CHERI STEVENSON, MS, CCC-SLP, ACCESS
   DAVID IVERS, DEVELOPMENTAL DISABILITIES PROVIDER ASSOCIATION

COMMENT: Therapy 1-18, Section V 3-18 and SPA #2018-008
The amendment to the state plan section 11. Physical Therapy and Related Services to reflect the change made in the governing Medicaid manuals effective 7/1/2017 is not complete.
The language in the state plan should be amended to mirror the language in the state plan sections Attachment 3.1-A, page 4a, 9. Clinic Services:
The language bolded in red below is what should be added in order to ensure consistency with the language in all state plan sections related to Occupational, Physical and Speech therapy.
For recipients over age 21, effective for dates of services on or after July 1, 2017, individual and group therapy are limited to six (6) units per week per discipline. One unit equals 15 minutes. Evaluations are limited to four (4) units per State Fiscal Year (July 1 through June 30). One unit equals 30 minutes. Extensions of the benefit limit will be provided if medically necessary.

RESPONSE: Agree that this was an oversight. This language will be added to mirror the other pages.

COMMENT: DMS-640
The proposed changes have resulted in a form that is cumbersome, extremely difficult to complete and results in duplication of other regulations already in place to manage utilization of services. The form also adds a service that falls under completely different regulations.
The following changes are recommended. These recommendations will not take away from the purpose and intent of the form. A proposed draft of the DMS-640 is also attached which incorporates the recommendations suggestions.
Suggested changes to the form itself:
• At the end of the first paragraph, add the following: "A prescription for therapy services is valid for the length of time specified by the prescribing physician, up to one year."
• Move "Evaluate/Treat is Not A Valid Prescription" to the very top of form.
• Change the term "beneficiary" to "patient" throughout the form so terminology is consistent with the first line of the form. (i.e., "Patient name").
• Add "ICD-10" before "Diagnosis" and "Code" after "Diagnosis". Prescribing physicians do not always provide ICD-10 codes; instead they will put a narrative which does not always match a particular code.
• Remove "ABA" from the form as this service falls under different regulations.
• Reformat the form so that the referral and treatment sections are separate and distinct.
• Move the checkbox for "Therapy Not Medically Necessary" to the bottom of the grid. The decision to check this box should be made by the physician after reviewing all supporting documentation for the requested therapy treatment/services.
• Under "Setting", combine "EIDT" and "ADDT" to "Day Treatment".
• Eliminate the following language by the Day Hab box "can only be in EIDT or ADDT, not both". This statement is confusing and unnecessary as controls are in place to ensure this does not happen. (Prior Authorization for beneficiaries ages 6 to 21 in EIDT program; MMIS limits on maximum units of day hab built into billing system)
• Remove language "Complete this block if this is a prescription for 90 minutes or less per week". The prescription should be written for the amount recommended per the evaluation report. The control is already in place that anything over 90 minutes per week must first be approved by the physician as medically necessary based on his review of the evaluation report and other supporting documentation. Additionally, any therapy recommended over 90 minutes per week must be prior authorized by the QIO.

• Remove language next to "Other Information": "Medical necessity justification for more than 90 minutes per week:" The requesting provider must submit an evaluation report and any other supporting documentation that justifies the medical necessity of the service to the physician when requesting the prescription for treatment. By signing the prescription (DMS-640), the physician has determined that the services are medically necessary. The physician should not have to duplicate the work that the performing provider has already done.
• Format the form so that everything fits on one page.

Suggested changes to the Instructions:

• Change "Beneficiary" to "Patient" throughout form.
• Add "ICD-10" before "Diagnosis" and "Code" after "Diagnosis".
• Move "If therapy is not medically necessary at this time, check the box at the bottom" to be after the ICD-10 bullet. If therapy is not medically necessary, there is no reason for the form to be completed for the service determined not to be medically necessary.
• Add the language "(OT,PT,ST) or hours (Day Habilitation)" after minutes and at the end of the sentence add "based on the setting where the treatment will be provided".
• Remove "Settings and Duration" as this is duplicate to previous instruction.
• Remove language next to "Other Information": "Medical necessity justification for more than 90 minutes per week". The requesting provider must submit an evaluation report and any other supporting documentation that justifies the medical necessity of the service to the physician when requesting the prescription for treatment. By signing the prescription (DMS-640), the physician has determined that the services are medically necessary.
• Remove the last two bullet points. This is an inconsistent practice as this is not required of any other medical service. For example, when prescribing medication for a patient, a physician does not have to contact the patient's specialist to include all of those medications on the same prescription form. This creates a hardship for the physician and his/her staff, as well as for the patient/guardian and the treating provider. What will happen if the physician accidentally leaves one of the services off the form? Also, if a new prescription is required for all services every time there is a change, why wouldn't the expiration date change for all of the services each time a new prescription was generated? This is neither logical, nor necessary.

Occupational, Physical, Speech Therapy Services

Section 214.400 D.11: IQ scores are required for all children who are school age and receiving language therapy. Exception: IQ scores are not required for children under ten (10) years of age.

214.420Intelligence Quotient (IQ) Testing

Children receiving language intervention therapy must have cognitive testing once they reach ten (10) years of age. This also applies to home-schooled children. If the IQ score is higher than the qualifying language scores, the child qualifies for language therapy; if the IQ score is lower than the qualifying language test scores, the child would appear to be functioning at or above the expected level. In this case, the child may be denied for language therapy. If a provider determines that therapy is warranted, an in-depth functional profile must be documented. However, IQ scores are not required for children under ten (10) years of age.

Neither the Department of Education, nor the American Speech-Language Hearing Association recognize IQ scores as a determinant of whether a child will benefit from speech/communication services and supports. Research has demonstrated that cognitive prerequisite (IQ) are neither sufficient, nor even necessary for language skills to emerge and/or improve. Attached is the position statement of the American Speech-Language Association.

Please consider these proposed changes. I feel strongly that they are necessary to ensure that children can continue to receive medically necessary speech, occupational, and physical therapy services in Arkansas.

RESPONSE: We agree with your comments. We will convene a workgroup to rework the DMS 640 based on public comments.

5. MICHELLE EDWARDS, COMMUNITY SCHOOL OF CLEBURNE COUNTY, INC.

COMMENT: Proposed DMS-640
Complete this block if this form is a prescription for 90 minutes or less per week
This statement is included in the block that also Therapy rx but also includes EIDT Day Hab units – which will be hours/wk – not a max of 90 minutes per week. This distinction should be specified as this is a doctor prescription.

RESPONSE: We agree with your comments. We will convene a workgroup to rework the DMS 640 based on public comments.

6. MULTIPLE THERAPY PROVIDERS

COMMENT: § 214.400 D.11: IQ scores are required for all children who are school age and receiving language therapy. Exception: IQ scores are not required for children under ten (10) years of age.
214.420 Intelligence Quotient (IQ) Testing
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Neither the Department of Education, nor the American Speech-Language Hearing Association recognize IQ scores as a determinant of whether a child will benefit from speech/communication services and supports. Research has demonstrated that cognitive prerequisite {IQ) are neither sufficient, nor even necessary for
language skills to emerge and/or improve. Attached is the position statement of the American Speech- Language Association.

Position Statement on Access to Communication Services and Supports: Concerns Regarding the Application of Restrictive "Eligibility" Policies

National Joint Committee for the Communication Needs of Persons With Severe Disabilities

About this Document

This position statement was developed by the National Joint Committee for the Communication Needs of Persons With Severe Disabilities. This position statement Is an official policy of the American Speech-Language-Hearing Association. National Joint Committee member organizations and their respective representatives who prepared this statement Include the American Association on Mental Retardation, Mary Ann Romski; the American Occupational Therapy Association, Jane Rourk; the American Speech-Language-Hearing Association, Beth Mineo Mollica, Rose Sevcik, Diane Paul-Brown (ex officio), and Alex F. Johnson (monitoring vice president); the Council for Exceptional Children, Division for Communicative Disabilities and Deafness, Lee McLean (chair); RESNA, Kevin

Caves; TASH, Pat Miranda and Martha Snell; and the United States Society for Augmentative and Alternative Communication, David Yoder. This statement was approved by ASHA's Legislative Council (LC 4 2002) at the Spring 2002 meeting.

Eligibility policies and practices often preclude children and adults with severe disabilities [1] from accessing needed communication services and

supports. Communication services and supports may include instruction of individuals and their communication partners, assistive technology. and environmental modifications, and may be delivered through a variety of service delivery models. [2] The expected outcome of such services and supports is to increase or to prevent decline in the individual's meaningful participation in daily activities. Categorical denial of communication services and supports without consideration of a person's unique communication needs may violate federal statute, and may also violate state law, regulation, and policy.

Position Statement.

It Is the position of the National Joint Committee for the Communication Needs of Persons With Severe Disabilities that eligibility for communication services and supports should be based on individual communication needs. Communication services and supports should be evaluated, planned, and provided by an interdisciplinary team with expertise in communication and language form, content, and function, as well as in augmentative and alternative communication (MC). Decisions regarding team composition, types, amounts, and duration of services provided, intervention setting, and ser.1Ice delivery models should be based on the Individual's communication needs and preferences. Eligibility determinations based on a priori [3] criteria violate recommended practice principles by precluding consideration of Individual needs. These a priori criteria Include, but are not limited to: (a) discrepancies between cognitive and communication functioning; (b) chronological age; (c) diagnosis; (d) absence of cognitive or other skills purported to be prerequisites; (e) failure to benefit from previous communication services and supports; (f) restrictive Interpretations of educational, vocational, and/or medical necessity; (g) lack of appropriately trained personnel; and (h) lack of adequate funds or other resources,

References

Morris, **W.** (Ed.). (1981). *The American Heritage Dictionary of the English Language.* Boston: Houghton Mifflin Company.

National Joint Committee for the Communication Needs of Persons With Severe Disabilities. (1992, **March).** Guidelines for meeting the communication needs of persons with severe disabilities. *Asha,* 34(Supplement #7), 1-8.

Paul-Brown, 0., & Caperton, C. (2001). inclusive practices for preschool children with specific language Impairments. In **M.** J, Guralnick (Ed.), *Early Childhood Inclusion: Focus on change* (pp. 433-463), Baltimore: Brookes.

Notes

[1] **Persons with severe disabilities Include persons with severe to profound mental retardation, autism, and other disorders that result in severe** social-communication • and cognitive • communication impairments" (National Joint Committee for the Communication Needs of Persons with Severe Disabilities, 1992, p. 2).

[2] Service delivery model include both direct service and "indirect," consultative/collaborative service models, and any combination of these models Identified as most appropriate to meet the Individual's needs (See Paul-Brown & Caperton, 2001).

[3] a priori is defined as "made before or without examination and not supported by factual study" (Morris, 1981).

Index terms: admission/discharge criteria, people with disabilities

Reference this material as: National Joint Committee for the communication Needs of Persons With Severe disabilities. (2003), *Position statement on accessible communication services and supports: Concerns regarding the application of restorative "eligibility [...]* [Position Statement]. Available from www.asha.org/palicy or www.asha.org/njc.

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RESPONSE: We did not change this requirement in July, 2017, and we are not changing it now. However, you raise good points which should be considered in a strategic manner by a group of experts. We will present this comment to our therapy work group.

6. CAROLINE CHANG, MS, OTR/L, OT TEAM LEADER, ACCESS GROUP, INC.
OTHER THERAPY PROVIDERS

COMMENT:

Arkansas Division of Medical Services
Therapy and Habilitation Services for Medicaid Eligible Beneficiaries
PRESCRIPTION/REFERRAL
(Evaluate/Treat is Not a Valid Prescription)

The **Primary Care Physician** (PCP) or attending physician must use this form to make a referral for evaluation or prescribe medically necessary Medicaid therapy services. The PCP or attending physician must check the appropriate box or boxes indicating the modality. Providers of therapy services are responsible for obtaining renewed PCP referrals at least once a year in compliance with Section I 171.400 and Section II 214.00 of the Arkansas Medicaid Therapy services provider manual. A prescription for therapy services is valid for the length of time specified by the prescribing physician, up to one year.

Referral for evaluation (check all that apply) ☐ OT ☐ PT ☐ ST

Patient Name: _____ Medicaid ID #: _____

Date Patient Was Last Seen In Office: _____

ICD-10 Diagnosis Code as Related to Prescribed Therapy: _____

☐ **Treatment**

Settings	Occupational Therapy (OT)	Physical Therapy (PT)	Speech Therapy (ST)	Day Habilitation
Day Treatment (Center Based)	_____Minutes/week _____Duration- months	_____Minutes/week _____Duration-months	_____Minutes/week _____Duration-months	_____hours/week _____Duration-months
Public School Based	_____Minutes/week _____Duration- months	_____Minutes/week _____Duration- months	_____Minutes/week _____Duration-months	
Private Clinic (Includes specialized therapy i.e. equine, etc.)	_____Minutes/week _____Duration-months)	_____Minutes/week _____Duration-months	_____Minutes/week _____Duration-months	
	☐ Therapy Not Medically Necessary	☐ Therapy Not Medically Necessary	☐ Therapy Not Medically Necessary	☐ Therapy Not Medically Necessary

Other Information: _____

_____ _____
Primary Care Physician (PCP) Name *(Please Print)* Provider ID Number/Taxonomy Code

_____ _____
Attending Physician Name *(Please Print)* Provider ID Number/Taxonomy Code

By signing as the PCP or Attending Physician, I hereby certify that I have carefully reviewed each element of the therapy treatment plan, that the goals are reasonable and appropriate for this patient, and in the event that this prescription is for a continuing plan I have reviewed the patients progress and adjusted the plan for his or her meeting or failure to meet the plan goals.

_____ _____
Physician Signature *(PCP or attending Physician)* Date

Return To (name of provider): _____

DMS-640 (Rev. 7/18)

Instructions for Completion

Form DMS-640 –Therapy and Habilitation Services for Medicaid Eligible Beneficiaries PRESCRIPTION/REFERRAL

- If the DMS-640 is used to make an initial referral for evaluation, check the box to indicate the appropriate therapy for the referral. After receiving the evaluation results and determining that therapy is medically necessary, you must use a separate DMS-640 form to prescribe the therapy. Check the treatment box for prescription and complete the form following the instructions below. If the referral and prescription are for previously prescribed services, you may check both boxes.
- Patient Name – Enter the patient's full name.
- Medicaid ID # – Enter the patient's Medicaid ID number.
- Return To - To be completed by requesting provider(s) to include provider/address/fax/secure email.

Physician or Physician's office staff must complete the following:

- Date Patient Was Last Seen In Office – Enter the date of the last time you saw this patient. (This could be either for a complete physical examination, a routine check-up or an office visit for other reasons requiring your personal attention.)
- ICD-10 Diagnosis Code as Related to Prescribed Therapy – Enter the ICD-10 diagnosis code that indicates or establishes medical necessity for prescribed therapy.
- If therapy is not medically necessary at this time, check the box at the bottom
- Prescription block – If the form is used for a prescription, enter the prescribed number of minutes (OT,PT,ST) or hours (Day Habilitation) per week and the prescribed duration (in months) of therapy based on the setting where the treatment will be provided.
- Other Information – Any other information pertinent to the patient's medical condition, plan of treatment, etc., may be entered.
- Primary Care Physician (PCP) Name and Provider ID Number and/or Taxonomy Code – Print the name of the prescribing PCP and his or her provider identification number and/or taxonomy code.
- Attending Physician Name and Provider ID Number and/or Taxonomy Code - If the Medicaid-eligible patient is exempt from PCP requirements, print the name of the prescribing attending physician and his or her provider identification number and/or taxonomy code.
- Physician Signature and Date – The prescribing physician must sign and date the prescription for therapy in his or her original signature.
- Arkansas Medicaid's criteria for electronic signatures as stated in Arkansas Code 25-31-103 must be met. For vendor's EHR systems that are not configurable to meet the signature criteria, the provider should print, date and sign the DMS-640 form. Providers will be in compliance if a scanned copy of the original document is kept in a format that can be retrieved for a specific beneficiary. Most electronic health record systems allow this type of functionality.
- When an electronic version of the DMS 640 becomes part of the physician/ or providers' electronic health record, the inclusion of extraneous patient and clinic information does not alter the form.

The original of the completed form DMS-640 must be maintained in the child's medical records by the prescribing physician. A copy of the completed form DMS-640 must be retained by the therapy provider(s).

What type of work space should be provided for students who received speech-language services in schools?

The quality of work settings and equipment varies widely in schools around the country. ASHA's 2002 Technical Report, Appropriate School Facilities for Students With Speech-Language-Hearing Disorders, addresses issues such as hearing screening, confidentiality, classroom acoustics, and advocacy for appropriate facilities for services to students with speech, language and hearing disorders.

Should Applied Behavioral Analysis (ABA) therapy be the only treatment for students who are on the autism spectrum?

The ASHA Issue Brief explains that all appropriate therapies should be provided to children with autism spectrum disorder (ASD) and that Applied Behavioral Analysis (ABA) should not be the sole means by which to treat children with ASD.

Eligibility and Dismissal Criteria

Does ASHA have recommended eligibility and dismissal criteria for educational settings?

ASHA does not recommend specific criteria for eligibility or dismissal of services for educational settings. Federal, state, and/or local guidelines determine criteria. For additional information, see Eligibility and Dismissal Criteria and Cognitive Referencing.

Can a child be eligible for speech-language services from a private practitioner and not eligible for services in schools?

SLPs in private practice provide a broad spectrum of communication services based on their education and experience. These services range from treating disorders of language, speech sound production, voice, and fluency to addressing accent reduction and literary skills, to name a few. SLPs in private practice are not held to the same eligibility guidelines and can treat disorders that may not be addressed in a school setting.

In school settings, speech-language pathology services must conform to federal regulations created to implement the Individuals with Disabilities Education Act (IDEA), a law designed to ensure that all students receive a free appropriate public education (FAPE).

Determination of eligibility for services in schools is a multi-step process that includes screening, evaluation, observations from teachers, information from parents, and review of the student's work samples. The school-based individualized education program (IEP) team considers all of this information to answer these questions:

1. Is there a disability?
2. If so, is there an adverse effect on educational performance resulting from the disability?
3. If so, are specially designed instruction and/or related services and supports needed to help the student make progress in the general education curriculum?

In some cases, parents may want services beyond what is determined appropriate in the school setting. Parents may obtain services from an SLP in private practice at their own discretion and cost. Read more about eligibility criteria for speech-language services in the schools.

Are children who have commensurate IQ and language scores eligible for speech-language services?

Comparing IQ and language scores as a factor for eligibility for speech-language intervention is frequently referred to as *cognitive referencing.* Cognitive referencing is based on the assumption that language functioning cannot surpass cognitive levels. According to researchers, the relationship between language and cognition is not that simple. Some language abilities are more advanced, others are closely correlated, and still others are less advanced than general cognitive level. Research results in recent years have demonstrated that cognitive prerequisites are neither sufficient nor even necessary for language to emerge. Therefore, **ASHA does not support the use of cognitive referencing.** For additional information, see ASHA's Cognitive Referencing resource. New provisions in IDEA 2004 permitting identification of specific learning disabilities based on a student's response to instruction offer an alternative approach that can be applied to identification of a language disorder.

Can a school district deny speech-language pathology services to a student with a "mild" articulation disorder if the district decides that the disability does not "adversely affect educational performance"?

State and/or local school education agencies may apply different interpretations to the phrase "adversely affects educational performance"; however, they cannot deny IDEA-mandated services to a child with a speech or language impairment just because that child does not have a discrepancy in age/grade performance in an academic subject-matter area. If acquisition of adequate and appropriate communication skills is a required part of your school's academic standards and curriculum and is considered to be a basic skill necessary for all children attending school, then a child with a speech or language impairment has a disorder that adversely affects educational performance. Sound production errors may affect the way a student hears, speaks, reads, or writes phonemes, and thus can affect academic and social performance. For more information, see ASHA's Eligibility and Dismissal resource, "Adversely Affects Educational Performance" section.

Medicaid, Private Practice, and Independent Contracting

Can public schools bill Medicaid for speech-language pathology services?

To date, most states have implemented or plan to implement Medicaid billing in the schools. There are provisions in federal and state law requiring state and local education agencies to seek sources other than those available under Part B or Part C of IDEA to pay for services for students with disabilities. Schools are increasingly tapping other sources to help finance special education programs. Covered Medicaid benefits include speech-language pathology services identified in the child's individualized education program (IEP) or individualized family service plan (IFSP). Federal law dictates that private insurance must be pursued first by local education agencies (LEAs) using Medicaid funds because Medicaid is the "payer of last resort." This means that a reasonable effort must be made to collect from all potential payers before Medicaid can be billed. Parents retain the right

RESPONSE: Please see previous responses.

7. AMY JAMISON-CASAS, MS, CCC-SLP

COMMENT: Using outdated and archaic (not to mention cruel) cognitive referencing to disqualify children from treatment. This is NOT supported by current research and harms children and prevents them from progressing with functional communication and other language acquisition areas. If you could see a parent's face when being told their child who is finally thriving with a communication system's acquisition that the child cannot continue the one therapy that has brought hope to that family, simply because the child turned 10 years old and his IQ (often acquired by psychologists who are not skilled in individuals with severe communication impairments) was too low. Well, if you can picture that, surely you would insist this rule be overturned. In fact, I WAS that parent once. It hurts so deeply to think that the very funding source you're counting on to help your child gain as much independence as possible before you die...has a cut-off date for hope and progress. This simply cannot continue. What's more, policymakers in this area are opening themselves up for a class-action lawsuit at some point, given the evidence against cognitive referencing.

RESPONSE: Please see previous responses.

COMMENT: On the DMS-640, I believe a line for the Date of Birth should be included after the patient's name. Physicians always require we therapists include that anyway.

RESPONSE: We agree with your comments. We will convene a workgroup to rework the DMS 640 based on public comments.

8. David Ivers, Developmental Disabilities Provider Association (DDPA)

COMMENT: Suggested changes to the form itself:
• Throughout the DMS-640 wherever it states "therapy" should be amended to state ***"therapy and habilitation,"*** as appropriate.
• At the end of the first paragraph, add the following: ***"A prescription for therapy services is valid for the length of time specified by the prescribing physician, up to one year."***
• Move ***"Evaluate/Treat is Not A Valid Prescription"*** to the very top of form.
• Change the term ***"beneficiary"*** to ***"patient"*** throughout the form so terminology is consistent with the first line of the form. ***(i.e., "Patient name").***
• Add ***"ICD-10"*** before ***"Diagnosis"*** and **"Code"** after ***"Diagnosis"***. Prescribing physicians do not always provide ICD-10 codes; instead they will put a narrative which does not always match a particular code.
• Remove ***"ABA"*** from the form as this service falls under different regulations.
• Reformat the form so that the referral and treatment sections are separate and distinct.
• Move the checkbox for ***"Therapy Not Medically Necessary"*** to the bottom of the grid. The decision to check this box should be made by the physician after reviewing all supporting documentation for the requested therapy treatment/services.
• Under ***"Setting"***, combine ***"EIDT"*** and ***"ADDT"*** to ***"Day Treatment"***. Eliminate the following language by the Day Hab box ***"can only be in EIDT or ADDT, not both"***. This statement is confusing and unnecessary as controls are in place to ensure this does not happen. (Prior Authorization for

beneficiaries ages 6 to 21 in EIDT program; MMIS limits on maximum units of day hab built into billing system)

- Remove language ***"Complete this block if this is a prescription for 90 minutes or less per week"***. The prescription should be written for the amount recommended per the evaluation report. The control is already in place that anything over 90 minutes per week must first be approved by the physician as medically necessary based on his review of the evaluation report and other supporting documentation. Additionally, any therapy recommended over 90 minutes per week must be prior authorized by the QIO.
- Remove language next to ***"Other Information": "Medical necessity justification for more than 90 minutes per week:"*** The requesting provider must submit an evaluation report and any other supporting documentation that justifies the medical necessity of the service to the physician when requesting the prescription for treatment. By signing the prescription (DMS-640), the physician has determined that the services are medically necessary. The physician should not have to duplicate the work that the performing provider has already done.
- Format the form so that everything fits on one page.

COMMENT: Suggested changes to the Instructions:

- Change ***"Beneficiary"*** to ***"Patient"*** throughout form.
- Add ***"ICD-10"*** before ***"Diagnosis"*** and ***"Code"*** after ***"Diagnosis".***
- Move ***"If therapy is not medically necessary at this time, check the box at the bottom"*** to be after the ICD-10 bullet. If therapy is not medically necessary, there is no reason for the form to be completed for the service determined not to be medically necessary.
- Add the language ***"(OT,PT,ST) or hours (Day Habilitation)"*** after minutes and at the end of the sentence add ***"based on the setting where the treatment will be provided".***
- Remove **"Settings and Duration"** as this is duplicate to previous instruction.
- Remove language next to ***"Other Information": "Medical necessity justification for more than 90 minutes per week"***. The requesting provider must submit an evaluation report and any other supporting documentation that justifies the medical necessity of the service to the physician when requesting the prescription for treatment. By signing the prescription (DMS-640), the physician has determined that the services are medically necessary.
- Remove the last two bullet points. This is an inconsistent practice as this is not required of any other medical service. For example, when prescribing medication for a patient, a physician does not have to contact the patient's specialist to include all of those medications on the same prescription form. This creates a hardship for the physician and his/her staff, as well as for the patient/guardian and the treating provider. What will happen if the physician accidentally leaves one of the services off the form? Also, if a new prescription is required for all services every time there is a change, why wouldn't the expiration date change for all of the services each time a new prescription was generated? This is neither logical, nor necessary.

RESPONSE: These comments are duplicative, please see our previous responses indicating that changes will be made to the DMS-640.

9. TINA OSBURN, OT, BUILDING BRIDGES (AT PUBLIC HEARING)

COMMENT: But the real reason I'm here is because I deal with paperwork all the time. And this new script, how many people have seen it? Okay. And how many people think it is terrible? Thank you. Amen. So, I sent you an e-mail, and I don't know if you got it, Melissa, and I might should have sent it to someone else, because I don't know if you got it or not. And physicians are very intelligent,

they can't fill out a script. Okay? And I argue with AFMC on a daily basis, and Dana hates me, because she won't tell me what she wants in a script and every day it changes. So, this is for the birds. (Indicating.) And I hope I don't know who designed it. I will be glad to consult and tell you what I do on a daily basis and how the physicians don't do it correctly, and I will work with somebody if we want to target and we want to look at utilization. I get that. But this will never be done, will never. And I spend my, days on the phone and so does Sheila, who does a great job with scripts. I mean, this is just going to be an added headache to everything else. Thank you.

RESPONSE: Please see previous responses.

10. AMANDA CLARK, BILLING MANAGER, AND KYM HANNAH, PHYSICAL THERAPIST, CHILDREN'S THERAPY SERVICES, INC.

COMMENT: Section 216.300 "Process for Requesting Extended Therapy Service" - redacted the Extension of Benefits process for evaluations exceeding 4 evaluations units per year.

o I'm sure this was an oversight when adding the new Therapy/EOB process for therapy over 90 minutes per week, but these two processes are different.

o For Extension of Benefits for evaluations, a denied Remittance Advice is required- and this has been crossed out, as has any mention of the process for creating Extension of Benefits for evaluations vs Pre-authorizations for therapy services over 90 days per week.

RESPONSE: This was an oversight and that process will be added back in.

COMMENT: The following changes to the proposed DMS-640 are recommended:

- At the end of-the first paragraph on the DMS-640, add the following: " prescription for therapy services is valid for I year unless the prescribing physician specifies a shorter period." This is the exact language in the current Occupational, Physical, Speech Therapy Services guide in section 204.000.
- Add "ICD-I0" before diagnosis and "Code" after diagnosis. AFMC requires an ICD-10 code on the prescription, but PCPs often write out the diagnosis, so the ICD-10 code has to be manually added to the prescription before submitting to AFMC.
- Remove ABA from this form as it falls under another provider type with strict credentialing regulations. ABA techniques provided by occupational, physical, or speech therapists in order to manage behavior during sessions so that they are able to perform occupational, physical or speech therapy is not ABA therapy. Billable ABA therapy is performed by a licensed BCBA or by a line therapist under the supervision of a licensed BCBA.
- Reformat the form so that the referral and treatment sections are separate and distinct.
- Add service type "DT - Developmental Therapy". This DMS-640 form replaces the Early Intervention prescription form, which had Developmental Therapy listed on it. Developmental Therapy is paid under the Medicaid program (for patients with active Medicaid) as well as through paid by the Early Intervention program. Developmental therapy can be provided by outpatient therapy providers in the patients' natural environment (it is not only provided in a Day Hab setting).
- Remove "Date Expires" - this could conflict with the duration entered and cause confusion for the dates for which the prescription covers. Could also cause another therapy provider's active prescription to end without their knowledge.

- Format the DMS-640 so that everything is on one page. It would be easy for the services portion of the DMS-640 form to be separated from the signatures and would also make it very easy for providers to fraudulently add signature pages from other valid prescriptions to create a signed prescription for another patient.
- Remove the last two bullet points. This is an inconsistent practice and could cause a lot of havoc as valid written prescription that have been used or could be used for Therapy EOB/Prior Authorization or retroactive reviews, could be rendered invalid and the therapy provider holding the active prescription would not know about it. Also, the practice of rewriting all of the service a patient receives multiple times a year would introduce unintentional inconsistencies. Accidentally missing writing in a service would cause that service to no longer be covered, which was not the PCP' s intention. These issues would cause delays in pre-authorization process as well as delays in patients being able to continue services.

RESPONSE: Please see comments above. The ultimate goal of the DMS-640 changes is to show a snap shot of a child receiving physical, occupational, and speech therapy services so that the physician and the individual providers know how much of these services a child is actually receiving. We have not seen multiple providers of developmental therapy billing for the same child. If this becomes an issue, we will revisit.