



Arkansas Department of Human Services

Division of Medical Services

Donaghey Plaza South
PO Box 1437
Little Rock, Arkansas 72203-1437
Internet Website: www.medicaid.state.ar.us
Telephone: (501) 682-8292 TDD: (501) 682-6789 or 1-877-708-8191 FAX: (501) 682-1197

OFFICIAL NOTICE

DMS-2002-AR-9 DMS-2002-I-5 DMS-2002-FF-2 DMS-2002-Y-6
DMS-2002-C-3 DMS-2002-L-14 DMS-2002-R-17 DMS-2002-YY-6
DMS-2002-F-1 DMS-2002-KK-13 DMS-2002-EE-4

TO: Health Care Provider – ARKids First-B; Child Health Management Services (CHMS); Developmental Day Treatment Clinic Services (DDTCS); Home Health; Hospital; Nurse Practitioner; Occupational, Physical, Speech Therapy; Physician; Podiatrist; Rehabilitative Hospital and Rehabilitative Services for Persons with Mental Illness (RSPMI)

DATE:

SUBJECT: Revisions in Occupational, Physical and Speech Therapy Services

I. Introduction

Effective for dates of service on or after January 1, 2003, revisions will be implemented in occupational, physical and speech therapy services policy. These revisions include coverage of make-up therapy sessions; coverage of services carried out by unlicensed therapy students and retrospective review guidelines for occupational, physical and speech therapy services.

II. Make-up Therapy Sessions

Effective for dates of service on or after January 1, 2003, make-up therapy sessions are covered in the event an occupational, physical or speech therapy session is canceled or missed. Make-up therapy sessions are covered for Medicaid payment if determined medically necessary and prescribed by the recipient's primary care physician (PCP). A prescription in addition to the one previously received is necessary and must be signed by the PCP.

Form DMS-640, Occupational, Physical and Speech Therapy for Medicaid Eligible Recipients Under Age 21 Prescription/Referral must be utilized by the PCP to prescribe make-up therapy sessions for Medicaid-eligible recipients under age 21.

III. Coverage Criteria for Therapy Services Carried Out by Unlicensed Therapy Students

Effective for dates of service on or after January 1, 2003, therapy services carried out by an unlicensed therapy student may be covered only when the following criteria is met.

- A. Therapies carried out 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.
- B. To qualify as providing the service, the licensed therapist must be present and engaged in student oversight during the entirety of any encounter that will be billed to Medicaid as occupational, physical or speech therapy.

IV. Guidelines for Retrospective Review of Occupational, Physical and Speech Therapy Services

Effective for dates of service on or after January 1, 2003, retrospective review of occupational, physical and speech therapy services will be implemented.

The purpose of retrospective review is promotion of effective, efficient and economical delivery of health care services of proper quality and assurance that services conform to appropriate professional standards.

The Professional Review Organization (PRO), Arkansas Foundation for Medical Care, Inc. (AFMC), under contract to the Arkansas Medicaid Program, performs retrospective reviews by reviewing medical records to determine if services delivered and reimbursed by Medicaid meet medical necessity requirements.

Specific guidelines have been developed for occupational, physical and speech therapy retrospective reviews. For your information, a copy of retrospective review guidelines for occupational and physical therapy and a copy of retrospective review guidelines for speech therapy are attached to this Official Notice.

- V. Failure to follow the instructions in the Arkansas Medicaid provider manual and failure to timely and completely respond to requests made by the Professional Review Organization (PRO) is considered a technical failure to establish eligibility for therapy services. The PRO does not have the authority to allow reconsideration for a technical denial.

Official Notice

DMS-2002-AR-9

DMS-2002-C-3

DMS-2002-F-1

Page 3

DMS-2002-I-5

DMS-2002-L-14

DMS-2002-KK-13

DMS-2002-FF-2

DMS-2002-R-17

DMS-2002-EE-4

DMS-2002-Y-6

DMS-2002-YY-6

If you need this material in an alternative format, such as large print, please contact our Americans with Disabilities Act Coordinator at (501) 682-8307 (voice) or at (501) 682-6789 and 1-877-708-8191 (TDD).

If you have questions regarding this notice, please contact the EDS Provider Assistance Center at In-State WATS 1-800-457-4454, or locally and Out-of-State at (501) 376-2211.

Thank you for your participation in the Arkansas Medicaid Program.

Kurt Knickrehm, Director
Department of Human Services

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

Guideline for Physical and Occupational Therapy Retrospective Review

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

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

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

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

Evaluations:

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

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

Guideline for Physical and Occupational Therapy Retrospective Review (Continued)

Standardized Testing:

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

The mental measurement yearbook is the standard reference to determine reliability/validity.

Other Objective Test and Measures:

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

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

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

Monitoring: May be used to insure that the child is maintaining a desired skill level or to assess the effectiveness and fit of equipment such as orthotics and other durable medical equipment. Monitoring frequency should be based on a time interval that is reasonable for the complexity of the problem being addressed.

Maintenance Therapy: Services that are performed primarily to maintain range of motion or to provide positioning services for the patient do not qualify for physical or occupational therapy services. These services can be provided to the child as part of a home program that can be implemented by the child's caregivers and do not necessarily require the skilled services of a physical or occupational therapist to perform safely and effectively.

Guideline for Physical and Occupational Therapy Retrospective Review (Continued)

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.

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 PT or OT co-sign progress notes.

Speech-Language Therapy Guidelines for Retrospective Review

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

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

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

Evaluations:

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

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

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

Birth to Three:

1. -(minus)1.5 SD (standard score of 77) below the mean in two areas (expressive, receptive) or a -(minus) 2.0 SD (standard score of 70) below the mean in one area to qualify for language therapy.

Speech-Language Therapy Guidelines for Retrospective Review (Continued)

2. Two language tests must be reported with at least one of these being a global norm-referenced standardized test with good reliability/validity. The second test may be criterion referenced.
3. All subtests, components, and scores must be reported for all tests.
4. All sound errors must be reported for articulation including positions and types of errors.
5. If phonological testing is submitted, a traditional articulation test must also be submitted with a standardized score.
6. Information regarding child's functional hearing ability must be included as a part of the therapy evaluation report.
7. Non-school aged children must be evaluated annually.
8. If the provider indicates the child cannot complete a norm-referenced test, the provider must submit an in-depth functional profile of the child's functional communication abilities. An in-depth functional profile is a description of a child's communication behaviors that specifically notes where such communication behaviors are impaired and justifies the medical necessity of therapy. Standardized forms are available for the completion of an in-depth functional profile, but a standardized form is not required.
9. Children must be evaluated at least annually. CHMS children (birth – 2) must be evaluated every 6 months.

Ages 3 – 21:

1. -(minus)1.5 SD (standard score of 77) below the mean in two areas (expressive, receptive, articulation) or a -(minus) 2.0 SD (standard score of 70) below the mean in one area (expressive, receptive, articulation)
2. Two language tests must be reported with at least one of these being a global norm-referenced standardized test with good reliability/validity. Criterion referenced tests will not be accepted for this age group.
3. All subtests, components, and scores must be reported for all tests.
4. All sound errors must be reported for articulation including positions and types of errors.
5. If phonological testing is submitted, a traditional articulation test must also be submitted with a standardized score.
6. Information regarding child's functional hearing ability must be included as a part of the therapy evaluation report.
7. Non-school aged children must be evaluated annually.
8. School-age children must have a full evaluation every three years (a yearly update is required) if therapy is school related; outside of school annual evaluations are required. "School related" means the child is of school-age, attends public school, and receives therapy provided by the school.

Speech-Language Therapy Guidelines for Retrospective Review (Continued)

9. If the provider indicates the child cannot complete a norm-referenced test, the provider must submit an in-depth functional profile of the child's functional communication abilities. An in-depth functional profile is a description of a child's communication behaviors that specifically notes where such communication behaviors are impaired and justifies the medical necessity of therapy. Standardized forms are available for the completion of an in-depth functional profile, but a standardized form is not required.
10. IQ scores are required on all children who are school-age and receiving language therapy.

IQ Testing:

Children receiving language intervention therapy must have cognitive testing once they start kindergarten. This also applies to home-schooled children. If the IQ score is higher than the qualifying language scores, then the child would qualify for language therapy; if the IQ score is lower than the qualifying language test scores, the child would appear to be functioning at or above expected level. In this case, the child may be denied for language therapy. If a provider determines that therapy is warranted, an in-depth functional profile must be submitted.

Feeding/Swallowing/Oral Motor:

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

Voice:

A medical evaluation is a prerequisite to voice therapy.

Progress Notes:

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