SECTION II - OCCUPATIONAL THERAPY, PHYSICAL THERAPY, AND SPEECH-LANGUAGE PATHOLOGY SERVICES~~OCCUPATIONAL, PHYSICAL, SPEECH-LANGUAGE THERAPY~~

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~~200.000 OCCUPATIONAL, PHYSICAL, SPEECH-LANGUAGE THERAPY SERVICES GENERAL INFORMATION~~

~~201.000 Arkansas Medicaid Participation Requirements~~ ~~10-15-09~~

~~Individual and group providers of occupational therapy, physical therapy and speech-language pathology services must meet the Provider Participation and enrollment requirements contained within Section 140.000 of this manual as well as the following criteria to be eligible to participate in the Arkansas Medicaid Program:~~

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

~~B. A provider of therapy services has the option of enrolling in the Title XVIII (Medicare) Program. Item 1-C. of the Contract To Participate In The Arkansas Medical Assistance Program Administered By The Division Of Medical Services Title XIX (Medicaid) further requires acceptance of assignment under Title XVIII (Medicare) in order to receive payment under Title XIX (Medicaid) for any applicable deductible or coinsurance that may be due and payable under Title XIX (Medicaid). Services furnished to an individual enrolled under Medicare who is also eligible for Medicaid, including Qualified Medicare Beneficiaries (QMB) may only be reimbursed on an assignment related basis. When a beneficiary is dually eligible for Medicare and Medicaid, providers must bill Medicare prior to billing Medicaid. The beneficiary may not be billed for the charges. Providers enrolled to participate in the Title XVIII (Medicare) Program must notify the Arkansas Medicaid Program of their National Provider Identifier.~~

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

~~1. A copy of all certifications and licenses verifying compliance with enrollment criteria for the therapy discipline to be practiced. (See Section 202.000 of this manual.)~~

~~2. If enrolled in the Title XVIII (Medicare) Program, an out-of-state provider must submit a copy of verification that reflects current enrollment in that program.~~

~~201.100 Group Providers of Therapy Services~~ ~~10-15-09~~

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

~~If a therapist, a therapy assistant, a speech-language pathologist or a speech-language pathology assistant is a member of a group, each individual therapist, speech-language pathologist, or assistant and the group must both enroll according to the following criteria:~~

~~A. Each individual within the group must enroll following the criteria established in Section 202.000 for the applicable therapy disciplines.~~

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

C. The group must also comply with subsequent certifications and license renewals as outlined in Section 201.000, parts F and G.

D. All group providers are "pay to" providers only. The service must be performed and billed by a Medicaid-enrolled and licensed therapist, speech-language pathologist, therapy assistant or speech-language pathology assistant within the group.

201.110 School Districts, Education Service Cooperatives, and Early Intervention Day Treatment, or Adult Developmental Day Treatment 1-1-21

A school district, education service cooperative, early Intervention Day Treatment (EIDT) program or Adult Developmental Day Treatment (ADDT) program may contract with or employ qualified therapy practitioners. Effective for dates of service on and after October 1, 2008, the individual therapy practitioner who actually performs a service on behalf of the facility must be identified on the claim as the performing provider when the facility bills for that service. This action is taken in compliance with the federal Improper Payments Information Act of 2002 (IPIA), Public Law 107-300 and the resulting Payment Error Rate Measurement (PERM) program initiated by the Centers for Medicare and Medicaid Services (CMS).

If a facility contracts with a qualified therapy practitioner, the criteria for group providers of therapy services apply (See Section 201.100 of the Occupational, Physical, Speech Language Therapy Services manual). The qualified therapy practitioner who contracts with the facility must be enrolled with Arkansas Medicaid. The contract practitioner who performs a service must be listed as the performing provider on the claim when the facility bills for that service.

If a facility employs a qualified therapy practitioner, that practitioner has the option of either enrolling with Arkansas Medicaid or requesting a Practitioner Identification Number **(View or print form DMS-7708)**. The employed practitioner who performs a service must be listed as the performing provider on the claim when the facility bills for that service.

The following requirements apply only to Arkansas school districts and education service cooperatives that employ (via a form W-4 relationship) qualified practitioners to provide therapy services.

A. The Arkansas Department of Education must certify a school district or education service cooperative.

1. The Arkansas Department of Education must provide a list, updated on a regular basis, of all school districts and education service cooperatives certified by the Arkansas Department of Education to the Medicaid Provider Enrollment Unit of the Division of Medical Services.

2. The Local Education Agency (LEA) number must be used as the license number for the school district or education service cooperative.

B. The school district or education service cooperative must enroll as a provider of therapy services. Refer to Section 201.000 for the process to enroll as a provider and for information regarding applicable restrictions to enrollment.

201.200 Providers of Therapy Services in Arkansas and Bordering States 10-13-03

Providers of occupational therapy, physical therapy and speech-language pathology services in Arkansas and the six bordering states (Louisiana, Mississippi, Missouri, Oklahoma, Tennessee and Texas) may be enrolled as **routine services providers** if they meet the participation requirements and enrollment criteria as specified in Section 201.000 and Section 202.000.

Routine services providers are enrolled as providers of routine occupational therapy, physical therapy and speech-language pathology services. Reimbursement may be available for all

~~therapy services covered in the Medicaid Program. Claims must be filed according to the specifications in this manual.~~

~~201.300 Providers in States Not Bordering Arkansas~~ ~~3-1-11~~

~~A. Providers in states not bordering Arkansas may enroll in the Arkansas Medicaid program as limited services providers only after they have provided services to an Arkansas Medicaid eligible beneficiary and have a claim or claims to file with Arkansas Medicaid.~~

~~To enroll, a non-bordering state provider must download an Arkansas Medicaid application and contract from the Arkansas Medicaid website and submit the application, contract and claim to Arkansas Medicaid Provider Enrollment. A provider number will be assigned upon approval of the provider application and the Medicaid contract.~~ **~~View or print the provider enrollment and contract package (Application Packet). View or print Medicaid Provider Enrollment Unit contact information.~~**

~~B. Limited services providers remain enrolled for one year.~~

~~1. If a limited services provider provides services to another Arkansas Medicaid beneficiary during the year of enrollment and bills Medicaid, the enrollment may continue for one year past the most recent claim's last date of service, if the enrollment file is kept current.~~

~~2. During the enrollment period, the provider may file any subsequent claims directly to the Medicaid fiscal agent.~~

~~3. Limited services providers are strongly encouraged to file subsequent claims through the Arkansas Medicaid website because the front-end processing of web-based claims ensures prompt adjudication and facilitates reimbursement.~~

~~202.000 Enrollment Criteria for Providers of Occupational, Physical, and Speech-Language Therapy Services~~

~~202.100 Occupational Therapy~~

~~202.110 Enrollment Criteria for a Qualified Occupational Therapist~~ ~~10-13-03~~

~~A. A qualified occupational therapist must:~~

~~1. Be certified by the National Board for Certification of Occupational Therapy (NBCOT), as required by Federal Regulations [42 CFR 440.110(b) (2) (i)]. A copy of the NBCOT certification must accompany the provider application and the Medicaid contract for enrollment as a Medicaid provider of occupational therapy.~~

~~**OR**~~

~~2. Be a graduate of an educational program in occupational therapy approved by the Committee on Allied Health Education and accreditation of American Medical Association and engaged in the supplemental clinical experience required before certification by NBCOT [42 CFR 440.110(b) (2) (ii)].~~

~~B. A qualified occupational therapist must be licensed to practice as an occupational therapist in his or her state. A copy of current licensure from his or her state must accompany the provider application and the Medicaid contract. Copies of subsequent license renewals must be provided when issued.~~

~~202.120 Enrollment Criteria for an Occupational Therapy Assistant~~ ~~10-13-03~~

~~A. An individual occupational therapy assistant must have at least an Associate Degree in Occupational Therapy from a program approved by the National Board for Certification of Occupational Therapy (NBCOT).~~

~~B. An occupational therapy assistant must be licensed to practice as an occupational therapy assistant by the Arkansas State Medical Board. A copy of current licensure must be submitted with the provider application and Medicaid contract. A copy of subsequent license renewals must be provided when issued.~~

~~C. An occupational therapy assistant must be under the "supervision" (as defined by the Arkansas State Medical Board) of a qualified licensed occupational therapist.~~

~~202.200 Physical Therapy~~

~~202.210 Enrollment Criteria for a Qualified Physical Therapist~~ ~~10-13-03~~

~~A. A qualified physical therapist must be a graduate of a program of physical therapy approved by both the Committee on Allied Health Education and Accreditation of the American Medical Association and the American Physical Therapy Association, as required by Federal Regulations [42 CFR 440.110(a) (2) (i)].~~

~~B. A qualified physical therapist must be licensed to practice as a physical therapist in his or her state [42 CFR 440.110 (a) (2) (ii)]. A copy of the current state licensure must accompany the provider application and the contract for provider enrollment. A copy of subsequent license renewals must be provided when issued.~~

~~202.220 Enrollment Criteria for a Physical Therapy Assistant~~ ~~10-13-03~~

~~A. A physical therapy assistant must have at least a bachelor's degree or college level associate degree in physical therapy approved by the American Physical Therapy Association.~~

~~B. A physical therapy assistant must provide proof of current licensure by the Arkansas State Board of Physical Therapy as a physical therapy assistant. A copy of current licensure must accompany the provider application and the Medicaid contract for provider enrollment. Subsequent license renewals must be provided when issued.~~

~~C. The physical therapy assistant must be under the "supervision" (as defined by the Arkansas State Board of Physical Therapy) of a qualified licensed physical therapist.~~

~~202.300 Speech-Language Pathology~~

~~202.310 Enrollment Criteria for a Speech-Language Pathologist~~ ~~10-13-03~~

~~A. A qualified speech-language pathologist must:~~

~~1. Have a certificate of clinical competence from the American Speech-Language-Hearing Association (ASHA), as required by Federal Regulations [42 CFR 440.110 (c) (2) (i)]. A copy of the current ASHA certificate must accompany the provider application and Medicaid contract for enrollment as a Medicaid provider of speech-language pathology services.~~

~~OR~~

~~2. Have completed the equivalent educational requirements (Doctoral or Master's level degree in speech-language pathology) and work experience necessary for the certificate of clinical competence from the American Speech-Language-Hearing Association (ASHA), as required by Federal Regulations [42 CFR 440.110 (c) (2) (ii)].~~

~~A copy of the written verification of the receipt of the application packet for the ASHA certificate of clinical competence must accompany the provider application and the Medicaid contract. A copy of the ASHA certificate of clinical competence must be provided when issued.~~

~~**OR**~~

3. ~~Have completed the academic program and is acquiring supervised work experience to qualify for the certificate of clinical competence from ASHA, as required by Federal Regulations [42 CFR 440.110 (c) (2) (iii)]. A copy of the Clinical Fellowship Year Plan Agreement that is filed with the state licensing board for a license to practice speech-language pathology must be submitted with the provider application and Medicaid contract.~~

B. ~~A qualified speech-language pathologist must be licensed to practice as a speech-language pathologist in his or her state. A copy of the state license must accompany the provider application and Medicaid contract. Subsequent license renewals must be provided when issued.~~

~~202.320 Enrollment Criteria for a Speech-Language Pathology Assistant~~ ~~10-13-03~~

A. ~~A speech-language pathology assistant must have at least a bachelor's degree in speech-language pathology.~~

B. ~~A speech-language pathology assistant must be currently registered with the Arkansas Board of Examiners in Speech-Language Pathology and Audiology (ABESPA). A copy of the current registration must accompany the provider application and the Medicaid contract. Subsequent renewals of registration must be provided when issued.~~

C. ~~A speech-language pathology assistant must be under the "supervision" (as defined by ABESPA) of a qualified speech-language pathologist.~~

~~202.330 State Licensure Exemptions Under Arkansas Code §17-100-104~~ ~~7-1-18~~

~~Arkansas Code §17-97-104, as amended, makes it lawful for a person to perform speech-language pathology services without Arkansas licensure as:~~

A. ~~A person performing speech-language pathology services solely within the confines or under the jurisdiction of a public school system if that person holds a valid and current certificate as a speech therapist or speech-language pathologist issued by the Arkansas Department of Education. [Arkansas Code §17-100-104, (4)]~~

B. ~~A person performing speech-language pathology services solely within the confines of the person's duties as an employee of the State of Arkansas, provided that the person was an employee of the State of Arkansas on January 1, 1993. [Arkansas Code §17-100-104, (7)]~~

C. ~~A person performing speech-language pathology services solely within the confines of the person's duties as an employee of any entity licensed or certified as a Developmental Disability Services community provider by the Division of Provider Services and Quality Assurance (DPSQA) Services. That person must hold a minimum of a bachelor's degree in speech-language pathology, must be supervised by a licensed speech-language pathologist and must comply with Arkansas regulations as a Speech-Language Pathology Support Personnel. [Arkansas Code §17-100-104 (8)]~~

~~203.000 Supervision~~ ~~1-1-21~~

~~The Arkansas Medicaid Program uses the following criteria to determine when supervision occurs within the Occupational, Physical, and Speech-Language Therapy Services Program.~~

~~A. The person who is performing supervision must be a paid employee of the enrolled Medicaid provider of therapy or speech-language pathology services who is filing claims for services.~~

~~B. The qualified therapist or speech-language pathologist must monitor and be responsible for the quality of work performed by the individual under his or her supervision.~~

~~1. The qualified therapist or speech-language pathologist must be immediately available to provide assistance and direction throughout the time the service is being performed. Availability by telecommunication is sufficient to meet this requirement.~~

~~2. When therapy services are provided by a licensed therapy assistant or speech-language pathology assistant who is supervised by a licensed therapist or speech-language pathologist, the supervising therapist or speech-language pathologist must observe a therapy session with a child and review the treatment plan and progress notes at a minimum of every 30 calendar days.~~

~~C. The qualified therapist or speech-language pathologist must review and approve all written documentation completed by the individual under his or her supervision prior to the filing of claims for the service provided.~~

~~1. Each page of progress note entries must be signed by the supervising therapist with his or her full signature, credentials and date of review.~~

~~2. The supervising therapist must document approval of progress made and any recommended changes in the treatment plan.~~

~~3. The services must be documented and available for review in the beneficiary's medical record.~~

~~D. The qualified therapist or speech-language pathologist may not be responsible for the supervision of more than 5 individuals.~~

~~203.100 Speech-Language Pathologist/Speech-Language Therapist Supervision~~ ~~1-1-21~~

~~Individuals **must** be under the supervision of a qualified speech-language pathologist if the following conditions exist.~~

~~A. The individual is employed by an Arkansas school district or educational service and meets **one** of the following:~~

~~1. Holds a current Arkansas teaching certificate as a Speech Therapist,~~

~~2. Holds a current Arkansas teaching certificate as a Speech Pathologist I,~~

~~3. Holds a current Arkansas teaching certificate as a Speech Pathologist II and does not meet any one of the Medicaid federally mandated requirements for a qualified speech-language pathologist. (See Section 202.300 of this manual.)~~

~~B. The individual is **not** employed by an Arkansas school district, an education service cooperative, a regular group provider of therapy services or the Division of Developmental Disabilities Services and:~~

~~1. Is licensed by the Arkansas Board of Examiners in Speech-Language Pathology and Audiology (ABESPA) as a speech-language pathologist, but~~

~~2. Does not meet any one of the Medicaid federally mandated requirements for qualified speech-language pathologist (See Section 202.300 of this manual.)~~

~~C. In the six bordering states (Louisiana, Mississippi, Missouri, Oklahoma, Tennessee and Texas) an individual provider of speech-language pathology services:~~

1. ~~Does not meet any one of the Medicaid federally mandated requirements for a qualified speech-language pathologist (see Section 202.300 of this manual) but~~

2. ~~The individual provider of speech-language pathology services must be licensed as a speech-language pathology assistant in his or her state.~~

~~204.000 Required Documentation~~ ~~7-1-18~~

~~All Provider Participation requirements detailed within Section 140.000 must be met. The additional documentation requirements below also apply to Occupational, Physical and Speech-Language Therapy providers:~~

~~A. Providers of therapy services are required to maintain the following records for each beneficiary of therapy services.~~

1. ~~A written referral for occupational therapy, physical therapy or speech-language pathology services is required from the patient's primary care physician (PCP) unless the beneficiary is exempt from PCP Managed Care Program requirements.~~

   a. ~~If the beneficiary is exempt from the PCP process, then the beneficiary's attending physician will make referrals for therapy services.~~

   b. ~~Providers of therapy services are responsible for obtaining renewed PCP referrals every twelve (12) months. Please refer to Section I of this manual for policies and procedures regarding PCP referrals.~~

2. ~~A written prescription for occupational, physical therapy and speech-language pathology services signed and dated by the PCP or attending physician.~~

   a. ~~The beneficiary's PCP or the physician specialist must sign the prescription.~~

   b. ~~A prescription for therapy services is valid for 1 year unless the prescribing physician specifies a shorter period.~~

3. ~~A treatment plan or plan of care (POC) for the prescribed therapy developed and signed by providers credentialed and licensed in the prescribed therapy or by a physician. The plan must include goals that are functional, measurable and specific for each individual client.~~

4. ~~Where applicable, an Individualized Family Service Plan (IFSP), Individual Program Plan (IPP) or *Individual Educational Plan (*IEP), established pursuant to Part C of the Individuals with Disabilities Education Act. *The entire volume of the IEP is not required for documentation purposes of retrospective review or audit of a facility's therapy services. Pages one (1) and two (2), the Goals and Objectives page (pertinent to the therapy requested) and the Signature Page of the IEP are all that are normally required for verification as review documentation.~~

5. ~~Where applicable, an *Individual Educational Plan (*IEP) established pursuant to Part B of the Individuals with Disabilities Education Act. *The entire volume of the IEP is not required for documentation purposes of retrospective review or audit of a facility's therapy services. Pages one (1) and two (2), the Goals and Objectives page (pertinent to the therapy requested) and the Signature Page of the IEP are all that are normally required for verification as review documentation.~~

6. ~~Description of specific therapy or speech-language pathology service(s) provided with date, actual time service(s) were rendered, and the name of the individual providing the service(s).~~

7. ~~All therapy evaluation reports, dated progress notes describing the beneficiary's progress signed by the individual providing the service(s) and any related correspondence.~~

8. ~~Discharge notes and summary.~~

B. Any individual providing therapy services or speech-language pathology services must have on file:

1. Verification of his or her qualifications. Refer to Section 202.000 of this manual.

2. When applicable, any written contract between the individual and the school district, education service cooperative or the Division of Developmental Disabilities Services.

C. Any group provider enrolled as a Medicaid provider is responsible for maintaining appropriate employment records for all qualified therapists, speech-language pathologists and for all therapy or speech-language pathology assistants employed by the group.

D. School districts or education service cooperatives must have on file all appropriate employment records for qualified therapists, speech-language pathologists and for all therapy or pathology assistants employed by the group. A copy of verification of the employee credentials and qualifications is to be maintained in the group provider's employee files.

E. A cooperative for multiple school districts that provides, by contractual agreement, the qualified speech-language pathologist to supervise speech-language pathology assistants or speech therapists must have on file the contractual agreement.

204.100 Electronic Signatures 10-8-10

Medicaid will accept electronic signatures provided the electronic signatures comply with Arkansas Code § 25-31-103 et seq.

205.000 The Physician's Role in the Occupational, Physical, Speech-Language Therapy Program 1-1-21

All occupational, physical, and speech-language therapy services must be medically necessary. Medicaid accepts a physician's diagnosis that clearly establishes and supports medical necessity for therapy treatment. These services require a referral from the beneficiary's primary care physician (PCP) or the attending physician if the beneficiary is exempt from PCP Managed Care Program requirements. (See Section I of this manual.) Therapy treatment services also require a prescription written by the physician who refers the beneficiary to the therapist for services.

206.000 The Role of the Occupational Therapist, Physical Therapist and Speech-Language Pathologist in the Child Health Services (EPSDT) Program 10-13-03

The Child Health Services (EPSDT) Program is a federally mandated child health component of Medicaid. It is designed to bring comprehensive health care to individuals eligible for medical assistance from birth to their 21st birthday. The purpose of this program is to detect and treat health problems in the early stages and to provide preventive health care, including necessary immunizations. Child Health Services (EPSDT) combines case management and support services with screening, diagnostic and treatment services delivered on a periodic basis.

A provider of therapy services may recommend an EPSDT screening for any child that is thought to need one. If a therapist receives a referral as a result of an EPSDT screening, therapy services may be provided.

A. Treatment means physician, hearing, visual, dental, or therapy services, and any other type of medical care and services recognized under state law to prevent or correct diseases or abnormalities detected by screening or by diagnostic procedures.

Physicians and other health professionals who do Child Health Services (EPSDT) screening may diagnose and treat health problems discovered during the screening or may refer the child to other appropriate sources for treatment.

B. If a condition is diagnosed through a Child Health Services (EPSDT) screen that requires treatment services not normally covered under the Arkansas Medicaid Program, those treatment services will also be considered for reimbursement if the service is medically necessary and permitted under federal Medicaid regulations.

207.000 Referral to First Connections program, pursuant to Part C of Individuals with Disabilities Education Act ("IDEA") 7-1-18

DDS is the lead agency responsible for the general administration and supervision of the programs and activities utilized to carry out the provisions of Part C of the IDEA. First Connections is the DDS program in Arkansas that administers, monitors, and carries out all Part C of IDEA activities and responsibilities for the state. The First Connections program ensures that appropriate early intervention services are available to all infants and toddlers from birth to thirty-six (36) months of age (and their families) that are suspected of having a developmental delay.

Federal regulations under Part C of the IDEA require "primary referral sources" to refer any child suspected of having a developmental delay or disability for early intervention services. A physical, occupational, or speech therapist is considered a primary referral source under Part C of IDEA regulations.

Each provider must, within two (2) working days of first contact, refer all infants and toddlers from birth to thirty-six (36) months of age for whom there is a diagnosis or suspicion of a developmental delay or disability. The referral must be made to the DDS First Connections Central Intake Unit, which serves as the State of Arkansas' single point of entry to minimize duplication and expedite service delivery. Each provider is responsible for maintaining documentation evidencing that a proper and timely referral to First Connections has been made.

208.000 Referral to LEA, pursuant to Part B of the Individuals with Disabilities Education Act (IDEA) 1-1-21

Local Education Agencies (LEA) have the responsibility to ensure that children from ages three (3) until entry into Kindergarten who have or are suspected of having a disability under Part B of IDEA ("Part B") receive a Free Appropriate Public Education.

Each therapist must, within two (2) working days of first contact, refer children ages three (3) until entry into Kindergarten for whom there is a diagnosis or suspicion of a developmental delay or disability. For children who are turning three years of age while receiving services at the center, the referral must be made at least 90 days prior to the child's third birthday. If the child begins services less than 90 days prior to their third birthday, the referral should be made in accordance with the late referral requirements of the IDEA.

The referral must be made to the LEA where that child resides. Each therapist is responsible for maintaining documentation evidencing that a proper and timely referral to has been made.

209.000 Third Party Liability 10-13-03

Title 42 Code of Federal Regulations (CFR), Part 433, Subpart D, Third Party Liability (see Section III of this manual) requires that all third party sources must be utilized before reimbursement is made by Medicaid. Part B of the Individuals with Disabilities Education Act and Section 504 of the Rehabilitation Act of 1973 prohibit a public agency from requiring parents, where they would incur a financial cost, to use insurance proceeds to pay for services that must be provided to a child with disabilities under the "free appropriate public education" requirements of these statutes.

Neither Part B of the Individuals with Disabilities Education Act nor Section 504 of the Rehabilitation Act of 1973 create exceptions to applicable Medicaid requirements cited in Title 42 CFR, Part 433, Subpart D relative to third party liability. All Medicaid providers, including school districts, education service cooperatives, individual and regular group providers,

~~must abide by the payment of claims provisions in Title 42 CFR, Part 433, Subpart D when third parties are involved.~~

~~210.000 PROGRAM COVERAGE~~

~~211.000 Introduction~~ ~~1-1-21~~

~~The Arkansas Medicaid Occupational, Physical, and Speech-Language Therapy Program reimburses therapy services for Medicaid-eligible individuals under the age of 21 in the Child Health Services (EPSDT) Program.~~

~~Therapy services for individuals aged 21 and older are only covered when provided through the following Medicaid Programs: Adult Developmental Day Treatment (ADDT), Hospital/Critical Access Hospital (CAH)/End-Stage Renal Disease (ESRD), Home Health, Hospice and Physician/Independent Lab/CRNA/Radiation Therapy Center. Refer to these Medicaid provider manuals for conditions of coverage and benefit limits.~~

~~Medicaid reimbursement is conditional upon providers' compliance with Medicaid policy as stated in this provider manual, manual update transmittals and official program correspondence.~~

~~All Medicaid benefits are based on medical necessity. Refer to the Glossary for a definition of *medical necessity*.~~

~~212.000 Scope~~ ~~1-1-21~~

~~Occupational therapy, physical therapy and speech-language pathology services are those services defined by applicable state and federal rules and regulations. These services are covered only when the following conditions exist.~~

~~A. Services are provided only by appropriately licensed individuals who are enrolled as Medicaid providers in keeping with the participation requirements in Section 201.000 of this manual.~~

~~B. Services are provided as a result of a referral from the beneficiary's primary care physician (PCP). If the beneficiary is exempt from the PCP process, then the attending physician must make the referrals.~~

~~C. Treatment services must be provided according to a written prescription signed by the PCP, or the attending physician, as appropriate.~~

~~D. Treatment services must be provided according to a treatment plan or a plan of care (POC) for the prescribed therapy, developed and signed by providers credentialed or licensed in the prescribed therapy or by a physician.~~

~~E. Medicaid covers occupational therapy, physical therapy, and speech-language therapy services when provided to eligible Medicaid beneficiaries under age 21 in the Child Health Services (EPSDT) Program by qualified occupational, physical, or speech-language therapy providers.~~

~~F. Therapy services for individuals over age 21 are only covered when provided through the following Medicaid Programs: Adult Developmental Day Treatment (ADDT), Hospital/Critical Access Hospital (CAH), Rehabilitative Hospital, Home Health, Hospice and Physician. Refer to these Medicaid provider manuals for conditions of coverage and benefit limits.~~

~~213.000 Exclusions~~ ~~10-13-03~~

~~An individual who has been admitted as an inpatient to a hospital or is residing in a nursing care facility is not eligible for occupational therapy, physical therapy and speech-language pathology services under this program. Individuals residing in residential care facilities and supervised living facilities may be eligible for these therapy services when provided on or off site from the facility.~~

~~214.000 Occupational, Physical, and Speech-Language Therapy Services~~ ~~1-1-21~~

~~A. Occupational, physical, and speech-language therapy services require a referral from the beneficiary's primary care physician (PCP) unless the beneficiary is exempt from PCP Program requirements. If the beneficiary is exempt from the PCP process, referrals for therapy services are required from the beneficiary's attending physician. All therapy services for beneficiaries under the age of 21 years require referrals and prescriptions be made utilizing the "Occupational, Physical and Speech-Language Therapy for Medicaid Eligible Beneficiaries Under Age 21" form DMS-640.~~

~~B. Occupational, physical, and speech-language therapy services also require a written prescription signed by the PCP or attending physician, as appropriate.~~

~~1. Providers of therapy services are responsible for obtaining renewed PCP referrals at least once every twelve (12) months even if the prescription for therapy is for one year.~~

~~2. A prescription for therapy services is valid for the length of time specified by the prescribing physician, up to one year.~~

~~C. When a school district is providing therapy services in accordance with a child's Individualized Education Program (IEP), a PCP referral is required at the beginning of each school year. The PCP referral for the therapy services related to the IEP can be for the 9-month school year.~~

~~D. The PCP or attending physician is responsible for determining medical necessity for therapy treatment.~~

~~1. The individual's diagnosis must clearly establish and support that the prescribed therapy is medically necessary.~~

~~2. Diagnosis codes and nomenclature must comply with the coding conventions and requirements established in **International Classification of Diseases Clinical Modification** in the edition Medicaid has certified as current for the patient's dates of service.~~

~~3. Please note the following diagnosis codes are not specific enough to identify the medical necessity for therapy treatment and may not be used.~~ **~~(View ICD codes.)~~**

~~E. Therapy services providers must use form DMS-640 – "Occupational, Physical and Speech-Language Therapy for Medicaid Eligible Beneficiaries Under Age 21 Prescription/Referral" – to obtain the PCP referral and the written prescription for therapy services for any beneficiary under the age of 21 years.~~ **~~View or print form DMS-640~~**~~. Exclusive use of this form will facilitate the process of obtaining referrals and prescriptions from the PCP or attending physician. A copy of the prescription must be maintained in the beneficiary's records. The original prescription is to be maintained by the physician. Form DMS-640 must be used for the initial referral for evaluation and a separate DMS-640 is required for the prescription. After the initial referral using the form DMS-640 and initial prescription utilizing a separate form DMS-640, subsequent referrals and prescriptions for continued therapy may be made at the same time using the same DMS-640. Instructions for completion of form DMS-640 are located on the back of the form. Medicaid will accept an electronic signature provided that it is compliance with Arkansas Code 25-31-103. When an electronic version of the DMS-640 becomes part of the physician or provider's~~

~~electronic health record, the inclusion of extraneous patient and clinic information does not alter the form.~~

~~To order copies from the Arkansas Medicaid fiscal agent use Form MFR-001 – Medicaid Forms Request.~~ **~~View or Print the Medicaid Form Request MFR-001~~**.

~~F. A treatment plan developed and signed by a provider who is credentialed and licensed in the prescribed therapy or by a physician is required for the prescribed therapy.~~

~~1. The plan must include goals that are functional, measurable, and specific for each individual child.~~

~~2. Services must be provided in accordance with the treatment plan, with clear documentation of service rendered. Refer to Section 204.000, part D, of this manual for more information on required documentation.~~

~~G. Make-up therapy sessions are covered in the event a therapy session is canceled or missed if determined medically necessary and prescribed by the beneficiary's PCP. Any make-up therapy session requires a separate prescription from the original prescription previously received. Form DMS-640 must be used by the PCP or attending physician for any make-up therapy session prescriptions.~~

~~H. Therapy services carried out by an unlicensed therapy student may be covered only when the following criteria are met:~~

~~1. Therapies performed by an unlicensed student must be under the direction of a licensed therapist, and the direction is such that the licensed therapist is considered to be providing the medical assistance.~~

~~2. To qualify as providing the service, the licensed therapist must be present and engaged in student oversight during the entirety of any encounter that the provider expects Medicaid to cover.~~

~~I. Refer to Section 260.000 of this manual for procedure codes and billing instructions and Section 216.100 of this manual for information regarding extended therapy benefits.~~

~~214.100 Utilization Review and Office of Medicaid Inspector General~~ ~~1-1-16~~

~~A. The Utilization Review and Office of Medicaid Inspector General of the Arkansas Medicaid Program have the responsibility for assuring quality medical care for Medicaid beneficiaries and for protecting the integrity of state and federal funds supporting the Medical Assistance Program. Those responsibilities are mandated by federal regulations.~~

~~B. The Utilization Review and Office of Medicaid Inspector General shall:~~

~~1. Conduct on-site medical audits for the purpose of verifying the nature and extent of services paid for by the Medicaid Program,~~

~~2. Research all inquiries from beneficiaries in response to the Explanation of Medicaid Benefits and~~

~~3. Retrospectively evaluate medical practice patterns and providers' patterns by comparing each provider's pattern to norms and limits set by all the providers of the same specialty.~~

~~214.200 Guidelines for Review of Occupational, Physical, and Speech-Language Therapy Services~~ ~~1-1-21~~

~~Prior authorization of extension of benefits is required when a physician prescribes more than 90 minutes of therapy per week in one or more therapy discipline(s). Retrospective review of occupational, physical, and speech-language therapy services is required for beneficiaries under~~

~~age 21 who are receiving 90 minutes per week or less of therapy services in each discipline or who are receiving rehabilitation therapy after an injury, illness or surgical procedure. The purpose of all review is the promotion of effective, efficient and economical delivery of health care services.~~

~~Retrospective review of occupational, physical, and speech-language evaluations is required for beneficiaries under age 21 who receive an evaluation less than six months from the previous evaluation when the provider is utilizing a complexity code rather than a timed code.~~

~~The Quality Improvement Organization (QIO), under contract to the Medicaid Program, performs retrospective reviews by reviewing medical records to determine if services delivered and reimbursed by Medicaid meet medical necessity requirements.~~ **~~View or print QIO contact information.~~**

~~Specific guidelines have been developed for occupational, physical, and speech-language therapy retrospective reviews. These guidelines may be found in Sections 214.300 and 214.400.~~

~~214.210 Retrospective Therapy Review Process~~ ~~7-1-18~~

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

~~On a calendar quarterly basis, the Quality Improvement Organization (QIO) under contract with Arkansas Medicaid, will select and review a percentage random sample of all the therapy services billed and paid during the past three months (previous quarter) that were either (1) 90 minutes or less per week or (2) were provided pursuant to a rehabilitation diagnosis (related to an injury, illness or surgical procedure). The request for record copies is mailed to each provider along with instructions for returning the records. The request asks for the child's parent/guardian name and address and lists the child's name, date of birth, Medicaid identification number, dates of services, type of therapy, date of request and a listing of the documentation required for review. The provider(s) must provide the information to the QIO within 30 calendar days of the request date printed in the record request cover letter. If the requested information is not received within the 30 day timeframe, a medical necessity denial is issued.~~

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

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

~~Records will not be accepted via facsimile or email.~~

~~214.220 Medical Necessity Review~~ ~~7-1-18~~

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

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

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

~~214.230 Utilization Review~~ ~~7-1-18~~

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

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

~~214.240 Denial/Due Process~~ ~~7-1-18~~

~~Therapy Reviews may result in either a medical necessity or a utilization denial. For utilization only denials, the service provider is notified in writing of the denied services. The denial notification provides case specific rationale for the denial and will include instructions for requesting reconsideration. If the denial is for medical necessity, the PCP or attending physician and the services provider(s) will be notified in writing of the medical necessity denial. Each denial letter contains case specific denial rationale. The PCP denial letter informs the physician~~

~~that a denial for therapy services on a specific Medicaid beneficiary has been issued. It states that he is being notified for information only because he might be called upon by the providers(s) to assist in the request for reconsideration. For either denial type, the provider is allowed 35 calendar days to submit additional information for reconsideration. Reconsideration review will not be performed if the additional information does not contain substantially different information than that previously submitted. Only one reconsideration is allowed per denial.~~

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

~~214.250 Reconsideration Review~~ ~~3-1-06~~

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

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

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

~~214.260 Complaints~~ ~~10-1-08~~

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

~~214.300 Occupational and Physical Therapy Guidelines for Review~~ ~~7-1-18~~

~~A. Medical Necessity~~

~~Occupational and physical therapy services must be medically necessary to the treatment of the individual's illness or injury. A diagnosis alone is not sufficient documentation to support the medical necessity of therapy. 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.)~~

~~B. Evaluations and Report Components~~

~~To establish medical necessity, a comprehensive assessment in the suspected area of deficit must be performed. A comprehensive assessment must include:~~

~~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, if the child is 12 months of age or younger, gestational age. The child should be tested in the child's dominant language; if not, an explanation must be provided in the evaluation.~~

   ~~**NOTE: To calculate a child's gestational age, subtract the number of weeks born before 40 weeks of gestation from the chronological age. Therefore, a 7-month-old, former 28 week gestational age infant has a corrected age of 4 months according to the following equation:**~~

   ~~**7 months - [(40 weeks) - 28 weeks) / 4 weeks]**~~

   ~~**7 months - [(12) / 4 weeks]**~~

   ~~**7 months - [3]**~~

   ~~**4 months**~~

5. ~~Standardized test results, including all subtest scores, if applicable. 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.~~

6. ~~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.~~

7. ~~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 (strengths and weaknesses).~~

8. ~~An interpretation of the results of the evaluation, including recommendations for therapy/minutes per week.~~

9. ~~A description of functional strengths and limitations, a suggested treatment plan and potential goals to address each identified problem.~~

10. ~~Signature and credentials of the therapist performing the evaluation.~~

C. ~~Interpretation and Eligibility: Ages Birth to 21~~

1. ~~Tests used must be norm-referenced, standardized and specific to the therapy provided.~~

2. ~~Tests must be age appropriate for the child being tested.~~

3. ~~All subtests, components and scores must be reported for all tests used for eligibility purposes.~~

4. ~~Eligibility for therapy will be based upon a score of -1.5 standard deviations (SD) below the mean or greater in at least one subtest area or composite score on a norm-referenced, standardized test. When a -1.5 SD or greater is not indicated by the test, a criterion-referenced test along with informed clinical opinion must be included to support the medical necessity of 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 the Accepted Tests sections for a list of standardized tests accepted by Arkansas Medicaid for retrospective reviews.~~

7. ~~Range of Motion: A limitation of greater than ten degrees and/or documentation of how a deficit limits function.~~

8. ~~Muscle Tone: Modified Ashworth Scale.~~

9. ~~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.~~

10. ~~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.~~

11. ~~Children (birth to age 21) receiving services outside of the public schools, and adults receiving services in an Adult Developmental Day Treatment (ADDT) program, must be evaluated annually.~~

12. ~~Children (age three to 21) receiving services within public schools, as a part of an Individual Program Plan (IPP) or an Individual Education Plan (IEP), must have a full evaluation every three years; however, an annual update of progress is required. "School-related" means the child is of school age, attends public school and receives therapy provided by the school.~~

D. ~~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 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 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.~~

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 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.~~

~~214.310 Accepted Tests for Occupational Therapy~~ ~~7-1-18~~

~~Tests used must be norm-referenced, standardized, age appropriate and specific to the suspected area(s) of deficit. The following list of tests is not all-inclusive. When using a test that is not listed below, the provider must include an explanation and justification in the evaluation report to support the use of the chosen test. The *Mental Measurement Yearbook (MMY)* is the standard reference for determining the reliability and validity of the test(s) administered in an evaluation. Providers should refer to the *MMY* for additional information regarding specific tests. These definitions are applied to the lists of accepted tests:~~

- ~~STANDARDIZED: Tests that are used to determine the presence or absence of deficits; any diagnostic tool or procedure that has a standardized administration and scoring process and compares results to an appropriate normative sample.~~
- ~~SUPPLEMENTAL: Tests and tools that are not norm-referenced, such as screeners, criterion-referenced measures, descriptive design tools, structured probes, and clinical analysis procedures. These tools are numerous with new ones being frequently created/published. These measures are only used to further document deficits and support standardized test results. These measures do not replace the use of standardized tests. You are free to use supplemental tools of your own choosing to guide data collection, to generate in-depth, functional profiles, and/or to support standardized testing when appropriate, or as indicated in these regulations. (See Section 214.400, part D, paragraph 8.)~~
- ~~CLINICAL OBSERVATIONS: Clinical observations have a supplemental role in the evaluation process and should always be included. They are especially important when standard scores do not accurately reflect a child's deficits in order to qualify the child for therapy. A detailed narrative or description of a child's limitations and how they affect functional performance may constitute the primary justification of medical necessity when a standardized evaluation is inappropriate. (See Section 214.400, part D, paragraph 8.)~~

A. ~~Occupational Therapy Tests — Standardized (Newer editions of currently listed tests are also acceptable. Previous versions that have original protocols available are also accepted.)~~

~~Test~~	~~Abbreviation~~
~~Adaptive Behavior Scale — School Edition~~	~~ABS-S~~
~~Ashworth Scale~~	
~~Box & Block Test of Manual Dexterity~~	~~BBT~~
~~Bruininks-Oseretsky Test of Motor Proficiency~~	~~BOMP~~
~~Bruininks-Oseretsky Test of Motor Proficiency — Second Edition~~	~~BOT-2~~
~~Children's Handwriting Evaluation Scale~~	~~CHES~~
~~Cognitive Performance Test~~	~~CPT~~
~~DeGangi-Berk Test of Sensory Integration~~	~~TSI~~
~~Developmental Test of Visual Motor Integration~~	~~VMI~~
~~Developmental Test of Visual Perception, Second Edition~~	~~DTVP~~
~~Evaluation Tool of Children's Handwriting~~	~~ETCH~~

~~Test~~	~~Abbreviation~~
~~Functional Independence Measure — young version~~	~~WeeFIM~~
~~Functional Independence Measure — 7 years of age to adult~~	~~FIM~~
~~Jacobs Prevocational Skills Assessment~~	
~~Kohlman Evaluation of Living Skills~~	~~KELS~~
~~Miller Function and Participation Scales~~	~~M-Fun~~
~~Milwaukee Evaluation of Daily Living Skills~~	~~MEDLS~~
~~Motor Free Visual Perception Test~~	~~MVPT~~
~~Motor Free Visual Perception Test — Revised~~	~~MVPT-R~~
~~Mullen Scales of Early Learning~~	~~MSEL~~
~~Peabody Developmental Motor Scales — 2~~	~~PDMS-2~~
~~Pediatric Evaluation of Disability Inventory~~ ~~**NOTE: The PEDI can also be used for older children whose functional abilities fall below that expected of a 7 ½ year old with no disabilities. In this case, the scaled score is the most appropriate score to consider.**~~	~~PEDI~~
~~Purdue Pegboard Test~~	
~~Range of Motion~~	~~ROM~~
~~Sensory Integration and Praxis Test~~	~~SIPT~~
~~Sensory Integration Inventory Revised~~	~~SII-R~~
~~Sensory Processing Measure~~	~~SPM~~
~~Sensory Processing Measure — Preschool~~	~~SPM-P~~
~~Sensory Profile, Adolescent/Adult~~	
~~Sensory Profile, Infant/Toddler~~	
~~Sensory Profile~~	
~~Sensory Profile School Companion~~	
~~Test of Handwriting Skills~~	~~THS~~
~~Test of Infant Motor Performance~~	~~TIMP~~
~~Test of Visual Motor Integration~~	~~TVMI~~
~~Test of Visual Motor Skills~~	~~TVMS~~
~~Test of Visual Motor Skills — R~~	~~TVMS-R~~
~~Test of Visual Perceptual Skills~~	~~TVPS~~
~~Test of Visual Perceptual Skills — Upper Level~~	~~TVPS~~
~~Toddler and Infant Motor Evaluation~~	~~TIME~~
~~Wide Range Assessment of Visual Motor Abilities~~	~~WRAVMA~~

~~214.320 Accepted Tests for Physical Therapy~~ ~~7-1-17~~

~~Tests used must be norm-referenced, standardized, age appropriate and specific to the suspected area(s) of deficit. The following list of tests is not all-inclusive. When using a test that is not listed below, the provider must include an explanation and justification in the evaluation report to support the use of the chosen test. The *Mental Measurement Yearbook (MMY)* is the standard reference for determining the reliability and validity of the tests administered in an evaluation. Providers should refer to the *MMY* for additional information regarding specific tests. These definitions are applied to the following lists of accepted tests:~~

~~STANDARDIZED: Tests that are used to determine the presence or absence of deficits; any diagnostic tool or procedure that has a standardized administration and scoring process and compares the results to an appropriate normative sample.~~

~~SUPPLEMENTAL: Tests and tools that are not norm-referenced, such as screeners, criterion-referenced measures, descriptive design tools, structured probes, and clinical analysis procedures. These tools are numerous with new ones being frequently created/published. These measures are only used to further document deficits and support standardized test results. These measures do not replace the use of standardized tests. You are free to use supplemental tools of your own choosing to guide data collection, to generate in-depth, functional profiles, and/or to support standardized testing when appropriate, or as indicated in these regulations. (See Section 214.400, part D, paragraph 8.)~~

~~CLINICAL OBSERVATIONS: Clinical observations have a supplemental role in the evaluation process and should always be included. They are especially important when standard scores do not accurately reflect a child's deficits in order to qualify the child for therapy. A detailed narrative or description of a child's limitations and how they affect functional performance may constitute the primary justification of medical necessity when a standardized evaluation is inappropriate (See Section 214.400, part D, paragraph 8).~~

~~A. Physical Therapy Tests — Standardized (Newer editions of currently listed tests are also acceptable. Previous versions that have original protocols available are also accepted.)~~

~~Test~~	~~Abbreviation~~
~~Alberta Infant Motor Scale~~	~~AIMS~~
~~Adaptive Behavior Inventory~~	~~ABI~~
~~Adaptive Behavior Scale — School, Second Edition~~	~~ABS-S:2~~
~~Ashworth Scale~~	
~~Assessment of Adaptive Areas~~	~~AAA~~
~~Bruininks-Oseretsky test of Motor Proficiency~~	~~BOMP~~
~~Bruininks-Oseretsky Test of Motor Proficiency, Second Edition~~	~~BOT-2~~
~~Comprehensive Trail-Making Test~~	~~CTMT~~
~~Functional Independence Measure for Children~~	~~WeeFIM~~
~~Functional Independence Measure — 7 years of age to adult~~	~~FIM~~
~~Gross Motor Function Measure~~	~~GMFM~~
~~Movement Assessment Battery for Children~~	~~Movement ABC~~
~~Mullen Scales of Early Learning~~	~~MSEL~~
~~Peabody Developmental Motor Scales, Second Edition~~	~~PDMS-2~~
~~Pediatric Balance Scale~~	~~PBS~~

~~Test~~	~~Abbreviation~~
~~Pediatric Evaluation of Disability Inventory~~ ~~**NOTE: The PEDI can also be used for older children whose functional abilities fall below that expected of a 7 ½ year old with no disabilities. In this case, the scaled score is the most appropriate score to consider.**~~	~~PEDI~~
~~Range of Motion — Functional Performance Impairments~~	~~ROM~~
~~Sensory Processing Measure~~	~~SPM~~
~~Sensory Processing Measure-Preschool~~	~~SPM-P~~
~~Test of Infant Motor Performance~~	~~TIMP~~
~~Test of Gross Motor Development, Second Edition~~	~~TGMD-2~~
~~Toddler and Infant Motor Evaluation~~	

~~214.400 Speech-Language Therapy Guidelines for Review~~ ~~1-1-21~~

~~A. Medical Necessity~~

~~Speech-language therapy services must be medically necessary to the treatment of the individual's illness or injury. A diagnosis alone is not sufficient documentation to support the medical necessity of therapy. 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.)~~

~~B. Types of Communication Disorders~~

~~1. Language Disorders — Impaired comprehension and/or use of spoken, written and/or other symbol systems. This disorder may involve the following components: forms of language (phonology, morphology, syntax), content and meaning of language (semantics, prosody), function of language (pragmatics) and/or the perception/processing of language. Language disorders may involve one, all or a combination of the above components.~~

~~2. Speech Production Disorders — Impairment of the articulation of speech sounds, voice and/or fluency. Speech Production disorders may involve one, all or a combination of these components of the speech production system.~~

~~A speech production disorder may manifest as an individual sound deficiency, i.e., traditional articulation disorder, incomplete or deviant use of the phonological system, i.e., phonological disorder, or poor coordination of the oral-motor mechanism for purposes of speech production, i.e., verbal and/or oral apraxia, dysarthria.~~

~~3. Oral Motor/Swallowing/Feeding Disorders — Impairment of the muscles, structures and/or functions of the mouth (physiological or sensory-based) involved with the entire act of deglutition from placement and manipulation of food in the mouth~~

through the oral and pharyngeal phases of the swallow. These disorders may or may not result in deficits to speech production.

C. Evaluation and Report Components

1. STANDARDIZED SCORING KEY:

Mild: Scores between 84-78; -1.0 standard deviation

Moderate: Scores between 77-71; -1.5 standard deviations

Severe: Scores between 70-64; -2.0 standard deviations

Profound: Scores of 63 or lower; -2.0+ standard deviations

2. LANGUAGE: To establish medical necessity, results from a comprehensive assessment in the suspected area of deficit must be reported. (Refer to Section 214.400, part D, paragraphs 9-12 for required frequency of re-evaluations.) A comprehensive assessment for Language disorder must include:

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, if the child is 12 months of age or younger, gestational age. The child should be tested in the child's dominant language; if not, an explanation must be provided in the evaluation.

NOTE: To calculate a child's gestational age, subtract the number of weeks born before 40 weeks of gestation from the chronological age. Therefore, a 7-month-old, former 28 week gestational age infant has a corrected age of 4 months according to the following equation:

7 months - [(40 weeks) - 28 weeks) / 4 weeks]

7 months - [(12) / 4 weeks]

7 months - [3]

4 months

e. Results from an assessment specific to the suspected type of language disorder, including all relevant scores, quotients and/or indexes, if applicable. A comprehensive measure of language must be included for initial evaluations. Use of one-word vocabulary tests alone will not be accepted. (Review Section 214.410 — Accepted Tests for Speech-Language Therapy.)

f. 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.

g. Oral-peripheral speech mechanism examination, which includes a description of the structure and function of the orofacial structures.

h. Formal or informal assessment of hearing, articulation, voice and fluency skills.

i. An interpretation of the results of the evaluation including recommendations for frequency and intensity of treatment.

j. A description of functional strengths and limitations, a suggested treatment plan and potential goals to address each identified problem.

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

3. SPEECH PRODUCTION (Articulation, Phonological, Apraxia): To establish medical necessity, results from a comprehensive assessment in the suspected area of deficit

~~must be reported. (Refer to Section 214.400, part D, paragraphs 9-12 for required frequency of re-evaluations.) A comprehensive assessment for Speech Production (Articulation, Phonological, Apraxia) disorder must include:~~

~~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, if the child is 12 months of age or younger, gestational age. The child should be tested in the child's dominant language; if not, an explanation must be provided in the evaluation.~~

~~**NOTE: To calculate a child's gestational age, subtract the number of weeks born before 40 weeks of gestation from the chronological age. Therefore, a 7-month-old, former 28 week gestational age infant has a corrected age of 4 months according to the following equation:**~~

~~**7 months - [(40 weeks) - 28 weeks) / 4 weeks]**~~

~~**7 months - [(12) / 4 weeks]**~~

~~**7 months - [3]**~~

~~**4 months**~~

~~e. Results from an assessment specific to the suspected type of speech production disorder, including all relevant scores, quotients and/or indexes, if applicable. All errors specific to the type of speech production disorder must be reported (e.g., positions, processes, motor patterns). (Review Section 214.410 — Accepted Tests for Speech-Language Therapy.)~~

~~f. 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.~~

~~g. Oral-peripheral speech mechanism examination, which includes a description of the structure and function of orofacial structures.~~

~~h. Formal screening of language skills. Examples include, but are not limited to, the Fluharty-2, KLST-2, CELF-4 Screen or TTFC.~~

~~i. Formal or informal assessment of hearing, voice and fluency skills.~~

~~j. An interpretation of the results of the evaluation, including recommendations for frequency and intensity of treatment.~~

~~k. A description of functional strengths and limitations, a suggested treatment plan and potential goals to address each identified problem.~~

~~l. Signature and credentials of the therapist performing the evaluation.~~

~~4. SPEECH PRODUCTION (Voice): To establish medical necessity, results from a comprehensive assessment in the suspected area of deficit must be reported. (Refer to Section 214.400, part D, paragraphs 9-12 for required frequency of re-evaluations.) A comprehensive assessment for Speech Production (Voice) disorder must include:~~

~~a. A medical evaluation to determine the presence or absence of a physical etiology is not a prerequisite for evaluation of voice disorder; however, it is required for the initiation of treatments related to the voice disorder. See Section 214.400 D4.~~

~~b. Date of evaluation.~~

~~c. Child's name and date of birth.~~

d. ~~Diagnosis specific to therapy.~~

e. ~~Background information including pertinent medical history; and, if the child is 12 months of age or younger, gestational age. The child should be tested in the child's dominant language; if not, an explanation must be provided in the evaluation.~~

~~NOTE: To calculate a child's gestational age, subtract the number of weeks born before 40 weeks of gestation from the chronological age. Therefore, a 7-month-old, former 28 week gestational age infant has a corrected age of 4 months according to the following equation:~~

~~7 months - [(40 weeks) - 28 weeks) / 4 weeks]~~

~~7 months - [(12) / 4 weeks]~~

~~7 months - [3]~~

~~4 months~~

f. ~~Results from an assessment relevant to the suspected type of speech production disorder, including all relevant scores, quotients and/or indexes, if applicable. (Review Section 214.410 – Accepted Tests for Speech Language Therapy.)~~

g. ~~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.~~

h. ~~Oral-peripheral speech mechanism examination, which includes a description of the structure and function of orofacial structures.~~

i. ~~Formal screening of language skills. Examples include, but are not limited to, the Fluharty-2, KLST-2, CELF-4 Screen or TTFC.~~

j. ~~Formal or informal assessment of hearing, articulation and fluency skills.~~

k. ~~An interpretation of the results of the evaluation, including recommendations for frequency and intensity of treatment.~~

l. ~~A description of functional strengths and limitations, a suggested treatment plan and potential goals to address each identified problem.~~

m. ~~Signature and credentials of the therapist performing the evaluation.~~

5. ~~SPEECH PRODUCTION (Fluency): To establish medical necessity, results from a comprehensive assessment in the suspected area of deficit must be reported. (Refer to Section 214.400, part D, paragraphs 9-12 for required frequency of re-evaluations.) A comprehensive assessment for Speech Production (Fluency) disorder must include:~~

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, if the child is 12 months of age or younger, gestational age. The child should be tested in the child's dominant language; if not, an explanation must be provided in the evaluation.~~

~~NOTE: To calculate a child's gestational age, subtract the number of weeks born before 40 weeks of gestation from the chronological age. Therefore, a 7-month-old, former 28 week gestational age infant has a corrected age of 4 months according to the following equation:~~

~~7 months - [(40 weeks) - 28 weeks) / 4 weeks]~~

~~7 months - [(12) / 4 weeks]~~

~~7 months - [3]~~

~~4 months~~

~~e. Results from an assessment specific to the suspected type of speech production disorder, including all relevant scores, quotients and/or indexes, if applicable. (Review Section 214.410 — Accepted Tests for Speech-Language Therapy.)~~

~~f. 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.~~

~~g. Oral-peripheral speech mechanism examination, which includes a description of the structure and function of orofacial structures.~~

~~h. Formal screening of language skills. Examples include, but are not limited to, the Fluharty-2, KLST-2, CELF-4 Screen or TTFC.~~

~~i. Formal or informal assessment of hearing, articulation and voice skills.~~

~~j. An interpretation of the results of the evaluation, including recommendations for frequency and intensity of treatment.~~

~~k. A description of functional strengths and limitations, a suggested treatment plan and potential goals to address each identified problem.~~

~~l. Signature and credentials of the therapist performing the evaluation.~~

~~6. ORAL MOTOR/SWALLOWING/FEEDING: To establish medical necessity, results from a comprehensive assessment in the suspected area of deficit must be reported. (Refer to Section 214.400, part D, paragraphs 9-12 for required frequency of re-evaluations.) A comprehensive assessment for Oral Motor/Swallowing/Feeding disorder must include:~~

~~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, if the child is 12 months of age or younger, gestational age. The child should be tested in the child's dominant language; if not, an explanation must be provided in the evaluation.~~

~~**NOTE: To calculate a child's gestational age, subtract the number of weeks born before 40 weeks of gestation from the chronological age. Therefore, a 7-month-old, former 28 week gestational age infant has a corrected age of 4 months according to the following equation:**~~

~~**7 months - [(40 weeks) - 28 weeks) / 4 weeks]**~~

~~**7 months - [(12) / 4 weeks]**~~

~~**7 months - [3]**~~

~~**4 months**~~

~~e. Results from an assessment specific to the suspected type of oral motor/swallowing/feeding disorder, including all relevant scores, quotients and/or indexes, if applicable. (See Section 214.410 — Accepted Tests for Speech-Language Therapy.)~~

f. If swallowing problems and/or signs of aspiration are noted, then include a statement indicating that a referral for a videofluoroscopic swallow study has been made.

g. 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.

h. Formal or informal assessment of hearing, language, articulation voice and fluency skills.

i. An interpretation of the results of the evaluation, including recommendations for frequency and intensity of treatment.

j. A description of functional strengths and limitations, a suggested treatment plan and potential goals to address each identified problem.

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

D. Interpretation and Eligibility: Ages Birth to 21

1. LANGUAGE: Two language composite or quotient scores (i.e., normed or standalone) in the area of suspected deficit must be reported, with at least one being from a norm-referenced, standardized test with good reliability and validity. (Use of two one-word vocabulary tests alone will not be accepted.)

a. For children age birth to three: criterion-referenced tests will be accepted as a second measure for determining eligibility for language therapy.

b. For children age three to 21: criterion-referenced tests will not be accepted as a second measure when determining eligibility for language therapy. (When use of standardized instruments is not appropriate, see Section 214.400, part D, paragraph 8).

c. Age birth to three: Eligibility for language therapy will be based upon a composite or quotient score that is -1.5 standard deviations (SD) below the mean or greater from a norm-referenced, standardized test, with corroborating data from a criterion-referenced measure. When these two measures do not agree, results from a third measure that corroborate the identified deficits are required to support the medical necessity of services.

d. Age three to 21: Eligibility for language therapy will be based upon 2 composite or quotient scores from 2 tests, with at least 1 composite or quotient score on each test that is -1.5 standard deviations (SD) below the mean or greater. When -1.5 SD or greater is not indicated by both of these tests, a third standardized test indicating a score -1.5 SD or greater is required to support the medical necessity of services.

2. ARTICULATION AND/OR PHONOLOGY: Two tests and/or procedures must be administered, with at least one being a norm-referenced, standardized test with good reliability and validity.

Eligibility for articulation and/or phonological therapy will be based upon standard scores (SS) of -1.5 SD or greater below the mean from two tests. When -1.5 SD or greater is not indicated by both of these tests, corroborating data derived from clinical analysis procedures can be used to support the medical necessity of services (review Section 214.410 — Accepted Tests for Speech-Language Therapy).

3. APRAXIA: Two tests and/or procedures must be administered, with at least one being a norm-referenced, standardized test with good reliability and validity.

Eligibility for apraxia therapy will be based upon standard scores (SS) of -1.5 SD or greater below the mean from two tests. When -1.5 SD or greater is not indicated by both of these tests, corroborating data from a criterion-referenced test and/or accepted clinical can be used to support the medical necessity of services (review Section 214.410 — Accepted Tests for Speech-Language Therapy).

4. ~~VOICE: Due to the high incidence of medical factors that contribute to voice deviations, a medical evaluation is a requirement for eligibility for voice therapy.~~

   ~~Eligibility for voice therapy will be based upon a medical referral for therapy and a functional profile of voice parameters that indicates a moderate or severe deficit/disorder.~~

5. ~~FLUENCY: Two tests and/or procedures must be administered, with at least one being a norm-referenced, standardized test with good reliability and validity.~~

   ~~Eligibility for fluency therapy will be based upon standard scores (SS) of -1.5 SD or greater below the mean from two tests. When -1.5 SD or greater is not indicated by both of these tests, descriptive data from an affect measure and/or accepted clinical procedures can be used to support the medical necessity of services. (Review Section 214.410 – Accepted Tests for Speech-Language Therapy.)~~

6. ~~ORAL MOTOR/SWALLOWING/FEEDING: An in-depth, functional profile of oral motor structures and function.~~

   ~~Eligibility for oral-motor/swallowing/feeding therapy will be based upon an in-depth functional profile of oral motor structures and function using a thorough protocol (e.g., checklist, profile) that indicates a moderate or severe deficit or disorder. When moderate or severe aspiration has been confirmed by a videofluoroscopic swallow study, the patient can be treated for pharyngeal dysphagia via the recommendations set forth in the swallow study report.~~

7. ~~All subtests, components and scores used for eligibility purposes must be reported.~~

8. ~~When administration of standardized, norm-referenced instruments is inappropriate, the provider must submit an in-depth functional profile of the child's communication abilities. An in-depth functional profile is a detailed narrative or description of a child's communication behaviors that specifically explains and justifies the following:~~

   a. ~~The reason standardized testing is inappropriate for this child,~~

   b. ~~The communication impairment, including specific skills and deficits, and~~

   c. ~~The medical necessity of therapy.~~

   d. ~~A variety of supplemental tests and tools exist that may be useful in developing an in-depth functional profile.~~

9. ~~Children (birth to age 21) receiving services outside of the schools must be evaluated annually, and adults receiving services in an Adult Developmental Day Treatment (ADDT) program.~~

10. ~~Children (age three to 21) receiving services within schools as part of an Individual Program Plan (IPP) or an Individual Education Plan (IEP) must have a full evaluation every three years; however, an annual update of progress is required. "School-related" means the child is of school age, attends public school and receives therapy provided by the school.~~

~~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 the entry with a full signature and credentials.~~

8. ~~Graduate students must have the supervising speech-language pathologist co-sign progress notes.~~

~~214.410 Accepted Tests for Speech-Language Therapy~~ ~~7-1-17~~

~~Tests used must be norm-referenced, standardized, age appropriate and specific to the disorder, or components of the disorder, being assessed. The following list of tests is not all-inclusive. When using a test that is not listed below, the provider must include an explanation and justification in the evaluation report to support the use of the chosen test. The *Mental Measurement Yearbook (MMY)* is the standard reference to determine the reliability and validity of the test(s) administered in the evaluation. Providers should refer to the *MMY* for additional information regarding specific tests. These definitions are applied to the following lists of accepted tests:~~

- ~~STANDARDIZED: Tests that are used to determine the presence or absence of deficits; any diagnostic tool or procedure that has a standardized administration and scoring process and compares results to an appropriate normative sample.~~
- ~~SUPPLEMENTAL: Tests and tools that are not norm-referenced, such as screeners, criterion-referenced measures, descriptive design tools, structured probes, and clinical analysis procedures. These tools are numerous with new ones being frequently created/published. These measures are only used to further document deficits and support standardized test results. These measures do not replace the use of standardized tests. You are free to use supplemental tools of your own choosing to guide data collection, to generate in-depth, functional profiles, and/or to support standardized testing when appropriate, or as indicated in these regulations. (See Section 214.400, part D, paragraph 8.)~~
- ~~CLINICAL ANALYSIS PROCEDURES: Specific analysis methods used for in-depth examination of clinical data obtained during assessment and used to further document deficits and support standardized results. Clinical analysis procedures may not replace standardized tests. Exception: Procedures from this list may be used to analyze data collected and assist in generating an in-depth, functional profile. (See Section 214.400, part D, paragraph 8.)~~
- ~~CLINICAL OBSERVATIONS: Clinical observations have an important role in the evaluation process and should always be included. They are especially important when standard scores do not accurately reflect a child's deficits in order to qualify the child for therapy. A detailed narrative or description of the child's communication behaviors (in-depth, functional profile) may constitute the primary justification of medical necessity. (See Section 241.200, part D, paragraph 8.)~~
- ~~STANDARDIZED SCORING KEY:~~

  ~~Mild: Scores between 84-78; -1.0 standard deviation~~

  ~~Moderate: Scores between 77-71; -1.5 standard deviations~~

  ~~Severe: Scores between 70-64; -2.0 standard deviations~~

  ~~Profound: Scores of 63 or lower; -2.0+ standard deviations~~

~~A. Language Tests — Standardized (Newer editions of currently listed tests are also acceptable. Previous versions that have original protocols available are also accepted.)~~

~~Test~~	~~Abbreviation~~
~~Assessment of Language-Related Functional Activities~~	~~ALFA~~

~~Test~~	~~Abbreviation~~
~~Assessment of Literacy and Language~~	~~ALL~~
~~Behavior Rating Inventory of Executive Function~~	~~BRIEF~~
~~Behavioral Assessment of the Dysexecutive Syndrome for Children~~	~~BADS-C~~
~~Brief Test of Head Injury~~	~~BTHI~~
~~Children's Communication Checklist [Diagnostic for pragmatics]~~	~~CCC~~
~~Clinical Evaluation of Language Fundamentals — Preschool~~	~~CELF-P~~
~~Clinical Evaluation of Language, Fifth Edition~~	~~CELF-5~~
~~Clinical Evaluation of Language Fundamentals Metalinguistics~~	~~CELF-5~~
~~Communication Abilities Diagnostic Test~~	~~CADeT~~
~~Communication Activities of Daily Living, Second Edition~~	~~CADL-2~~
~~Comprehensive Assessment of Spoken Language~~	~~CASL~~
~~Comprehensive Receptive and Expressive Vocabulary Test, Second Edition~~	~~CREVT-2~~
~~Comprehensive Test of Phonological Processing~~	~~CTOPP-2~~
~~Diagnostic Evaluation of Language Variation — Norm-Referenced~~	~~DELV-NR~~
~~Emerging Literacy and Language Assessment~~	~~ELLA~~
~~Expressive Language Test~~	~~ELT-2~~
~~Expressive One-Word Picture Vocabulary Test, 4000 Edition~~	~~EOWPVT-4~~
~~Fullerton Language Test for Adolescents, Second Edition~~	~~FLTA~~
~~Goldman-Fristoe-Woodcock Test of Auditory Discrimination~~	~~GFWTAD~~
~~HELP Test-Elementary~~	~~HELP~~
~~Illinois Test of Psycholinguistic Abilities, Third Edition~~	~~ITPA-3~~
~~Language Processing Test, Third Edition~~	~~LPT-3~~
~~Listening Comprehension Test Adolescent~~	~~LCT-A~~
~~Listening Comprehension Test, Second Edition~~	~~LCT-2~~
~~Montgomery Assessment of Vocabulary Acquisition~~	~~MAVA~~
~~Mullen Scales of Early Learning~~	~~MSEL~~
~~Oral and Written Language Scales~~	~~OWLS II~~
~~Peabody Picture Vocabulary Test, Fourth Edition~~	~~PPVT-4~~
~~Phonological Awareness Test, Second Edition~~	~~PAT-2~~
~~Preschool Language Scale, Fourth Edition~~	~~PLS-4~~
~~Receptive One-Word Picture Vocabulary Test, Fourth Edition~~	~~ROWPVT-4~~
~~Receptive-Expressive Emergent Language Test, Third Edition~~	~~REEL-3~~
~~Ross Information Processing Assessment, Second Edition~~	~~RIPA-2~~
~~Scales of Cognitive Ability for Traumatic Brain Injury~~	~~SCATBI~~
~~Social Competence and Behavior Evaluation, Preschool Edition~~	~~SCBE~~

~~Test~~	~~Abbreviation~~
~~Social Emotional Assessment/Evaluation~~	~~SEAM~~
~~Social Language Development Test – Adolescent~~	~~SLDT-A~~
~~Social Language Development Test – Elementary~~	~~SLDT-E~~
~~Social Responsiveness Scale~~	~~SRS~~
~~Social Skills Rating System — Preschool & Elementary Level~~	~~SSRS-PE~~
~~Social Skills Rating System — Secondary Level~~	~~SSRS-S~~
~~Strong Narrative Assessment Procedure~~	~~SNAP~~
~~Structured Photographic Expressive Language Test~~	~~SPELT-3~~
~~Test of Adolescent and Adult Language, Fourth Edition~~	~~TOAL-4~~
~~Test of Adolescent /Adult Word Finding~~	~~TAWF~~
~~Test for Auditory Comprehension of Language, Fourth Edition~~	~~TACL-4~~
~~Test of Auditory Perceptual Skills — Revised~~	~~TAPS-R~~
~~Test of Auditory Perceptual Skills, Third Edition~~	~~TAPS-3~~
~~Test of Auditory Reasoning and Processing Skills~~	~~TARPS~~
~~Test of Early Communication and Emerging Language~~	~~TECEL~~
~~Test of Early Language Development, Third Edition~~	~~TELD-3~~
~~Test of Expressive Language~~	~~TEXL~~
~~Test of Language Development — Intermediate, Fourth Edition~~	~~TOLD-I:4~~
~~Test of Language Development — Primary, Fourth Edition~~	~~TOLD-P:4~~
~~Test of Narrative Language~~	~~TNL~~
~~Test of Phonological Awareness~~	~~TOPA-2~~
~~Test of Pragmatic Language, Second Edition~~	~~TOPL-2~~
~~Test of Problem Solving — Adolescent~~	~~TOPS-2~~
~~Test of Problem Solving — Revised Elementary~~	~~TOPS-3~~
~~Test of Reading Comprehension, Third Edition~~	~~TORC-2~~
~~Test of Semantic Skills: Intermediate~~	~~TOSS-I~~
~~Test of Semantic Skills: Primary~~	~~TOSS-P~~
~~Test of Word Finding, Third Edition~~	~~TWF-3~~
~~Test of Word Finding in Disclosure~~	~~TWFD~~
~~Test of Word Knowledge~~	~~TOWK~~
~~Test of Written Language, Fourth Edition~~	~~TWL-4~~
~~The Listening Test~~	
~~Wepman's Auditory Discrimination Test, Second Edition~~	~~ADT~~
~~Word Test — 2 Adolescent~~	~~WT2A~~
~~Word Test — 3 Elementary~~	~~WT3E~~

~~B. Language — Clinical Analysis Procedures — Language sampling and analysis, which may include, but is not limited to, the following:~~

~~Test~~	~~Abbreviation~~
~~Mean Length of Utterance~~	~~MLU~~
~~Type-Token Ratio~~	~~TTR~~
~~Developmental Sentence Score~~	~~DSS~~
~~Structural analysis (Brown's stages)~~	
~~Semantic analysis~~	
~~Discourse analysis~~	

~~C. Speech Production Tests — Standardized~~

~~Test~~	~~Abbreviation~~
~~Apraxia Battery for Adults, Second Edition~~	~~ABA-2~~
~~Arizona Articulation Proficiency Scale, Third Edition~~	~~Arizona-3~~
~~Assessment of Intelligibility of Dysarthric Speech~~	~~AIDS~~
~~Bernthal-Bankson Test of Phonology~~	~~BBTOP~~
~~Clinical Assessment of Articulation and Phonology, Second Edition~~	~~CAAP-2~~
~~Diagnostic Evaluation of Articulation and Phonology, U.S. Edition~~	~~DEAP~~
~~Goldman-Fristoe Test of Articulation, Third Edition~~	~~GFTA-3~~
~~Hodson Assessment of Phonological Patterns — Third Edition~~	~~HAPP-3~~
~~Kaufman Speech Praxis Test~~	~~KSPT~~
~~Khan-Lewis Phonological Analysis~~	~~KLPA-3~~
~~Photo Articulation Test, Third Edition~~	~~PAT-3~~
~~Slosson Articulation Language Test with Phonology~~	~~SALT-P~~
~~Smit-Hand Articulation and Phonology Evaluation~~	~~SHAPE~~
~~Structured Photographic Articulation Test II Featuring Dudsberry~~	~~SPAT-D II~~
~~Stuttering Severity Instrument for Children and Adults~~	~~SSI-3~~
~~Test for Childhood Stuttering~~	~~TOCS~~
~~Weiss Comprehensive Articulation Test~~	~~WCAT~~

~~D. Speech Production: Tests and tools that are not norm-referenced, such as screeners, criterion-referenced measures, descriptive-design tools, structured probes, and clinical analysis procedures. These tools are numerous with new ones being frequently created/published. These measures are only used to further document deficits and support standardized test results. These measures do not replace the use of standardized tests. You are free to use supplemental tools of your own choosing to guide data collection, to generate in-depth, functional profiles, and/or to support standardized testing when appropriate, or as indicated in these regulations. (See Section 214.400, part D, paragraph 8.)~~

E. Speech Production — Clinical Analysis Procedures — Speech sampling and analysis, which may include the following:

1. Debra Beckman's oral-motor assessment procedures
2. Food chaining questionnaire
3. Instrumentation-based voice evaluation
4. Item and replica analysis
5. Percentage of consonants correct
6. Percentage of intelligibility
7. Percentage of phonemes correct
8. Percentage of syllables stuttered
9. Perceptual voice evaluation
10. Phonetic inventory
11. Phonological process analysis
12. Suzanne Evans-Morris oral-motor assessment procedures

215.000 Speech Generating Device (SGD) Evaluation 1-1-21

Arkansas Medicaid covers evaluations for speech generating devices (SGDs) under the following conditions.

A. Prior authorization by the Division of Medical Services Utilization Review Section is required for approval of the SGD evaluation. (See Section 231.000 of this manual for prior authorization procedures for SGD evaluations.)

B. A multidisciplinary team must conduct the SGD evaluation. The evaluation team must meet the following requirements:

1. A speech-language pathologist must lead the team. The speech-language pathologist must be licensed by the Arkansas Board of Examiners for Speech-Language Pathology and Audiology and have a Certification of Clinical Competence from the American Speech-Language and Hearing Association.
2. The team must also include an occupational therapist. The occupational therapist must be licensed by the Arkansas State Medical Board. A physical therapist should be added to the team if it is determined that there is a need for assistance in the evaluation as it relates to the positioning and seating in utilizing specific SGD equipment. The physical therapist must be licensed by the Arkansas State Board of Physical Therapy.
3. The speech-language pathologist, occupational therapist, and physical therapist must have verifiable training and experience in the use and evaluation of SGD equipment. Their knowledge must include, but not be limited to, the equipment's use and its working capabilities, access and mounting requirements, and information on training, warranties, and maintenance.
4. The team may also include regular and special educators, caregivers and parents, vocational rehabilitation counselors, behavior analysts, and others.
5. The team must use an interdisciplinary approach in the evaluation, incorporating the goals, objectives, skills, and knowledge of various disciplines.
6. Team members must disclose any financial relationship they have with device manufacturers and must certify that their recommendations are based on a

~~comprehensive evaluation and preferred practice patterns and are not due to any financial or personal incentive.~~

7. ~~The team must use at least three SGDs with different language/storage systems during the evaluation and these devices must not be from the same manufacturer or product line.~~

8. ~~The recommended SGD is prior authorized for purchase only after the client has completed a minimum of a four-week trial period that includes extensive experience with the requested system. Data must be collected during the trial period and document that the client can successfully use the recommended device. If the client cannot demonstrate successful use of the recommended device, subsequent trial periods with different devices shall occur until a device is identified that the client can successfully use. Information about the trial period must be documented in the evaluation report.~~

~~A trial period is not required when replacing an existing SGD unless the client's needs have changed, the current device is no longer available, and/or another device or method of access is being considered as more appropriate.~~

~~C. After the team has completed the evaluation and the trial, the evaluation report must be submitted to the prosthetics provider who will request prior authorization for the SGD.~~

~~The evaluation report must meet the following requirements.~~

1. ~~The report must indicate the medical reason for the SGD and pertinent background information.~~

2. ~~The report must include information about the client's current speech/language and communication abilities. Information from speech-language diagnostic testing must be current within one year.~~

3. ~~The report must indicate limitations of the client's current communication abilities, systems and devices used, and current communication needs.~~

4. ~~The report must include information on sensory functioning, including vision and hearing, as related to the SGD.~~

5. ~~The report must include information regarding the client's postural and motor abilities. The report must include optimal access/selection technique needed for independent use of SGD. It may include a description of the control interfaces needed between the SGD and other devices such as power mobility.~~

6. ~~The report must include a description of the functional placement of the SGD such as mounting devices, carrying cases, straps, etc.~~

7. ~~The report must indicate the client's ability to use various graphic and auditory symbol forms.~~

8. ~~The report must include information on vocabulary storage/rate enhancement techniques considered and justification for those deemed most appropriate.~~

9. ~~The report must summarize the client's required device features and delineate features of devices presented.~~

10. ~~The report must give specific recommendations of the system and justify why one system is more appropriate than the others presented.~~

11. ~~The report must include information about the trial period documenting that the client could successfully use the recommended device. This documentation must include information on length of trial, frequency of use of SGD, environments, activities and communication partners involved, access method(s) used, portability of the device, symbolic language system and rate enhancement used, number of symbols and layout of overlay used, a sample of language expressed, client's level of~~

~~independence (prompting strategies) using the device and expressing various language functions, and a summary of baseline and end of trial data.~~

12. ~~The report must include a description of the recommended device and all components and accessories.~~

13. ~~The report must include an initial treatment plan for implementing use of the device. The plan shall identify who will be responsible for delivering and programming the SGD; who will develop initial goals and objectives for functional use of SGD; and who will train the client's team members and communication partners in the proper use, programming, care and maintenance of the SGD.~~

14. ~~The speech-language pathologist and all other professionals directly involved in the evaluation must sign the SGD evaluation report. All professionals involved must also sign a non-conflict disclosure stating that they do not have financial relationship or other affiliation with a SGD manufacturer.~~

~~Refer to Section 215.100 of this manual for SGD evaluation benefits and Section 260.000 for billing procedures.~~

~~215.100 Speech Generating Devices (SGD) Evaluation Benefit~~ ~~1-1-21~~

~~One speech generating device (SGD)evaluation may be performed by a speech-language pathologist every three years, based on medical necessity.~~

~~216.000 Therapy Benefits~~

~~216.100 Extended Therapy Services~~ ~~1-1-21~~

~~Arkansas Medicaid applies the following therapy benefits to all therapy services in this program:~~

A. ~~Medicaid will reimburse for annual occupational, physical, and speech-language therapy evaluations in accordance with the attached procedure codes sheet.~~ ~~**View or print the procedure codes for therapy services**~~.

B. ~~Medicaid will reimburse up to 90 minutes of occupational, physical, and speech-language therapy weekly, per discipline, without authorization. Additional therapy units will require an extended therapy request.~~

C. ~~All requests for extended therapy services must comply with Sections 216.300 through 216.315.~~

~~216.300 Process for Requesting Extended Therapy Services~~ ~~7-1-18~~

A. ~~Requests for extended therapy services for beneficiaries under age 21~~ and adults receiving services in an Adult Developmental Day Treatment (ADDT) ~~must be sent to Arkansas Medicaid's Quality Improvement Vendor (QIO).~~ ~~**View or print the QIO contact information.**~~ ~~The request must meet the medical necessity requirement, and adequate documentation must be provided to support this request.~~

1. ~~Requests for extended therapy services are considered only after a claim is denied because a benefit is exceeded.~~

2. ~~The request must be received by the QIO within ninety (90) calendar days of the date of the benefits-exceeded denial. The count begins on the next working day after the date of the Remittance and Status Report (RA) on which the benefits-exceeded denial appears.~~

3. ~~Submit with the request a copy of the Medical Assistance Remittance and Status Report reflecting the claim's benefits-exceeded denial. Do not send a claim.~~

4. ~~The QIO will not accept requests sent via electronic facsimile (FAX) or e-mail.~~

B. ~~Form DMS-671, Request for Extension of Benefits for Clinical, Outpatient, Laboratory, and X-Ray Services, must be utilized for requests for extended therapy services.~~ **View or print form DMS-671**. ~~Consideration of requests requires correct completion of all fields on this form. The instructions for completion of this form are located on the back of the form. The provider must sign, including credentials, and date the request form. An electronic signature is accepted provided it is in compliance with Arkansas Code 25-31-103. All applicable documentation that supports the medical necessity of the request should be attached.~~

~~216.305 Documentation Requirements~~ ~~1-1-09~~

A. ~~To request extended therapy services, all applicable documentation that support the medical necessity of extended benefits is required.~~

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

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

~~216.310 QIO Extended Therapy Services Review Process~~ ~~1-1-21~~

~~The following is a step-by-step outline of the extended therapy services review process:~~

A. ~~Requests are screened for completeness and researched to determine the beneficiary's eligibility for Medicaid.~~

B. ~~The documentation submitted is reviewed by an appropriate clinician reviewer. If, in the judgment of the clinician reviewer, the documentation supports the medical necessity, the clinician reviewer may approve the request. An approval letter is generated and mailed to the provider the following day.~~

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

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

E. ~~Providers may request administrative reconsideration of an adverse decision or the provider and/or the beneficiary may appeal as provided in Section 160.000 of this manual.~~

F. ~~During administrative reconsideration of an adverse decision, if the extended therapy services original denial was due to incomplete documentation, but complete documentation that supports medical necessity is submitted with the reconsideration request, the clinician reviewer may approve the extension of benefits without referral to a physician adviser.~~

G. ~~During administrative reconsideration of an adverse decision, if the extended therapy services original denial was due to lack of proof of medical necessity or the documentation does not allow for approval by the clinician reviewer, the original documentation, reason for the denial and new information submitted will be referred to a different physician adviser for reconsideration.~~

H. All parties will be notified in writing of the outcome of the reconsideration. Reconsiderations approved generate an approval number and are mailed to the provider for inclusion with billing for the requested service. Adverse decisions that are upheld through the reconsideration remain eligible for an appeal by the provider and/or the beneficiary as provided in Section 160.000 of this manual.

216.315 Administrative Reconsideration 7-1-18

A request for administrative reconsideration of the denial of services must be in writing and sent to the QIO within 30 calendar days of the denial. The request must include a copy of the denial letter and additional supporting documentation.

The deadline for receipt of the reconsideration request will be enforced pursuant to Sections 190.012 and 190.013 of this manual. A request received by the QIO within thirty-five (35) calendar days of a denial will be deemed timely.

220.000 Recoupments

220.100 Recoupment Process 10-1-08

The Division of Medical Services (DMS), Utilization Review Section (UR) is required to initiate the recoupment process for all claims that Medicaid's contracted Quality Improvement Organization (QIO), has denied for not meeting the medical necessity requirement. In May 2004, UR began recoupment, as appropriate, based on QIO findings during retrospective reviews.

Medicaid will send the provider an Explanation of Recoupment Notice that will include the claim date of service, Medicaid beneficiary name and ID number, service provided, amount paid by Medicaid, amount to be recouped, and the reason the claim has been denied.

230.000 PRIOR AUTHORIZATION

231.000 Prior Authorization Request Procedures for Speech Generating Device (SGD) Evaluation 1-1-21

To perform an evaluation for the speech generating device (SGD), the provider must request prior authorization from the QIO, using the following procedures.

A. A primary care physician (PCP) written referral is required for prior authorization of the SGD evaluation. If the beneficiary is exempt from the PCP process, then the attending physician must make the referral.

B. The physical and intellectual capabilities (functional level) of the beneficiary must be documented in the referral. The referring physician must justify the medical reason the individual requires the SGD.

C. If the beneficiary is currently receiving speech-language therapy, the speech-language pathologist must document the prerequisite communication skills for the speech generating system and the cognitive level of the beneficiary.

D. A completed Request for Prior Authorization and Prescription Form (DMS-679) must be used to request prior authorization. **View or print form DMS-679 and instructions for completion.** Copies of form DMS-679 can be requested using the Medicaid Form Request, HP-MFR-001. **View or print the Medicaid Form Request HP-MFR-001.**

E. Submit the request to the Division of Medical Services. **View or print the Division of Medical Services contact information.**

F. For approved requests, a PA control number will be assigned and entered in item 10 on the DMS-679 and returned to the provider. For denied requests, a denial letter with the reason for denial will be mailed to the requesting provider and the Medicaid beneficiary.

NOTE: Prior authorization for therapy services only applies to the speech generating evaluation. Refer back to Section 215.000 for additional information.

231.100 Reconsideration of Prior Authorization Determination 1-1-21

Reconsideration of a denial may be requested within thirty (30) calendar days of the denial date. Requests must be made in writing and must include additional documentation to substantiate the medical necessity of the SGD evaluation.

232.000 Appealing an Adverse Action 8-1-06

Please see Section 190.003 for information regarding administrative appeals.

250.000 REIMBURSEMENT

251.000 Method of Reimbursement 10-13-03

Reimbursement is based on the lesser of the amount billed or the Arkansas Title XIX (Medicaid) maximum charge allowed.

The Arkansas Medicaid maximum rate for the licensed therapy assistant or licensed speech-language pathology assistant is based on 80% of the amount reimbursed to the licensed therapist or speech-language pathologist.

Therapy and speech-language pathology services are reimbursed according to the number of minutes in a unit. A full unit of service must be rendered in order to bill a unit of service. Partial units must not be rounded up and are not reimbursable.

To ensure quality in the delivery of group therapy services, maximum group size for each therapy discipline is four (4) clients.

Refer to Section 262.100 of this manual for procedure codes for all therapy and speech-language pathology services.

251.010 Fee Schedules 12-1-12

Arkansas Medicaid provides fee schedules on the Arkansas Medicaid website. The fee schedule link is located at **https://medicaid.mmis.arkansas.gov/** under the provider manual section. The fees represent the fee-for-service reimbursement methodology.

Fee schedules do not address coverage limitations or special instructions applied by Arkansas Medicaid before final payment is determined.

Procedure codes and/or fee schedules do not guarantee payment, coverage or amount allowed. Information may be changed or updated at any time to correct a discrepancy and/or error. Arkansas Medicaid always reimburses the lesser of the amount billed or the Medicaid maximum.

252.000 Rate Appeal Process 10-13-03

A provider may request reconsideration of a Program decision by writing to the Assistant Director, Division of Medical Services. This request must be received within 20 calendar days following the application of policy and/or procedure or the notification of the provider of its rate. Upon receipt of the request for review the Assistant Director will determine the need for a

~~Program/Provider conference and will contact the provider to arrange a conference if needed. Regardless of the Program decision the provider will be afforded the opportunity for a conference, if he or she so wishes, for a full explanation of the factors involved and the Program decision. Following review of the matter, the Assistant Director will notify the provider of the action to be taken by the Division within 20 calendar days of receipt of the request for review or the date of the Program/Provider conference.~~

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

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

~~260.000 BILLING PROCEDURES~~

~~261.000 Introduction to Billing~~ ~~7-1-20~~

~~Occupational, Physical, and Speech-Language Therapy providers use the CMS-1500 form to bill the Arkansas Medicaid Program on paper for services provided to eligible Medicaid beneficiaries. Each claim may contain charges for only one (1) beneficiary.~~

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

~~262.000 CMS-1500 Billing Procedures~~

~~262.100 Occupational, Physical, Speech-Language Therapy Procedure Codes~~ ~~1-1-21~~

~~Occupational, physical, and speech-language therapy procedure codes can be found by following this link:~~ ~~**View or print the procedure codes for therapy services.**~~

~~262.200 National Place of Service Codes~~ ~~1-1-21~~

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

~~Place of Service~~	~~Place of Service Code~~
~~Doctor's Office~~	~~11~~
~~Patient's Home~~	~~12~~
~~Independent Clinic (EIDT/ADDT)~~	~~49~~
~~Day Care Facility~~	~~52~~
~~Night Care Facility~~	~~52~~
~~Other Locations~~	~~99~~
~~Residential Treatment Center~~	~~56~~

~~262.300 Billing Instructions - Paper Only~~ ~~11-1-17~~

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

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

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

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

~~262.310 Completion of the CMS-1500 Claim Form~~ ~~1-1-21~~

~~Field Name and Number~~	~~Instructions for Completion~~
~~1. (type of coverage)~~	~~Not required.~~
~~1a. INSURED'S I.D. NUMBER (For Program in Item 1)~~	~~Beneficiary's or participant's 10-digit Medicaid or ARKids First-A or ARKids First-B identification number.~~
~~2. PATIENT'S NAME (Last Name, First Name, Middle Initial)~~	~~Beneficiary's or participant's last name and first name.~~
~~3. PATIENT'S BIRTH DATE~~	~~Beneficiary's or participant's date of birth as given on the individual's Medicaid or ARKids First-A or ARKids First-B identification card. Format: MM/DD/YY.~~
~~SEX~~	~~Check M for male or F for female.~~
~~4. INSURED'S NAME (Last Name, First Name, Middle Initial)~~	~~Required if insurance affects this claim. Insured's last name, first name, and middle initial.~~
~~5. PATIENT'S ADDRESS (No., Street)~~	~~Optional. Beneficiary's or participant's complete mailing address (street address or post office box).~~
~~CITY~~	~~Name of the city in which the beneficiary or participant resides.~~
~~STATE~~	~~Two-letter postal code for the state in which the beneficiary or participant resides.~~
~~ZIP CODE~~	~~Five-digit zip code; nine digits for post office box.~~
~~TELEPHONE (Include Area Code)~~	~~The beneficiary's or participant's telephone number or the number of a reliable message/contact/ emergency telephone.~~
~~6. PATIENT RELATIONSHIP TO INSURED~~	~~If insurance affects this claim, check the box indicating the patient's relationship to the insured.~~
~~7. INSURED'S ADDRESS (No., Street)~~	~~Required if insured's address is different from the patient's address.~~
~~CITY~~	
~~STATE~~	

Field Name and Number	Instructions for Completion
~~ZIP CODE~~	
~~TELEPHONE (Include Area Code)~~	
~~8. RESERVED~~	~~Reserved for NUCC use.~~
~~9. OTHER INSURED'S NAME (Last name, First Name, Middle Initial)~~	~~If patient has other insurance coverage as indicated in Field 11d, the other insured's last name, first name, and middle initial.~~
~~a. OTHER INSURED'S POLICY OR GROUP NUMBER~~	~~Policy and/or group number of the insured individual.~~
~~b. RESERVED~~	~~Reserved for NUCC use.~~
~~SEX~~	~~Not required.~~
~~c. EMPLOYER'S NAME OR SCHOOL NAME~~	~~Required when items 9 a-d are required. Name of the insured individual's employer and/or school.~~
~~d. INSURANCE PLAN NAME OR PROGRAM NAME~~	~~Name of the insurance company.~~
~~10. IS PATIENT'S CONDITION RELATED TO:~~	
~~a. EMPLOYMENT? (Current or Previous)~~	~~Check YES or NO.~~
~~b. AUTO ACCIDENT?~~	~~Required when an auto accident is related to the services. Check YES or NO.~~
~~PLACE (State)~~	~~If 10b is YES, the two-letter postal abbreviation for the state in which the automobile accident took place.~~
~~c. OTHER ACCIDENT?~~	~~Required when an accident other than automobile is related to the services. Check YES or NO.~~
~~d. CLAIM CODES~~	~~The "Claim Codes" identify additional information about the beneficiary's condition or the claim. When applicable, use the Claim Code to report appropriate claim codes as designated by the NUCC. When required to provide the subset of Condition Codes, enter the condition code in this field. The subset of approved Condition Codes is found at~~ **www.nucc.org** ~~under Code Sets.~~
~~11. INSURED'S POLICY GROUP OR FECA NUMBER~~	~~Not required when Medicaid is the only payer.~~
~~a. INSURED'S DATE OF BIRTH~~	~~Not required.~~
~~SEX~~	~~Not required.~~
~~b. OTHER CLAIM ID NUMBER~~	~~Not required.~~
~~c. INSURANCE PLAN NAME OR PROGRAM NAME~~	~~Not required.~~

Field Name and Number	Instructions for Completion
d. IS THERE ANOTHER HEALTH BENEFIT PLAN?	When private or other insurance may or will cover any of the services, check YES and complete items 9, 9a and 9d. Only one box can be marked.
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE	Enter "Signature on File," "SOF" or legal signature.
13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE	Enter "Signature on File," "SOF" or legal signature.
14. DATE OF CURRENT: ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)	Required when services furnished are related to an accident, whether the accident is recent or in the past. Date of the accident. Enter the qualifier to the right of the vertical dotted line. Use Qualifier 431 Onset of Current Symptoms or Illness; 484 Last Menstrual Period.
15. OTHER DATE	Enter another date related to the beneficiary's condition or treatment. Enter the qualifier between the left-hand set of vertical, dotted lines. The "Other Date" identifies additional date information about the beneficiary's condition or treatment. Use qualifiers: 454 Initial Treatment 304 Latest Visit or Consultation, 453 Acute Manifestation of a Chronic Condition 439 Accident 455 Last X-Ray 471 Prescription 090 Report Start (Assumed Care Date) 091 Report End (Relinquished Care Date) 444 First Visit or Consultation
16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION	Not required.
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	Primary Care Physician (PCP) referral is required for Occupational, Physical, and Speech-Language Therapy Services. Enter the referring physician's name.
17a. (blank)	Not required.
17b. NPI	Enter NPI of the referring physician.
18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES	When the serving/billing provider's services charged on this claim are related to a beneficiary's or participant's inpatient hospitalization, enter the individual's admission and discharge dates. Format: MM/DD/YY.

~~Field Name and Number~~	~~Instructions for Completion~~
~~19. ADDITIONAL CLAIM INFORMATION~~	~~For tracking purposes, occupational, physical, and speech-language therapy providers are required to enter one of the following therapy codes:~~
~~Code~~	~~Category~~
~~A~~	~~Individuals from birth through 2 years who are receiving therapy services under an Individualized Family Services Plan (IFSP) through the Division of Developmental Disabilities Services.~~
~~B~~	~~Individuals ages 0 to 6 years who are receiving therapy services under an Individualized Plan (IP) through the Division of Developmental Disabilities Services.~~ ~~**NOTE: This code is to be used only when all three of the following conditions are in place: 1) The individual receiving services has not attained the age of 6. 2) The individual receiving services is receiving the services under an Individualized Plan. 3) The Individualized Plan is through the Division of Developmental Disabilities Services.**~~
~~When using code C or D, providers must also include the 4-digit LEA (local education agency) code assigned to each school district. For example: C1234~~	
~~C (and 4-digit LEA code)~~	~~Individuals ages 3 to 5 years who are receiving therapy services under an Individualized Education Program (IEP) through a school district or education service cooperative.~~ ~~**NOTE: This code set is to be used only when all three of the following conditions are in place: 1) The individual receiving services is 3 years old and is not yet 5 years old. 2) The individual is receiving the services under an IEP maintained by a school district or education service cooperative. 3) Therapy services are being furnished by a) the school district or an ESC, which is an enrolled Medicaid therapy provider, or by b) a Medicaid-enrolled therapist or therapy group provider.**~~
~~D (and 4-digit LEA code)~~	~~Individuals ages 5 to 21 years who are receiving therapy services under an IEP through a school district or an education service cooperative.~~ ~~**NOTE: This code set is to be used only when all three of the following conditions are in place: 1) The individual receiving services is 5 years old and is not yet 21 years old. 2) The individual is receiving the services under an IEP. 3) The IEP is through a school district or an education service cooperative.**~~

Field Name and Number	Instructions for Completion
E	Individuals ages 18 through 20 years who are receiving therapy services through the Division of Developmental Disabilities Services.
F	Individuals ages 18 through 20 years who are receiving therapy services from individual or group providers not included in any of the previous categories (A-E).
G	Individuals ages birth through 17 years who are receiving therapy/pathology services from individual or group providers not included in any of the previous categories (A-F).
20. OUTSIDE LAB?	Not required.
$ CHARGES	Not required.
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY	Enter the applicable ICD indicator to identify which version of ICD codes is being reported. Use "9" for ICD-9-CM. Use "0" for ICD-10-CM. Enter the indicator between the vertical, dotted lines in the upper right-hand portion of the field. Diagnosis code for the primary medical condition for which services are being billed. Use the appropriate International Classification of Diseases until further notice. List no more than 12 diagnosis codes. Relate lines A-L to the lines of service in 24E by the letter of the line. Use the highest level of specificity.
22. RESUBMISSION CODE	Reserved for future use.
ORIGINAL REF. NO.	Any data or other information listed in this field does not/will not adjust, void or otherwise modify any previous payment or denial of a claim. Claim payment adjustments, voids, and refunds must follow previously established processes in policy.
23. PRIOR AUTHORIZATION NUMBER	The prior authorization or benefit extension control number if applicable.
24A. DATE(S) OF SERVICE	The "from" and "to" dates of service for each billed service. Format: MM/DD/YY. 1. On a single claim detail (one charge on one line), bill only for services provided within a single calendar month. 2. Providers may bill on the same claim detail for two or more sequential dates of service within the same calendar month when the provider furnished equal amounts of the service on each day of the date sequence.
B. PLACE OF SERVICE	Two-digit national standard place of service code. See Section 262.200 for codes.

Field Name and Number	Instructions for Completion
C. EMG	Enter "Y" for "Yes" or leave blank if "No." EMG identifies if the service was an emergency.
D. PROCEDURES, SERVICES, OR SUPPLIES	
CPT/HCPCS	Enter the correct CPT or HCPCS procedure code from Sections 262.100 through 262.120.
MODIFIER	Modifier(s) if applicable.
E. DIAGNOSIS POINTER	Enter the diagnosis code reference letter (pointer) as shown in Item Number 21 to relate to the date of service and the procedures performed to the primary diagnosis. When multiple services are performed, the primary reference letter for each service should be listed first; other applicable services should follow. The reference letter(s) should be A-L or multiple letters as applicable. The "Diagnosis Pointer" is the line letter from Item Number 21 that relates to the reason the service(s) was performed.
F. $ CHARGES	The full charge for the service(s) totaled in the detail. This charge must be the usual charge to any client, patient, or other beneficiary of the provider's services.
G. DAYS OR UNITS	The units (in whole numbers) of service(s) provided during the period indicated in Field 24A of the detail.
H. EPSDT/Family Plan	Enter E if the services resulted from a Child Health Services (EPSDT) screening/referral.
I. ID QUAL	Not required.
J. RENDERING PROVIDER ID #	Enter the 9-digit Arkansas Medicaid provider ID number of the individual who furnished the services billed for in the detail or
NPI	Enter NPI of the individual who furnished the services billed for in the detail.
25. FEDERAL TAX I.D. NUMBER	Not required. This information is carried in the provider's Medicaid file. If it changes, please contact Provider Enrollment.
26. PATIENT'S ACCOUNT NO.	Optional entry that may be used for accounting purposes; use up to 16 numeric or alphabetic characters. This number appears on the Remittance Advice as "MRN."
27. ACCEPT ASSIGNMENT?	Not required. Assignment is automatically accepted by the provider when billing Medicaid.
28. TOTAL CHARGE	Total of Column 24F – the sum all charges on the claim.

~~Field Name and Number~~	~~Instructions for Completion~~
~~29. AMOUNT PAID~~	~~Enter the total of payments previously received on this claim. Do not include amounts previously paid by Medicaid. *Do **not** include in this total the automatically deducted Medicaid or ARKids First-B co-payments.~~
~~30. RESERVED~~	~~Reserved for NUCC use.~~
~~31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS~~	~~The provider or designated authorized individual must sign and date the claim certifying that the services were personally rendered by the provider or under the provider's direction. "Provider's signature" is defined as the provider's actual signature, a rubber stamp of the provider's signature, an automated signature, a typewritten signature, or the signature of an individual authorized by the provider rendering the service. The name of a clinic or group is not acceptable.~~
~~32. SERVICE FACILITY LOCATION INFORMATION~~	~~If other than home or office, enter the name and street, city, state, and zip code of the facility where services were performed.~~
~~a. (blank)~~	~~Not required.~~
~~b. (blank)~~	~~Not required.~~
~~33. BILLING PROVIDER INFO & PH #~~	~~Billing provider's name and complete address. Telephone number is requested but not required.~~
~~a. (blank)~~	~~Enter NPI of the billing provider or~~
~~b. (blank)~~	~~Enter the 9-digit Arkansas Medicaid provider ID number of the billing provider.~~

~~262.400 Special Billing Procedures~~ ~~7-1-18~~

~~Services must be billed according to the care provided and to the extent each procedure is provided.~~

~~Extended therapy services may be requested for all medically necessary therapy services for beneficiaries under age 21. Refer to Sections 216.000 through 216.310 of this manual for more information.~~

200.000 OCCUPATIONAL THERAPY, PHYSICAL THERAPY, AND SPEECH-LANGUAGE PATHOLOGY GENERAL INFORMATION

201.000 Arkansas Medicaid Participation Requirements 1-1-22

201.100 Individual Service Provider Participation Requirements 1-1-22

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

A. Complete the Provider Participation and enrollment requirements contained within Section 140.000 of this manual; and

B. Meet the participation requirements of the applicable service discipline in Section 202.000 of this manual.

201.200 Group Service Provider Participation Requirements 1-1-22

A. Group providers of occupational therapy, physical therapy, and speech-language pathology services must meet the following requirements to be eligible to participate in the Arkansas Medicaid Program:

1. Complete the Provider Participation and enrollment requirements contained within Section 140.000 of this manual; and

2. Each individual therapist, therapy assistant, speech-language pathologist, and speech language pathologist assistant providing services on behalf of the group must meet the participation requirements for the applicable service discipline in Section 202.000 and also be enrolled in the Arkansas Medicaid Program.

B. Group providers of occupational therapy, physical therapy, and speech-language pathology services are "pay to" providers only. The service must be performed and billed by a Medicaid-enrolled and licensed therapist, speech-language pathologist, therapy assistant, or speech-language pathology assistant within the group.

201.300 School District, Education Service Cooperative, and Early Intervention Day Treatment Provider Participation Requirements 1-1-22

A. School districts and education service cooperatives must be certified by the Arkansas Department of Education in order to participate in the Arkansas Medicaid Program.

B. Early Intervention Day Treatment (EIDT) providers must have an EIDT license issued by the Arkansas Department of Human Services, Division of Provider Services and Quality Assurance (DPSQA) in order to participate in the Arkansas Medicaid Program.

C. A school district, education service cooperative, or EIDT program may elect to employ or contract with the therapists, speech-language pathologists, therapy assistants, and speech-language pathology assistants that perform those services on its behalf.

1. If a school district, education service cooperative, or EIDT program contracts with a therapist, speech-language pathologist, therapy assistant, or speech-language pathology assistant to perform services on its behalf, then the practitioner must meet the participation requirements for the applicable service discipline in Section 202.000 and be enrolled in the Arkansas Medicaid Program.

2. If a school district, education service cooperative, or EIDT program employs a therapist, speech-language pathologist, therapy assistant, or speech-language pathology assistant to perform services on its behalf, the practitioner has the option of either enrolling with the Arkansas Medicaid Program or requesting a Practitioner Identification Number. **View or print form DMS-7708**.

D. The individual practitioner who performs a service must be identified on the claim as the performing provider when the school district, education service cooperative, or EIDT program bills for that service.

201.400 Service Providers in Arkansas and Bordering States 1-1-22

Providers of occupational therapy, physical therapy, and speech-language pathology services in Arkansas and the six (6) bordering states (Louisiana, Mississippi, Missouri, Oklahoma,

Tennessee, and Texas) may enroll as Arkansas Medicaid service providers if they meet the enrollment requirements specified in Section 201.100 and Section 201.200, as applicable.

201.500 Service Providers in States Not Bordering Arkansas 1-1-22

Providers of occupational therapy, physical therapy, and speech-language pathology services in states not bordering Arkansas may enter into a single case agreement and enroll as a limited Arkansas Medicaid service provider to a single Arkansas Medicaid eligible client. A separate single case agreement must be entered into for each Arkansas Medicaid eligible client. A provider will retain their limited service provider status for one (1) year after the most recent claim's last date of service. **View or print the provider enrollment and contract package (Application Packet).**

202.000 Occupational Therapy, Physical Therapy, and Speech-Language Pathology Service Provider Participation Requirements

202.100 Occupational Therapy

202.110 Occupational Therapist Participation Requirements 1-1-22

A. An occupational therapist must be either:

1. Certified by the National Board for Certification in Occupational Therapy; or
2. A graduate of a program in occupational therapy, who is accredited by the Commission on Accreditation of Allied Health Education Programs and actively acquiring the supplemental clinical experience required to be certified by the National Board for Certification in Occupational Therapy.

B. An occupational therapist must be licensed to practice as an occupational therapist in the therapist's state of residence.

202.120 Occupational Therapy Assistant Participation Requirements 1-1-22

A. An occupational therapy assistant must have an associate (or more advanced) degree in occupational therapy from a program approved by the National Board for Certification in Occupational Therapy.

B. An occupational therapy assistant must be licensed to practice as an occupational therapy assistant in the therapist's state of residence.

C. An occupational therapy assistant must be under the supervision of a licensed occupational therapist enrolled in the Arkansas Medicaid Program. See Supervision requirements in Section 203.000.

202.200 Physical Therapy

202.210 Physical Therapist Participation Requirements 1-1-22

A. A physical therapist must be a graduate of a physical therapy program accredited by both the Commission on Accreditation of Allied Health Education Programs and the American Physical Therapy Association.

B. A physical therapist must be licensed to practice as a physical therapist in the therapist's state of residence.

202.220 Physical Therapy Assistant Participation Requirements 1-1-22

A. A physical therapy assistant must have an associate (or more advanced) degree in physical therapy from a program approved by the American Physical Therapy Association.

B. A physical therapy assistant must be licensed to practice as a physical therapy assistant in his or her state of residence.

C. The physical therapy assistant must be under the supervision of a licensed physical therapist enrolled in the Arkansas Medicaid Program. See Supervision requirements in Section 203.000.

202.300 Speech-Language Pathology

202.310 Speech-Language Pathologist Participation Requirements 1-1-22

A. A speech-language pathologist must have completed or received one (1) of the following:

1. A certificate of clinical competence from the American Speech-Language-Hearing Association;
2. The educational and work experience requirements necessary to qualify for a certificate of clinical competence from the American Speech-Language-Hearing Association (ASHA); or
3. The educational requirements and be actively acquiring the supervised work experience requirements to qualify for a certificate of clinical competence from ASHA.

B. A speech-language pathologist must be licensed to practice as a speech-language pathologist in the pathologist's state of residence.

202.320 Speech-Language Pathology Assistant Participation Requirements 1-1-22

A. A speech-language pathology assistant must have a bachelor's (or more advanced) degree in speech-language pathology.

B. A speech-language pathology assistant must be licensed to practice as a speech-language pathology assistant in the pathologist's state of residence.

C. A speech-language pathology assistant must be under the supervision of a qualified speech-language pathologist enrolled in the Arkansas Medicaid Program. See Supervision requirements in Section 203.000.

202.330 Speech-Language Pathology Licensure Exemptions Under Arkansas Code §17-100-104 1-1-22

Arkansas Code §17-97-104, allows the following individuals to perform speech-language pathology services without state licensure:

A. An individual performing speech-language pathology services solely within the confines or under the jurisdiction of a public school system if the individual holds a valid and current certificate as a speech therapist or speech-language pathologist issued by the Arkansas Department of Education.

B. An individual performing speech-language pathology services solely within the confines of their duties as an employee of the State of Arkansas, provided that the person was an employee of the State of Arkansas on January 1, 1993.

C. An individual performing speech-language pathology services solely within the confines of their duties as an employee of any entity licensed or certified as a Developmental Disability Services community provider by the Division of Provider Services and Quality Assurance Services if the individual:

1. Holds a minimum of a bachelor's degree in speech-language pathology;
2. Is supervised by a licensed speech-language pathologist; and
3. Complies with Arkansas regulations as a Speech-Language Pathology Support Personnel.

202.400 Services by an Unlicensed Student **1-1-22**

Occupational therapy, physical therapy, and speech-language pathology services carried out by an unlicensed student may be covered only when a licensed provider of the service is present and engaged in student oversight during the entirety of the encounter, such that the licensed provider is considered to be providing the service.

203.000 Supervision **1-1-22**

~~A. A supervising therapist or speech-language pathologist must be a paid employee of the Arkansas Medicaid provider that is filing claims for services.~~

~~B~~A. A therapist or speech-language pathologist is responsible for the quality of work performed by each therapy assistant or speech-language pathology assistant under the therapist's supervision.

1. A supervising therapist or speech-language pathologist must be immediately available to provide assistance and direction throughout the time the service is being performed. Availability by telecommunication is sufficient to meet this requirement.
2. A therapist or speech-language pathologist must conduct an in-person observation of each therapy assistant or speech-language pathology assistant that they supervise throughout a service session at least once every thirty (30) calendar days.
3. A therapist or speech-language pathologist must review the treatment plan and progress notes of each therapy assistant or speech-language pathology assistant that they supervise at least once every thirty (30) calendar days.

~~C~~B. A therapist or speech-language pathologist must review and approve all written documentation completed by a therapy assistant or speech-language pathology assistant under their supervision prior to the filing of claims for the service provided.

1. Each page of progress note entries must be signed by the supervising therapist or speech-language pathologist with their full signature, credentials, and date of review.
2. The supervising therapist or speech-language pathologist must document approval of progress made and any recommended changes in the treatment plan.
3. All supervision activities must be documented and available for review in the client's service record.

~~D~~C. A therapist or speech-language pathologist may not supervise more than five (5) therapy assistants or speech-language pathology assistants at any given time.

204.000 Documentation Requirements **1-1-22**

204.100 Documentation Requirements for all Medicaid Providers 1-1-22

See Section 140.000 for the documentation that is required for all Arkansas Medicaid Program providers.

204.200 Occupational Therapy, Physical Therapy, and Speech-Language Pathology Documentation Requirements 1-1-22

A. Occupational therapy, physical therapy, and speech-language pathology providers are required to maintain the following documentation in each client's service record:

1. A written referral for occupational therapy, physical therapy, or speech-language pathology services signed and dated within the past twelve (12) months by the client's primary care or attending physician or certified nurse practitioner.
2. A written prescription for occupational, physical therapy, or speech-language pathology services signed and dated by the client's primary care or attending physician or certified nurse practitioner within the past twelve (12) months (unless the prescription specifies a shorter period).
3. A treatment plan for the prescribed occupational therapy, physical therapy, or speech-language pathology services developed and signed by a provider licensed in the prescribed discipline(s) or the prescribing physician or certified nurse practitioner. See Section 214.110(C).
4. Where applicable, an Individualized Family Service Plan established pursuant to Part C of the Individuals with Disabilities Education Act.
5. Where applicable, the Individual Treatment Plan developed by the Early Childhood Developmental Specialist assigned to the client by the Early Intervention Day Treatment program.
6. Where applicable, the Individual Educational Plan (IEP) established pursuant to Part B of the Individuals with Disabilities Education Act.
   a. The entire volume of the IEP is not required.
   b. The following are the only required pages of the IEP:
      i. First page;
      ii. Present Level of Academic Achievement and Functional Performance page(s);
      iii. Goals and Objectives page(s) (pertinent to the service requested);
      iv. Services Summary/Schedule of Services page(s); and
      v. Signature page.
7. Service delivery documentation, which must include for each individual session:
   a. Client's name;
   b. The date and beginning and ending time of service session;
   c. A description of specific services provided and the activities rendered during each session;
   d. The full name, credentials, and signature of the rendering therapist, therapist assistant, speech-language pathologist or speech-language pathologist assistant are provided for each session; and
   e. Weekly or more frequent progress notes signed or initialed by the therapist or speech-language pathologist overseeing the services, describing the client's status with respect to his or her goals and objectives.

8. All evaluation reports, progress notes, and any related correspondence.

9. Discharge notes and summary, if applicable.

B. Any individual provider of occupational therapy, physical therapy, or speech-language pathology services must maintain:

1. Verification of their required qualifications. Refer to Section 202.000 of this manual; and

2. Any written contract between the individual provider and the group provider, school district, education service cooperative, and EIDT program on behalf of which they provide services.

C. Any group provider, school district, education service cooperative, and EIDT program must maintain appropriate employment, certification, and licensure records for all individuals employed or contracted by the group to provide occupational therapy, physical therapy, or speech-language pathology services. If an individual practitioner provides services to a group provider, school district, education service cooperative, and EIDT program pursuant to a contract, then a copy of the contractual agreement must be maintained.

205.000 Electronic Signatures 1-1-22

The Arkansas Medicaid program will accept electronic signatures in compliance with Arkansas Code § 25-31-103 et seq.

206.000 Required Referral to First Connections pursuant to Part C of Individuals with Disabilities Education Act ("IDEA") 1-1-22

First Connections is the program in Arkansas that administers, monitors, and carries out all Part C of IDEA activities and responsibilities for the state. Each occupational therapy, physical therapy, and speech-language pathology service provider must, within two (2) working days of first contact, refer to the First Connections program any infant or toddler from birth to thirty-six (36) months of age for whom there is a diagnosis or suspicion of a developmental delay or disability. The referral must be made to the DDS First Connections Central Intake Unit. **View or print referral form.** Each provider is responsible for documenting that a proper and timely referral to First Connections has been made.

207.000 Required Referral to Local Education Agency ("LEA") pursuant to Part B of IDEA 1-1-22

A. Each occupational therapy, physical therapy, and speech-language pathology service provider must, within two (2) working days of first contact, refer to the Local Education Agency (LEA) any child three (3) years of age or older that has not entered kindergarten for whom there is a diagnosis or suspicion of a developmental delay or disability.

B. Each occupational therapy, physical therapy, and speech-language pathology service provider must refer any child under three (3) years of age that they are currently serving to the LEA at least ninety (90) days prior to the child's third birthday. If the child begins services less than ninety (90) days prior to their third birthday, the referral should be made in accordance with the late referral requirements of the IDEA.

C. Referrals must be made to the LEA where the child resides.

D. Each service provider is responsible for maintaining documentation evidencing that a proper and timely referral to has been made.

210.000 PROGRAM COVERAGE

211.000 Introduction 1-1-22

The Arkansas Medicaid Program will reimburse enrolled providers for medically necessary covered services when such services are provided pursuant to a plan of care to Medicaid-eligible individuals under twenty-one (21) years of age in the Child Health Services (EPSDT) Program. Medicaid reimbursement is conditional upon compliance with this manual, manual update transmittals, and official program correspondence.

A. Occupational therapy, physical therapy, and speech-language pathology services for individuals twenty-one (21) years of age and older are not covered services under this manual.

B. Refer to one (1) of the following Medicaid program manuals for the coverage and requirements related to occupational therapy, physical therapy, and speech-language pathology services for individuals twenty-one (21) years of age and older:

1. Hospital/Critical Access Hospital (CAH)/End-Stage Renal Disease (ESRD);
2. Home Health;
3. Hospice;
4. Adult Developmental Day Treatment; and
5. Physician/Independent Lab/CRNA/Radiation Therapy Center.

212.000 Client Eligibility Requirements 1-1-22

212.100 Child Health Services (EPSDT) Participation 1-1-22

A client must be under twenty-one (21) years of age and participating in the EPSDT program to be eligible to receive occupational therapy, physical therapy, or speech-language pathology services through the Arkansas Medicaid Program.

212.200 Referral to Evaluate 1-1-22

A. Occupational therapy, physical therapy, and speech-language pathology services require a written referral signed by the client's primary care or attending physician or certified nurse practitioner, as appropriate.

1. The original referral is to be maintained by the physician or certified nurse practitioner.
2. A copy of the referral must be maintained in the client's service record.

B. A referral for occupational therapy, physical therapy, and speech-language pathology services must be renewed at least once every twelve (12) months; however, when a school district is providing the occupational therapy, physical therapy, or speech-language pathology services in accordance with a client's Individualized Education Program (IEP), a referral is required at the beginning of each school year.

212.300 Treatment Prescription 1-1-22

A. Occupational therapy, physical therapy, and speech-language pathology services require a written prescription signed by the client's primary care or attending physician or certified nurse practitioner, as appropriate.

1. The original prescription is to be maintained by the physician or certified nurse practitioner.

2. A copy of the prescription must be maintained in the client's service record.

B. A prescription for occupational therapy, physical therapy, or speech-language pathology services is valid for the shorter of the length of time specified on the prescription or one (1) year.

C. The prescription for occupational therapy, physical therapy, and speech-language pathology services must be on a form DMS-640 – "Occupational, Physical and Speech Therapy for Medicaid Eligible Beneficiaries Under Age 21 Prescription/Referral". **View or print form DMS-640.**

D. The prescription must demonstrate the medical necessity for the occupational therapy, physical therapy, or speech-language pathology services.

1. The client's diagnosis must clearly establish and support the prescribed occupational therapy, physical therapy, or speech-language pathology services.

2. The prescription diagnosis codes and nomenclature must comply with the coding conventions and requirements established in the International Classification of Diseases Clinical Modification for the edition certified by the Arkansas Medicaid Program for the client's dates of service.

3. The following diagnosis codes are not specific enough to identify the medical necessity for occupational therapy, physical therapy, or speech-language pathology services and may not be used. **(View ICD codes.)**

212.400 Comprehensive Assessment 1-1-22

A. Occupational therapy, physical therapy, and speech-language pathology services must be medically necessary as demonstrated by the results of a comprehensive assessment in the area of deficit.

1. A diagnosis alone is not sufficient documentation to demonstrate medical necessity.

2. The comprehensive assessment must indicate each the following:

a. The provision of occupational therapy, physical therapy, or speech-language pathology services would be an effective treatment for the client's condition under accepted standards of practice;

b. The prescribed occupational therapy, physical therapy, or speech-language pathology services are of a level of complexity or the client's condition is such that the services can be only be safely and effectively performed by or under the supervision of a licensed occupational therapist, physical therapist, or speech-language pathologist, as appropriate; and

c. There is a reasonable expectation that the occupational therapy, physical therapy, or speech-language pathology services will result in meaningful improvement or prevent a worsening of the client's condition.

3. The frequency, intensity, and duration of the prescribed occupational therapy, physical therapy, and speech-language pathology services must be medically necessary based on the results of the comprehensive assessment and realistic for the age of the client.

B. Each comprehensive assessment specific to the suspected area(s) of deficit must include the following:

1. The client's name and date of birth;

2. The diagnosis specific to the service and suspected area(s) of deficit;

3. Background information on the client including pertinent medical history;

4. The gestational age, if the client is less than twelve (12) months of age;
   a. To calculate a client's gestational age, subtract the number of weeks born before forty (40) weeks of gestation from the chronological age of the client.
   b. For example, a client who is thirty-two (32) weeks of age and who was born in the twenty-eighth week of gestation would have a gestational age of twenty (20) weeks according to the following equation: 32 weeks - (40 weeks - 28 weeks) = 20 weeks.
5. One (1) or more standardized evaluations of the client specific to the suspected area(s) of deficit, including all relevant scores, quotients, and indexes, if applicable.
   a. See Sections 212.500 and 212.510 for requirements relating to occupational therapy and physical therapy standardized evaluations.
   b. See Sections 212.500 and 212.520 for requirements relating to speech-language pathology standardized evaluations.
   c. If administration of a standardized evaluation instrument is inappropriate or unavailable, then an in-depth, detailed narrative functional profile of the client's abilities and deficits may be used as a substitute for a standardized evaluation if it specifically includes the following:
      i. The reason a standardized evaluation is inappropriate for or cannot be used with the client;
      ii. The client's functional impairment(s), including specific skills and deficits;
      iii. A list of supplemental assessments, evaluations, tools, and tests conducted to document deficits and develop the in-depth functional profile; and
      iv. The rationale, contributing factors, and specific results of any supplemental assessments, evaluations, tools, tests, clinical observation, and clinical analysis procedures conducted that indicate that occupational therapy, physical therapy, or speech-language pathology services are medically necessary for the client.
6. An interpretation of the results of the standardized evaluation and in-person clinical observations, including recommendations for the frequency, duration, and intensity of the occupational therapy, physical therapy, or speech-language pathology services.
7. A description of functional strengths and limitations of the client, a suggested treatment plan, and goals to address each identified problem.
8. The signature and credentials of the qualified practitioner that performed the standardized evaluation.

C. All aspects of a comprehensive assessment for occupational therapy, physical therapy, or speech-language pathology services, including the administration of the standardized evaluation, must be communicated and conducted in the client's primary or preferred language.

D. Supplemental screeners, evaluations, tools, assessments, clinical observation, and clinical analysis procedures used as part of the comprehensive assessment to support the qualifying standardized evaluation(s) results do not have to conform to the requirements of Section 212.510 and Section 212.520; however, these supplemental measures cannot be used to replace the use of a qualifying standardized evaluation except as provided in Section 212.400(B)(5)(c).

212.410 Occupational and Physical Therapy Comprehensive Assessments **1-1-22**

In addition to those requirements in Section 212.400(B), each comprehensive assessment used to establish medical necessity for occupational therapy and physical therapy services must

include objective information describing the client's gross and fine motor abilities and deficits, such as range of motion measurements, manual muscle testing, muscle tone, or a narrative description of the client's functional mobility skills.

212.420 Speech-Language Pathology Comprehensive Assessments 1-1-22

A. In addition to those requirements in Section 212.400(B), each comprehensive assessment used to establish medical necessity for speech-language pathology services must include:

1. An oral-peripheral speech mechanism examination, which must include a description of the structure and function of the orofacial structures; and

2. An assessment of hearing, articulation, voice, and fluency skills. For a suspected voice, fluency, or speech production disorder, there must also be a formal screening of language skills performed using an instrument such as the Fluharty-2, KLST-2, CELF-4 Screen or TTFC.

B. Depending on the type of communication disorder suspected, the following are required to be included as part of a comprehensive assessment used to establish medical necessity:

1. Language Disorder: a comprehensive measure of language must be included for initial eligibility purposes. Use of one-word vocabulary tests alone will not be accepted;

2. Speech Production Disorder: a comprehensive measure with all errors specific to the type of speech production disorder reported (for example, positions, processes, and motor patterns);

3. Voice Disorder: a medical evaluation to determine the presence or absence of a physical etiology is required as part of the comprehensive assessment; and

4. Oral Motor, Swallowing, or Feeding Disorder: if swallowing problems or signs of aspiration are noted, then a referral for a videofluoroscopic swallow study must be made and documented as part of the comprehensive assessment.

212.500 Standardized Evaluation 1-1-22

A. Except as provided in Section 212.400(B)(5)(c), one (1) or more standardized evaluations are a required component of the comprehensive assessment used to establish a client's eligibility to receive occupational therapy, physical therapy, and speech-language pathology services.

1. Beneficiaries receiving occupational therapy, physical therapy, or speech-language pathology services outside of public schools must receive an annual standardized evaluation(s) to demonstrate continued eligibility.

2. Beneficiaries receiving occupational therapy, physical therapy, or speech-language pathology services as a part of an Individual Program Plan (IPP) or an Individual Education Plan (IEP) through public schools must receive a standardized evaluation(s) every three (3) years to demonstrate continued eligibility; however, an annual update of the client's progress is required.

B. Section 212.510(B), Section 212.510(C), and Section 212.520(B) link to the list of the standardized evaluation instruments and clinical analysis procedures that are accepted by the Arkansas Medicaid Program for the purpose of establishing eligibility to receive occupational therapy, physical therapy, and speech-language pathology services, respectively.

C. The lists of standardized evaluation instruments and clinical analysis procedures accepted by the Arkansas Medicaid Program for establishing eligibility for occupational therapy, physical therapy, and speech-language pathology services is not all-inclusive.

D. When using a standardized evaluation instrument that is not on the Arkansas Medicaid approved list, a justification must be included in the evaluation report explaining why the chosen instrument is valid, reliable, and appropriate for purposes of establishing eligibility for services.

E. Any standardized evaluation used to establish eligibility for occupational therapy, physical therapy, and speech-language pathology services must conform to the following standards:

1. The evaluation must be norm-referenced and specific to the service provided;
2. The evaluation must be age appropriate for the client;
3. All evaluation subtests, components, and scores must be reported;
   a. Evaluation results must be reported as standard scores, Z scores, T scores, or percentiles; age-equivalent and percentage of delay scores cannot be used to determine eligibility; and
   b. Evaluation results should be adjusted for prematurity if the client is under one (1) year old, and the adjustment should be noted in the evaluation report.
4. The evaluation must be performed by a qualified evaluator that has the credentials and training recommended by the evaluation instrument.

212.510 Occupational and Physical Therapy Standardized Evaluations 1-1-22

A. The medical necessity of occupational therapy and physical therapy services is established by a score on a standardized evaluation performed within the past ~~six~~twelve (12~~6~~) months that indicates a composite or subtest area score of at least one point five (1.5) standard deviations below the mean.

B. **View or print the list of standardized evaluation instruments** accepted by Arkansas Medicaid Program to establish eligibility for Occupational therapy services.

C. **View or print the list of standardized evaluation instruments** accepted by Arkansas Medicaid Program to establish eligibility for Physical therapy services.

212.520 Speech-Language Pathology Standardized Evaluations 1-1-22

A. The standardized evaluation(s) and required scoring to establish medical necessity for speech-language pathology services varies depending on the suspected communication disorder.

1. Language Disorder: impaired comprehension or use of spoken language, written, or other symbol systems. A language disorder may involve one (1) or any combination of the following components: phonology, morphology, syntax, semantics, prosody, and pragmatics.
   a. Children birth to three (3) years of age: a score on a standardized evaluation performed within the past ~~six~~twelve (12~~6~~) months that indicates a composite or quotient score of at least one point five (1.5) standard deviations below the mean, along with corroborating data from a second criterion referenced evaluation.
   b. Children three (3) to twenty-one (21) years of age: a score on two (2) standardized evaluations performed within the past ~~six~~twelve (12~~6~~) months that both result in a composite or quotient score of at least one point five (1.5) standard deviations below the mean.
   c. If both evaluations do not agree or do not indicate a composite or quotient score on a of at least one point five (1.5) standard deviations below the mean, then a third evaluation may be used to demonstrate medical necessity;

however, for a client from three (3) to twenty-one (21) years of age, the third evaluation must be a norm-referenced, standardized evaluation that results in a composite or quotient score on a of at least one point five (1.5) standard deviations below the mean.

2. Speech Production (Articulation, Phonological, and Apraxia): a score on two (2) standardized evaluations performed within the past ~~six~~twelve (12~~6~~) months that both result in standard scores of at least one point five (1.5) standard deviations below the mean. If only one (1) evaluation results in a standard score of at least one point five (1.5) standard deviations below the mean, then corroborating data from clinical analysis procedures can be used as a substitute for a second evaluation.

3. Voice Disorder: a detailed functional profile of voice parameters that indicate a moderate or severe voice deficit or disorder.

4. Fluency: a standardized evaluation and at least one (1) supplemental tool to address affective components each performed within the last ~~six~~twelve (12~~6~~) months. The results of the standardized evaluation and supplemental tool must establish one of the following:

   a. The client is within three (3) years of stuttering onset and exhibits significant risk factors for persistent developmental stuttering;

   b. The client has a persistent stutter and a score on a standardized evaluation within one (1.0) standard deviation from the mean or greater during functional speaking tasks; or

   c. A score on a standardized evaluation that indicates either:

      i. A standard score within one (1.0) standard deviation from the mean or greater; or

      ii. An index score of at one point five (1.5) standard deviations below the mean when comparing beneficiaries who stutter to individuals who do not stutter.

5. Oral Motor, Swallowing, or Feeding Disorder: an in-depth functional profile of oral motor structures and function using a comprehensive checklist or profile protocol that indicates a moderate or severe oral motor, swallowing, or feeding deficit or disorder.

B. **View or print the list of standardized evaluation instruments** and clinical analysis procedures accepted by Arkansas Medicaid Program to establish eligibility for Speech-language Pathology services.

213.000 Exclusions 1-1-22

An individual who has been admitted as an inpatient to a hospital or is residing in a nursing care facility is not eligible for occupational therapy, physical therapy, or speech-language pathology services under this manual.

214.000 Covered Services 1-1-22

The Arkansas Medicaid Program will only reimburse for the covered services listed in Sections 214.100 through 214.600 delivered in a manner in compliance with this manual, manual update transmittals, and official program correspondence.

214.100 Occupational Therapy, Physical Therapy, and Speech-Language Pathology Evaluation and Treatment Planning Services 1-1-22

A. A provider may be reimbursed for medically necessary occupational therapy, physical therapy, and speech-language pathology evaluation and treatment planning services. Occupational therapy, physical therapy, and speech-language pathology evaluation and treatment planning services are a component of the process of determining a client's

eligibility for occupational therapy, physical therapy, and speech-language pathology services and developing an eligible client's treatment plan.

B. Medical necessity for occupational therapy, physical therapy, and speech-language pathology evaluation and treatment planning services is demonstrated by a referral from the client's physician or certified nurse practitioner that demonstrates the medical necessity of occupational therapy, physical therapy, and speech-language pathology evaluation and treatment planning services.

C. The treatment plan must be developed and signed by an enrolled provider who is licensed in the prescribed service discipline or by the prescribing physician or certified nurse practitioner. The treatment plan must include goals that are functional, measurable, and specific for each individual client.

D. Medically necessary occupational therapy, physical therapy, and speech-language pathology evaluation and treatment planning services are reimbursed on a per unit basis based on complexity. The billable unit includes time spent administering and scoring a standardized evaluation, clinical observation, administering supplemental test and tools, writing an evaluation report and comprehensive assessment along with time spent developing the treatment plan. **View or print the billable occupational therapy, physical therapy, and speech-language pathology evaluation and treatment planning complexity codes and descriptions**.

214.200 Speech Generating Device Evaluation Services 1-1-22

A. A provider may be reimbursed for medically necessary evaluations for Speech Generating Devices (SGDs) upon receiving prior authorization. See Section 231.000.

B. An SGD evaluation must be performed by a multi-disciplinary team that, at a minimum, meets the following parameters:

1. The team must be led by a speech-language pathologist licensed by the Arkansas Board of Examiners for Speech-Language Pathology and Audiology who has a Certification of Clinical Competence from the American Speech-Language and Hearing Association;
2. The team must include an occupational therapist licensed by the Arkansas State Medical Board;
3. The team must include a physical therapist if it is determined there is a need for assistance in the evaluation as it relates to the positioning and seating in utilizing specific SGC equipment;
4. The speech-language pathologist, occupational therapist, and physical therapist must have documented and verifiable training and experience in the use and evaluation of SGD equipment, including without limitation knowledge concerning the SGD equipment's use and working capabilities, mounting and training requirements, warranties, and maintenance;
5. The team may include any other practitioners or individuals determined necessary to perform a complete evaluation, including without limitation educators, parents, behavior analysts, and vocational rehabilitation counselors, as appropriate; and
6. Team members must disclose any financial relationship they have with SGD device manufacturers and must certify that their recommendations are based on a comprehensive evaluation and preferred practice patterns and are not due to any financial or personal incentive.

C. The multi-disciplinary team must evaluate at least three (3) SGD systems from different manufacturers and product lines using an interdisciplinary approach incorporating the goals, objectives, skills, and knowledge of various disciplines.

1. The recommended SGD is prior authorized for purchase only after the client has completed a minimum of a four-week trial period that includes extensive experience with the requested system.
    a. Data must be collected during the trial period and document that the client can successfully use the recommended SGD device.
    b. If the client cannot demonstrate successful use of the recommended SGD device, subsequent trial periods with different devices shall occur until a device is identified that the client can successfully use. Information about the trial period must be documented in the evaluation report.
2. A trial period is not required when replacing an existing SGD unless the client's needs have changed, the current SGD device is no longer available, or another device or method of access is being considered as more appropriate.

D. After the team has completed the evaluation, the evaluation report must be submitted to the selected prosthetics provider. The evaluation report must include the following:

1. The medical necessity for the SGD and pertinent background information;
2. Information about the client's current speech-language and communication abilities over the last year;
3. Limitations of the client's current communication abilities, a list of the systems and devices the client currently uses, and the client's current communication needs;
4. Information on the client's sensory functioning, including vision and hearing, as related to the SGD;
5. Information regarding the client's postural and motor abilities. The report must include optimal access/selection technique needed for independent use of SGD;
6. A description of the functional placement of the SGD (such as mounting devices, carrying cases, and straps);
7. An indication of the client's ability to use various graphic and auditory symbol forms;
8. Information on vocabulary storage and rate enhancement techniques considered and the justification for those deemed most appropriate;
9. A summary of the client's required device features and delineate features of devices presented;
10. A specific recommendation for an SGD system, including a description of the SGD system, all components and accessories, and justification of why the recommended SGD system is more appropriate than the others;
11. Information about the trial period documenting that the client could successfully use the recommended device, including at a minimum:
    a. Length of trial;
    b. Frequency of use of SGD;
    c. Environments, activities, and communication partners involved;
    d. Access method(s) used;
    e. Portability of the SGD;
    f. Symbolic language system and rate enhancement used;
    g. Number of symbols and layout of overlay used;
    h. Sample of language expressed;
    i. Client's level of independence (prompting strategies) using the SGD and expressing various language functions; and
    j. A summary of baseline and end of trial data.

12. An initial treatment plan for implementing use of the device, which must identify:
    a. Who will be responsible for delivering and programming the SGD;
    b. Who will develop initial goals and objectives for functional use of SGD; and
    c. Who will train the client's team members and communication partners in the proper use, programming, care, and maintenance of the SGD.
13. The signature of the speech-language pathologist and all other professionals directly involved in the evaluation on both the evaluation report and a non-conflict disclosure stating that they do not have financial relationship or other affiliation with a SGD manufacturer.

E. Medically necessary evaluations for SGDs are covered once every three (3) years. The billable unit includes time spent meeting with the multi-disciplinary team, administering any supplemental instruments, tests and tools, and writing an evaluation report. **View or print the billable augmented communication device evaluation codes and descriptions**.

214.300 Occupational Therapy Services 1-1-22

A. An enrolled provider may be reimbursed for medically necessary occupational therapy services. Occupational therapy services must be medically necessary in accordance with Section 212.400.

B. A group occupational therapy provider may contract with or employ its occupational therapy practitioners. The group provider must identify the individual occupational therapist or occupational therapy assistant as the performing provider on the claim when the group occupational therapy provider bills the Arkansas Medicaid Program for the occupational therapy service. The individual occupational therapist or occupational therapy assistant performing the occupational therapy must be enrolled with the Arkansas Medicaid Program and the criteria for group providers of occupational therapy services would apply. See Section 202.000.

C. All occupational therapy services furnished by an occupational therapy provider must be provided according to a treatment plan developed by a licensed occupational therapist. All occupational therapy services must be provided, documented, and billed in accordance with this manual.

D. Medically necessary occupational therapy services are reimbursed on a per unit basis and are covered up to six (6) units per week without authorization. See Section 216.000 regarding requests for an extension of benefits to be reimbursed for in excess of six (6) units of occupation therapy services per week. Refer to Section 214.600 regarding occupational therapy services via telecommunication. **View or print the billable occupational therapy codes and descriptions.**

214.400 Physical Therapy Services 1-1-22

A. An enrolled provider may be reimbursed for medically necessary physical therapy services. Physical therapy services must be medically necessary in accordance with Section 212.400.

B. A group physical therapy provider may contract with or employ its physical therapy practitioners. The group provider must identify the individual physical therapist or physical therapy assistant as the performing provider on the claim when the group physical therapy provider bills the Arkansas Medicaid Program for the physical therapy service. The individual physical therapist or physical therapy assistant performing the physical therapy must be enrolled with the Arkansas Medicaid Program and the criteria for group providers of physical therapy services would apply. See Section 202.000.

C. All physical therapy services furnished by a physical therapy provider must be provided according to a treatment plan developed by a licensed physical therapist. All physical therapy services must be provided, documented, and billed in accordance with this manual.

D. Medically necessary physical therapy services are reimbursed on a per unit basis and are covered up to six (6) units per week without authorization. See Section 216.000 regarding requests for an extension of benefits to be reimbursed for in excess of six (6) units of physical therapy services per week. Refer to Section 214.600 regarding physical therapy services via telecommunication. **View or print the billable physical therapy codes and descriptions.**

214.500 Speech-Language Pathology Services 1-1-22

A. An enrolled provider may be reimbursed for medically necessary speech-language pathology services. Speech-language pathology services must be medically necessary in accordance with Section 212.400.

B. A group speech-language pathology provider may contract with or employ its speech-language pathology practitioners. The group provider must identify the individual speech-language pathologist or speech-language pathology assistant as the performing provider on the claim when the group speech-language pathology provider bills the Arkansas Medicaid Program for the speech-language pathology service. The individual speech-language pathologist or speech-language pathology assistant performing the speech-language pathology service must be enrolled with the Arkansas Medicaid Program and the criteria for group providers of speech-language pathology services would apply. See Section 202.000.

C. All speech-language pathology services furnished by a speech-language pathology provider must be provided according to a treatment plan developed by a licensed speech-language pathologist. All speech-language pathology services must be provided, documented, and billed in accordance with this manual.

D. Medically necessary speech-language pathology services are reimbursed on a per unit basis and are covered up to six (6) units per week without authorization. See Section 216.100 regarding requests for an extension of benefits to be reimbursed for in excess of six (6) units of speech-language pathology services per week. Refer to Section 214.600 regarding speech-language pathology services via telecommunication. **View or print the billable speech-language pathology codes and descriptions**.

214.600 Telemedicine Services 1-1-22

A. An enrolled provider may be reimbursed for medically necessary occupational therapy, physical therapy, and speech-language pathology services delivered through telemedicine.

1. Occupational therapy, physical therapy, and speech-language pathology evaluation and treatment planning services may not be conducted through telemedicine and must be performed through traditional in-person methods.

2. Parental or guardian consent is required prior to telemedicine service delivery.

3. The plan of care and client service record must include the following:

a. A detailed assessment of the client that determines they are an appropriate candidate for service delivery by telemedicine based on the client's age and functioning level;

b. A detailed explanation of all on-site assistance or participation procedures the therapist or speech-language pathologist is implementing to ensure:

i. The effectiveness of telemedicine service delivery is equivalent to face-

to-face service delivery; and

ii. Telemedicine service delivery will address the unique needs of the client.

c. A plan and estimated timeline for returning service delivery to in-person if a client is not progressing towards goals and outcomes through telemedicine service delivery.

4. All telemedicine services must be delivered in accordance with the Arkansas Telemedicine Act Ark. Code Ann. § 17-80-401 to -407.

B. The service provider is responsible for ensuring service delivery through telemedicine is equivalent to in-person, face-to-face service delivery.

1. The service provider is responsible for ensuring the calibration of all clinical instruments and the proper functioning of all telecommunications equipment.

2. All services delivered through telemedicine must be delivered in a synchronous manner, meaning through real-time interaction between the practitioner and client via a telecommunication link.

3. A store and forward telecommunication method of service delivery where either the client or practitioner records and stores data in advance for the other party to review at a later time is prohibited, although correspondence, faxes, emails, and other non-real time interactions may supplement synchronous telemedicine service delivery.

C. Services delivered through telemedicine are reimbursed in the same manner and subject to the same benefit limits as in-person, face-to-face service delivery. **View or print the billable telecommunication codes and descriptions.**

216.000 Benefit Limits

216.100 Extension of Benefits for Occupation Therapy, Physical Therapy, and Speech-language Pathology Services 1-1-22

An enrolled provider must receive authorization to be reimbursed for more than six (6) units of medically necessary occupation therapy, physical therapy, or speech-language pathology services in a week.

216.300 Process for Requesting an Extension of Benefits 1-1-22

A. Requests for extension of benefits pursuant to Section 216,100 are sent to Arkansas Medicaid's Quality Improvement Vendor (QIO).

B. A request for extension of benefits must by submitted on a form DMS-671 – "Request for Extension of Benefits for Clinical, Outpatient, Laboratory, and X-Ray Services."

C. **View or print QIO request for extension of benefit submission instructions**.

216.305 Request for Extension of Benefits Documentation Requirements 1-1-22

A request for extension of benefits must include clinical documentation demonstrating the medical necessity of the request, and at a minimum include:

A. The physician or certified nurse practitioner referral and prescription for the amount of service requested;

B. The comprehensive assessment, diagnosis, clinical records, progress reports, and other information necessary to demonstrate the medical necessity of the request for extension of benefits by the performing provider; and

C. Be signed by the performing provider

216.310 Review Process for Request for Extension of Benefits 1-1-22

A. Requests for extension of benefits are initially screened for completeness and researched to determine the client's eligibility for Medicaid.

B. All documentation submitted with the request is reviewed by an appropriately licensed clinician.

1. If the reviewing clinician determines the documentation demonstrates the medical necessity of the request, then an approval letter is mailed to the requesting provider the following business day.

2. If the reviewing clinician determines the documentation does not demonstrate the medical necessity of the request, the request is referred to a physician for review.

a. If the reviewing physician determines the documentation demonstrates the medical necessity of the request, then an approval letter is mailed to the requesting provider the following business day.

b. If the reviewing physician determines the documentation does not demonstrate the medical necessity of the request, then a denial letter that includes the physician's rationale for denial of the request is mailed to the provider and the client the following business day.

3. A provider may request an administrative reconsideration of any denial of a request for extension of benefits in accordance with Section 218.000.

217.000 Retrospective Review 1-1-22

A. A retrospective review will be performed on billed occupational therapy, physical therapy, and speech-language pathology services. Retrospective Review is a dual review process:

1. A medical necessity review that determines whether the amount, duration, and frequency of services provided were medically necessary; and

2. A utilization review that determines whether billed services were prescribed and delivered as billed.

B. The Quality Improvement Organization (QIO) under contract with the Arkansas Medicaid Program will perform retrospective reviews by reviewing client service records.

1. The QIO will review a percentage random sample of all in-person occupational therapy, physical therapy, and speech-language pathology services billed and paid that were either: (1) ninety (90) minutes or less per week; or (2) were provided pursuant to a rehabilitation diagnosis (related to an injury, illness, or surgical procedure).

2. The QIO will review all billed and paid occupational therapy, physical therapy, and speech-language pathology services delivered via telecommunication, as described in Section 214.600.

3. The QIO will review all billed and paid occupational therapy, physical therapy, and speech-language pathology services which were less than six (6) months from the previous evaluation date when the provider is utilizing a complexity code rather than a timed procedure code.

C. The QIO will mail a letter to each billing provider requesting copies of the service records for those billed services subject to retrospective review along with instructions for returning the service records.

1. The provider must deliver the requested service records and other documentation to the QIO within thirty (30) calendar days of the date of the request.

2. If the requested services records and information is not received within the thirty (30) calendar day timeframe, a retrospective review denial is issued.

3. The QIO may grant reasonable extensions of time as deemed appropriate in its sole discretion.

217.100 Medical Necessity Review 1-1-22

A. Each submission is initially reviewed for completeness. If the service record submission is determined to be incomplete, a request for additional information will be sent to the provider.

B. If it is determined that a complete service record request was submitted, a qualified clinician will review the documentation in more detail to determine whether it meets Medicaid eligibility criteria for medical necessity. The medical necessity review includes:

1. Verifying the treatment prescription was submitted on a form DMS-640;

2. Verifying the prescription contains the client's name, Medicaid ID number, a valid diagnosis that establishes that the prescribed service is medically necessary, the quantity and duration of the prescribed service, and is signed and dated by the primary care or attending physician or certified nurse practitioner;

a. A DMS-640 with a stamped signature or with no signature date will be considered invalid; and

b. Changes made to the prescription that alter the type and quantity of services prescribed are invalid unless changes are initialed and dated by the physician or certified nurse practitioner.

C. If the qualified clinician determines the services were not medically necessary or the prescription is invalid, the service record is referred to an appropriately licensed reviewer.

D. If the licensed reviewer determines the services were not medically necessary or the prescription is invalid, the service record is referred to the Associate Medical Director (AMD) for the QIO for review.

E. The AMD will review the service record and make a final decision as to whether the services were medically necessary.

1. If the services are denied due to lack of medical necessity, the service provider, the client, and the prescribing physician or certified nurse practitioner are notified in writing of the denial.

2. Each denial letter contains the rationale for the denial that is case specific and information on how to request an administrative reconsideration.

217.200 Utilization Review 1-1-22

A. The utilization review compares the paid claims data to the daily treatment and weekly progress notes in the service record to verify that:

1. The proper procedure code and modifier, if required, were billed; and

2. All service delivery documentation required by Section 202.400(A)(7) is included and supports the billed services.

B. If the qualified clinician reviewer determines a service record does not support the billed services, the unsupported billed services are referred to an appropriately licensed reviewer.

C. If the licensed reviewer determines a submitted service record does not support the billed services, the unsupported billed services are referred to the Associate Medical Director (AMD) for review.

D. The AMD will review the service record and make a final decision as to whether the service record supports the billed services.

1. If services are denied as part of utilization review, the service provider is notified in writing of the denial.

2. Each denial letter contains the rationale for the denial that is case specific and information on how to request an administrative reconsideration.

218.000 Administrative Reconsideration 1-1-22

A. A provider may submit additional information for administrative reconsideration of a denial of a request for extension of benefits pursuant to Section 216.000, or a denial of billed services on retrospective review pursuant to Section 217.000, within thirty-five (35) calendar days of the date shown on the denial letter. **View or print the QIO administrative reconsideration submission instructions.**

1. Each request for administrative reconsideration must include a copy of the denial letter and additional information substantially different from the service record and information initially submitted. Re-submitting the exact same information that was included with initial submission that was denied will result in the denial being upheld.

2. Only one (1) reconsideration is allowed per denial.

B. All documentation submitted with the request for administrative reconsideration is reviewed by an appropriately licensed clinician.

1. If the reviewing clinician determines the denial is inappropriate, then an approval letter granting the reconsideration is mailed to the requesting provider.

2. If the reviewing clinician determines they cannot grant the reconsideration request for any reason, the request for administrative reconsideration is forwarded to a physician reviewer. The physician reviewer on administrative reconsideration must be different from the physician reviewer that issued that original denial.

C. The physician reviewer will make a final decision to grant the reconsideration request or uphold the denial. A written notification of the outcome of the reconsideration request is mailed to the service provider and will include a case specific rationale for granting the reconsideration request or upholding the denial.

D. Any denial that is upheld on administrative reconsideration remains eligible for appeal as provided in Section 190.003.

220.000 Recoupments

220.100 Recoupment Process 1-1-22

The Division of Medical Services, Utilization Review section will recoup payment from a provider for all claims that the contracted Quality Improvement Organization denies through Retrospective Review. The provider will be sent an Explanation of Recoupment Notice that will include the

claim date of service, Medicaid client name and ID number, service provided, amount paid by Medicaid, amount to be recouped, and the reason the claim has been denied.

230.000 PRIOR AUTHORIZATION

231.000 Prior Authorization Request for a Speech Generating Device (SGD) Evaluation 1-1-22

A. Prior authorization from the Division of Medical Services, Utilization Review Section is required for a provider to be reimbursed for conducting an Speech Generating Device (SGD) evaluation. **View or print SGD Prior Authorization request submission instructions.**

B. Each prior authorization request must include:

1. A referral from the client's physician or certified nurse practitioner that documents the physical and intellectual functioning level of the client and the medical reason the client requires an SGD evaluation;
2. If the client is currently receiving speech-language pathology services, documentation from the speech-language pathologist of the cognitive level of the client and the prerequisite communication skills requiring an SGD evaluation of the client; and
3. A completed Form DMS-679 Request for Prior Authorization and Prescription. **View or print Form DMS-679 and instructions.**

C. If a prior authorization request is approved, then a prior authorization control number will be entered in item 10 of the Form DMS-679 and returned to the provider. If a prior authorization request is denied, a denial letter with the reason for denial will be mailed to the requesting provider and the Medicaid client.

231.100 Administrative Reconsideration of Prior Authorization Denial 1-1-22

Administrative reconsideration of a denial of a prior authorization request in Section 231.000 may be requested within thirty (30) calendar days of the denial date. Requests must be made in writing and must include additional documentation to substantiate the medical necessity of the SGD evaluation. **View or print administrative reconsideration submission instructions**. Any denial that is upheld on administrative reconsideration remains eligible for appeal as provided in Section 190.003.

250.000 REIMBURSEMENT

251.000 Method of Reimbursement 1-1-22

A. Occupational therapy, physical therapy, and speech-language pathology services use fee schedule reimbursement methodology. Under the fee schedule methodology, reimbursement is made at the lower of the billed charge for the service or maximum allowable reimbursement for the service under the Arkansas Medicaid Program.

1. A full unit of service must be rendered in order to bill a unit of service.
2. Partial units of service may not be rounded up and are not reimbursable.

B. The maximum group size for occupational therapy, physical therapy, and speech-language pathology services is four (4) clients.

251.010 Fee Schedules 1-1-22

A. The Arkansas Medicaid program provides fee schedules on the Arkansas Medicaid website. **View or print the occupational, physical, and speech-language pathology services fee schedule.**

B. Fee schedules do not address coverage limitations or special instructions applied by the Arkansas Medicaid Program before final payment is determined.

C. Fee schedules and procedure codes do not guarantee payment, coverage, or the reimbursement amount. Fee schedule and procedure code information may be changed or updated at any time to correct a discrepancy or error.

State of Arkansas *As Engrossed: S3/31/21*
93rd General Assembly **A Bill**
Regular Session, 2021 HOUSE BILL 1068

By: Representative Pilkington

For An Act To Be Entitled

AN ACT TO CLARIFY THE TELEMEDICINE ACT; TO SPECIFY THAT THE HOME OF A PATIENT MAY BE AN ORIGINATING SITE FOR TELEMEDICINE AND THAT GROUP MEETINGS MAY BE PERFORMED VIA TELEMEDICINE; TO CLARIFY REIMBURSEMENT OF TELEMEDICINE SERVICES; AND FOR OTHER PURPOSES.

Subtitle

TO CLARIFY THE TELEMEDICINE ACT; TO SPECIFY THAT THE HOME OF A PATIENT MAY BE AN ORIGINATING SITE FOR TELEMEDICINE AND THAT GROUP MEETINGS MAY BE PERFORMED VIA TELEMEDICINE; AND TO CLARIFY REIMBURSEMENT OF TELEMEDICINE SERVICES.

BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF ARKANSAS:

SECTION 1. Arkansas Code § 17-80-402(3), concerning the definition of "originating site" within the Telemedicine Act, is amended to read as follows:

(3)(A) "Originating site" means a site at which a patient is located at the time healthcare services are provided to him or her by means of telemedicine.

(B) "Originating site" includes the home of a patient;

SECTION 2. Arkansas Code § 17-80-404, concerning the appropriate use of telemedicine, is amended to add an additional subsection to read as follows:

(f)(1) A healthcare professional may use telemedicine to perform group

meetings for healthcare services, including group therapy.

(2) Telemedicine for group therapy provided to adults who are participants in a program or plan authorized and funded under 42 U.S.C. § 1396a, as approved by the United States Secretary of Health and Human Services, may only be permitted if the Centers for Medicare and Medicaid Services allows telemedicine for group therapy provided to adults.

(3) Telemedicine shall not be used for group therapy provided to a child who is eighteen (18) years of age or younger.

SECTION 3. Arkansas Code § 23-79-1601(4), concerning the definition of "originating site" regarding coverage for services provided through telemedicine, is amended to read as follows:

(4)(A) "Originating site" means a site at which a patient is located at the time healthcare services are provided to him or her by means of telemedicine.

(B) "Originating site" includes the home of a patient;

/s/Pilkington

APPROVED: 4/19/21

State of Arkansas *As Engrossed: H1/25/21 H2/8/21 H2/10/21 S3/9/21 S3/17/21 S4/6/21 S4/12/21*
93rd General Assembly **A Bill**
Regular Session, 2021 HOUSE BILL 1063

By: Representatives Dotson, Pilkington
By: Senator Hester

For An Act To Be Entitled

AN ACT TO AMEND THE TELEMEDICINE ACT; TO AUTHORIZE ADDITIONAL REIMBURSEMENT FOR TELEMEDICINE VIA TELEPHONE; TO DECLARE AN EMERGENCY; AND FOR OTHER PURPOSES.

Subtitle

TO AMEND THE TELEMEDICINE ACT; TO AUTHORIZE ADDITIONAL REIMBURSEMENT FOR TELEMEDICINE VIA TELEPHONE; AND TO DECLARE AN EMERGENCY.

BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF ARKANSAS:

SECTION 1. Arkansas Code § 17-80-402(4), concerning the definition of a "professional relationship" as used under the Telemedicine Act, is amended to read as follows:

(4) “Professional relationship” means at a minimum a relationship established between a healthcare professional and a patient when:

(A) The healthcare professional has previously conducted an in-person examination of the patient and is available to provide appropriate follow-up care, when necessary, at medically necessary intervals;

(B) The healthcare professional personally knows the patient and the patient’s relevant health status through an ongoing personal or professional relationship and is available to provide appropriate follow-up care, when necessary, at medically necessary intervals;

(C) The treatment is provided by a healthcare professional in consultation with, or upon referral by, another healthcare professional who has an ongoing professional relationship with the patient and who has agreed to supervise the patient's treatment, including follow-up care;

(D) An on-call or cross-coverage arrangement exists with the patient's regular treating healthcare professional or another healthcare professional who has established a professional relationship with the patient;

(E) A relationship exists in other circumstances as defined by rule of the Arkansas State Medical Board for healthcare professionals under its jurisdiction and their patients; ~~or~~

(F) A relationship exists in other circumstances as defined by rule of a licensing or certification board for other healthcare professionals under the jurisdiction of the appropriate board and their patients if the rules are no less restrictive than the rules of the Arkansas State Medical Board; or

(G)(i) The healthcare professional who is licensed in Arkansas has access to a patient's personal health record maintained by a healthcare professional and uses any technology deemed appropriate by the healthcare professional, including the telephone, with a patient located in Arkansas to diagnose, treat, and if clinically appropriate, prescribe a noncontrolled drug to the patient.

(ii) For purposes of this subchapter, a health record may be created with the use of telemedicine and consists of relevant clinical information required to treat a patient, and is reviewed by the healthcare professional who meets the same standard of care for a telemedicine visit as an in-person visit;

SECTION 2. Arkansas Code § 17-80-403(c), concerning the establishment of a professional relationship, is amended to read as follows:

(c) "Professional relationship" does not include a relationship between a healthcare professional and a patient established only by the following:

(1) An internet questionnaire;

(2) An email message;

(3) Patient-generated medical history;

(4) ~~Audio-only communication, including without limitation interactive audio;~~

~~(5)~~ Text messaging;

~~(6)~~(5) A facsimile machine; or

~~(7)~~(6) Any combination ~~thereof~~ of means listed in subdivisions (c)(1)-(5) of this section.

SECTION 3. Arkansas Code § 23-79-1601(2)(C), concerning the definition of "health benefit plan", is amended to read as follows:

(C) "Health benefit plan" does not include:

(i) Disability income plans;

(ii) Credit insurance plans;

(iii) Insurance coverage issued as a supplement to liability insurance;

(iv) Medical payments under automobile or homeowners insurance plans;

(v) Health benefit plans provided under Arkansas Constitution, Article 5, § 32, the Workers' Compensation Law, § 11-9-101 et seq., or the Public Employee Workers' Compensation Act, § 21-5-601 et seq.;

(vi) Plans that provide only indemnity for hospital confinement;

(vii) Accident-only plans;

(viii) Specified disease plans; ~~or~~

(ix) Long-term-care-only plans; or

(x) Stand-alone dental or vision benefit plans;

SECTION 4. Arkansas Code § 23-79-1601(7), concerning the definition of "telemedicine", is amended to read as follows:

(7)(A) "Telemedicine" means the use of electronic information and communication technology to deliver healthcare services, including without limitation the assessment, diagnosis, consultation, treatment, education, care management, and self-management of a patient.

(B) "Telemedicine" includes store-and-forward technology

and remote patient monitoring.

(C) For the purposes of this subchapter, "telemedicine" does not include the use of:

(i)(a) Audio-only communication, ~~including without limitation interactive audio~~ unless the audio-only communication is real-time, interactive, and substantially meets the requirements for a healthcare service that would otherwise be covered by the health benefit plan.

(b) As with other medical services covered by a health benefit plan, documentation of the engagement between patient and provider via audio-only communication shall be placed in the medical record addressing the problem, content of conversation, medical decision-making, and plan of care after the contact.

(c) The documentation described in subdivision (7)(C)(i)(b) of this section is subject to the same audit and review process required by payers and governmental agencies when requesting documentation of other care delivery such as in-office or face-to-face visits;

(ii) A facsimile machine;

(iii) Text messaging; or

(iv) ~~Electronic mail systems~~ Email.

SECTION 5. Arkansas Code § 23-79-1602(e), concerning prohibitions on the coverage for telemedicine services, is amended to read as follows:

(e) A health benefit plan shall not impose on coverage for healthcare services provided through telemedicine:

(1) An annual or lifetime dollar maximum on coverage for services provided through telemedicine other than an annual or lifetime dollar maximum that applies to the aggregate of all items and services covered;

(2) A deductible, copayment, coinsurance, benefit limitation, or maximum benefit that is not equally imposed upon all healthcare services covered under the health benefit plan; ~~or~~

(3) A prior authorization requirement for services provided through telemedicine that exceeds the prior authorization requirement for in-person healthcare services under the health benefit plan;

(4) A requirement for a covered person to choose any commercial

telemedicine service provider or a restricted network of telemedicine-only providers rather than the covered person's regular doctor or provider of choice; or

(5) A copayment, coinsurance, or deductible that is not equally imposed upon commercial telemedicine providers as those imposed on network providers.

SECTION 6. EMERGENCY CLAUSE. It is found and determined by the General Assembly of the State of Arkansas that due to the coronavirus 2019 (COVID-19) pandemic, the Governor removed barriers to the use of telemedicine in an attempt to combat the coronavirus 2019 (COVID-19) pandemic; that these emergency actions will expire when the emergency proclamation expires, which could occur quickly; that on February 26, 2021, the Governor announced that the public health emergency was extended but that the Governor was going to lift some regulations related to the pandemic; that removing barriers to the use of telemedicine ensured that the citizens of Arkansas had the services that they needed, and removing these emergency proclamations regarding telemedicine would greatly disadvantage and harm the citizens of Arkansas who are utilizing telemedicine for healthcare services; that this bill maintains the policy changes allowed under the emergency proclamation, which would allow the citizens of Arkansas greater access to the use of telemedicine for healthcare services; and that this act is immediately necessary to ensure that the citizens of Arkansas have access to healthcare services provided via telemedicine. Therefore, an emergency is declared to exist, and this act being immediately necessary for the preservation of the public peace, health, and safety shall become effective on:

(1) The date of its approval by the Governor;

(2) If the bill is neither approved nor vetoed by the Governor, the expiration of the period of time during which the Governor may veto the bill; or

(3) If the bill is vetoed by the Governor and the veto is overridden, the date the last house overrides the veto.

/s/Pilkington

APPROVED: 4/21/21