



# Arkansas Department of Human Services

## Division of Medical Services

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**TO:** Arkansas Medicaid Health Care Providers – Home Health  
**DATE:** November 1, 2005  
**SUBJECT:** Provider Manual Update Transmittal #62

**REMOVE**

<b>Section</b>	<b>Date</b>
205.000 – 206.000	6-1-04
212.340 – 212.347	6-1-04
213.500 – 213.540	10-13-03

**INSERT**

<b>Section</b>	<b>Date</b>
205.000 – 206.000	11-1-05
212.340 – 212.343	11-1-05
213.500 – 213.515	11-1-05
218.000 – 218.165	11-1-05

**Explanation of Updates**

Section 205.000: This section is included to update a reference in the 3<sup>rd</sup> sentence of the introductory paragraph.

Section 206.000: This section is included to update a reference in the 2<sup>nd</sup> sentence of the introductory paragraph.

Section 212.340: This section is the first paragraph of former section 212.346. Former section 212.346 has been subdivided.

Sections 212.341 through 212.343: These sections are 3 of the 4 subdivisions of former section 212.346.

Sections 213.500 through 213.512: These sections replace former sections 213.500 through 213.540.

Section 213.513: This is a new section that sets forth the guidelines regarding appeals of benefit extension denials.

Section 213.514: This section sets forth the guidelines regarding continuation of services pending the outcome of a fair hearing.

Section 213.515: This section cites providers' and beneficiaries' rights to seek judicial relief in circuit court for adverse actions and determinations.

Section 218.000: This section is former section 212.341.

Section 218.100: This section is former section 212.342.

Section 218.110: This section is former section 212.343.

Section 218.120: This section is former section 212.344.

Section 218.130: This section is former section 212.345.

Section 218.140: This section is former section 212.347.

Sections 218.150 through 218.165: These new sections identify tests and the types of tests and documentation acceptable to the Medicaid Program in support of physical therapy for individuals under the age of 21.

Paper versions of this update transmittal have updated pages attached to file in your provider manual. See Section I for instructions on updating the paper version of the manual. For electronic versions, these changes will be automatically incorporated.

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

If you have questions regarding this transmittal, please contact the EDS Provider Assistance Center at 1-800-457-4454 (toll free) within Arkansas or locally and Out of state at (501) 376-2211.

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

Thank you for your participation in the Arkansas Medicaid Program.

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Roy Jeffus, Director

## SECTION II HOME HEALTH

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**205.000 Record Retention Requirements**

11-1-05

The record retention requirements in this section apply to the home health records of beneficiaries of all ages. Special documentation and record retention requirements apply to beneficiaries under the age of 21. See sections 218.000 through 218.165 for those additional requirements.

- A. All required records must be kept for a period of 5 years from the ending date of service or until all audit questions, appeal hearings, investigations or court cases are resolved, whichever period is longer.
- B. Providers are required, upon request, to furnish their records to authorized representatives of the Arkansas Division of Medical Services (DMS), the Medicaid Fraud Control Unit of the Office of the Attorney General and representatives of the Department of Health and Human Services.
- C. Furnishing records on request to authorized individuals and agencies is a contractual obligation of providers enrolled in the Medicaid Program. Sanctions will be imposed for failure to furnish medical records upon request.
- D. When the Medicaid Field Audit Unit conducts an audit of a provider's records, all documentation must be made available to authorized DMS personnel at the provider's place of business during normal business hours. Requested documentation that is stored off-site must be made available to DMS personnel within three business days.
- E. If an audit determines that recoupment of Medicaid payments is necessary, DMS will accept additional documentation for only thirty days after the date of the notification of recoupment. Additional documentation will not be accepted later.

**206.000 Documentation of Services**

11-1-05

Home health providers must maintain the following records for patients of all ages. (See sections 218.000 through 218.165 for additional documentation guidelines regarding physical therapy for patients under the age of 21.)

- A. Signed and dated patient assessments and plans of care, including physical therapy evaluations and treatment plans when applicable.
- B. Signed and dated case notes and progress notes from each visit by nurses, aides, physical therapy assistants and physical therapists.
- C. Signed and dated documentation of *pro re nata* (PRN) visits, which must include:
  1. The medical justification for each such unscheduled visit
  2. The patient's vital signs and symptoms
  3. The observations of and measures taken by agency staff and reported to the physician
  4. The physician's comments, observations and instructions.
- D. Verification, by means of the physician's signed and dated certification or by means of the physician's medical record of the visit, that the beneficiary had a physical examination, with a history or history update, no more than 12 months before the beginning date of each episode of care.
- E. Copies of current, signed and dated plans of care, including interim and short-term plan-of-care modifications, in each patient's medical records.

- F. Copies of plans of care, PCP referrals, case notes, etc., for all previous episodes of care within the period of required record retention.
- G. The registered nurse's instructions to home health aides, detailing the aide's duties at each visit.
- H. The registered nurse's (or physical therapist's when applicable) notes from supervisory visits.

- 212.340**      **Frequency, Intensity and Duration of Physical Therapy Services for Beneficiaries Under the Age of 21**      11-1-05
- A. Frequency, intensity and duration of physical therapy services must be medically necessary and realistic for the age of the patient and the severity of the deficit or disorder.
  - B. 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.
- 212.341**      **Monitoring**      11-1-05
- A. Monitoring may be used to ensure that the patient is maintaining a desired skill level or to assess the effectiveness and fit of equipment, such as orthotics and other durable medical equipment.
  - B. Monitoring frequency should be at intervals that are reasonable for the complexity of the problems being addressed.
- 212.342**      **Maintenance Therapy**      11-1-05
- A. Services that are performed primarily to maintain range of motion or to provide positioning services for the patient do not qualify for physical therapy services.
  - B. Such 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 required the skilled services of a physical therapist to be performed safely and effectively.
- 212.343**      **Duration of Services**      11-1-05
- A. Therapy services should be provided as long as reasonable progress is made toward established goals.
  - B. If reasonable functional progress cannot be expected with continued therapy, services should be discontinued and monitoring or establishment of a caregiver-administered home program should be implemented.



**213.500 Benefit Extensions 11-1-05**

Extensions of benefits are considered only for beneficiaries who have had a face-to-face evaluation and management (E&M) visit with their PCP or authorized attending physician within the twelve months preceding the beginning date of the requested extension.

- A. Benefit extensions are allowed for medically necessary home health skilled nursing visits and home health aide visits for beneficiaries of all ages.
- B. Benefit extensions for medically necessary medical supplies are allowed only for beneficiaries under the age of 21 in the Child Health Services (EPSDT) Program.
- C. Benefit extensions are allowed for medically necessary diapers and underpads for beneficiaries aged 3 and older.

**213.510 Benefit Extension Request Procedures 11-1-05**

- A. Submit requests for extensions of home health benefits to the Utilization Review Section. [View or print the Division of Medical Services UR/Home Health Extensions contact information.](#)
- B. A benefit extension request does not establish timely filing with respect to the one-year deadline for filing Medicaid claims.
  - 1. Only a clean claim establishes timely filing.
  - 2. See Section III of this manual for timely filing requirements.
- C. Minimum requirements for benefit extension requests are as follows.
  - 1. A completed benefit extension request form
    - a. For beneficiaries under the age of 21, use form DMS-602.
    - b. For beneficiaries aged 21 and older, use form DMS-699.
  - 2. Medical records substantiating medical necessity for additional services/supplies
  - 3. The current home health plan of care, signed and dated by the PCP or authorized attending physician
  - 4. The supervising registered nurse's case narrative
  - 5. The medical record of a comprehensive physical examination with history or history update within the twelve months preceding the beginning service date of the extended benefit period

**213.511 Benefit Extension Approvals 11-1-05**

- A. When a benefit extension is approved, a benefit extension control number is assigned.
- B. The approval notification letter lists the procedure codes approved for benefit extension, the approved dates or date-of-service range, the number of units of service authorized and the benefit extension control number.

**213.512 Benefit Extension Denials and Reconsideration Requests 11-1-05**

When an extension is denied or only partially approved, the provider and the beneficiary receive notification letters.

- A. The provider may request reconsideration of the extension request.

- B. Reconsideration may be given only once per date of service for home health visits and once per month for medical supplies and diapers and underpads.
- C. Reconsideration requests must contain all documentation originally submitted and the additional documentation that the provider believes justifies the request.
- D. Reconsideration of benefit extension requests is contingent upon the provider's submitting additional documentation to support the request.

**213.513****Appeals**

11-1-05

- A. A beneficiary may appeal a denied benefit extension by requesting a fair hearing.
- B. A provider may appeal on behalf of a beneficiary for whom an extension has been denied.
- C. An appeal request must be in writing and must be received by the Appeals and Hearings Section of the Department of Health and Human Services (DHHS) within 30 days of the first business day following the date of the postmarks on the envelopes in which the beneficiary and provider received their denial confirmations. [View or print the Department of Health and Human Services, Appeals and Hearings Section contact information.](#)

**213.514****Requesting Continuation of Services Pending the Outcome of an Appeal**

11-1-05

- A. A beneficiary may request that services be continued pending the outcome of an appeal.
- B. A provider may not, on behalf of a beneficiary, request continuation of services pending the outcome of an appeal.
  - 1. An appeal that includes a request to continue services must be received by the DHHS Appeals and Hearings Section within 10 days of the first business day following the date of the postmark on the envelope in which the beneficiary received the denial confirmation letter.
  - 2. When such requests are made and timely received by the Appeals and Hearings Section, DMS authorizes the services and notifies the provider and beneficiary.
  - 3. The provider will be reimbursed for services furnished under these circumstances and for which the provider correctly bills Medicaid.
- C. If the beneficiary loses the appeal, DMS will take action to recover from the beneficiary Medicaid's payments for the services that were provided pending the outcome of the appeal.

**213.515****Unfavorable Administrative Decisions – Judicial Relief**

11-1-05

Providers and Medicaid beneficiaries have standing to appeal to circuit court unfavorable administrative decisions under the Arkansas Administrative Procedures Act, § 25-15-201 *et. seq.*

**218.000****Additional Documentation Requirements for Physical Therapy Patients Under the Age of 21**

11-1-05

- A. Providers must maintain documentation supporting medical necessity of physical therapy services.
1. Medicaid requires a referral from the primary care physician (PCP) or a referral from the authorized attending physician if the beneficiary is exempt from mandatory PCP enrollment.
  2. Medicaid requires a written prescription for physical therapy, signed and dated by the PCP or the authorized attending physician. Providers of physical therapy for beneficiaries under the age of 21 must use form DMS-640, Occupational, Physical and Speech Therapy Services for Medicaid Eligible Recipients Under age 21 Prescription/Referral, to obtain the prescription. [View or print form DMS-640.](#)
    - a. The PCP or authorized attending physician must complete and sign form DMS-640 with his or her original signature. A rubber stamp or automated signature is not acceptable.
    - b. The PCP or authorized attending physician must maintain the original prescription (form DMS-640) in the beneficiary's medical record.
    - c. The home health provider must maintain a copy of the original prescription form in the patient's medical record.
  3. Medicaid requires that a physical therapy treatment plan be developed, signed and dated by a qualified physical therapist and/or a physician. The plan must include individualized goals that are functional, measurable and specific to the beneficiary's medical needs.
- B. Documentation must include, when applicable, an Individualized Family Services Plan (IFSP) established in accordance with part C of the Individuals with Disabilities Education Act (IDEA).
- C. Medicaid requires, when applicable, an Individualized Education Program (IEP) established in accordance with part B of IDEA.
- D. Documentation must be supported by therapy evaluation reports to substantiate medical necessity, signed or initialed and dated progress notes and any related correspondence.
- E. Documentation must include discharge notes and summary.

**218.100****Retrospective Review of Physical Therapy for Beneficiaries Under the Age of 21**

11-1-05

The guidelines set forth in sections 218.000 through 218.165 apply to home health physical therapy services for beneficiaries under the age of 21.

- A. Physical therapy services are medically prescribed services for the evaluation and treatment of movement dysfunction.
- B. Physical therapy services must be medically necessary for the treatment of the individual's illness or injury. To be considered medically necessary, the following conditions must be met.
1. The services must be considered under accepted standards of practice to be 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 therapist.

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.
- C. A diagnosis alone is not sufficient documentation to support the medical necessity of therapy. Assessment for physical therapy includes a comprehensive evaluation of the patient's physical deficits and functional limitations, and a treatment plan with goals that address each identified problem.
- D. The Quality Improvement Organization (QIO), Arkansas Foundation for Medical Care, Inc., (AFMC), under contract to the Arkansas Medicaid Program, performs retrospective reviews of medical records to determine the medical necessity of services reimbursed by Medicaid.
- E. Failure to follow the instructions in the Arkansas Medicaid provider manual and failure to respond to requests made by the QIO in a complete and timely manner are considered technical failures to establish eligibility for therapy services. The QIO does not have the authority to allow reconsideration of technical denials.

**218.110**      **Retrospective Review of Physical Therapy Evaluations  
for Beneficiaries Under the Age of 21**

11-1-05

A physical therapy evaluation must contain:

- A. The date of evaluation.
- B. The patient's name and date of birth.
- C. The diagnosis or diagnoses specifically applicable to the proposed therapy.
- D. Background information, including pertinent medical history.
- E. Standardized test results, including all subtest scores, if applicable. Test results, if applicable, should be adjusted for prematurity if the patient is a child one year old or younger. The test results must be noted in the evaluation.
- F. Objective information describing the patient's gross and fine motor abilities and deficits, which shall include range of motion measurements, manual muscle testing results and a narrative description of the patient's functional mobility skills.
- G. An assessment of the results of the evaluation, including recommendations for frequency and intensity of treatment.
- H. The signature and credentials of the qualified physical therapist or physician performing the evaluation.

**218.120**      **Retrospective Review of Standardized Testing for Beneficiaries  
Under the Age of 21**

11-1-05

Standardized tests must be norm-referenced and specific to physical therapy.

- A. A test must be age appropriate for the patient.
- B. Test results must be reported as standard scores, Z scores, T scores or percentiles. Age-equivalent scores and percentage of delay are not sufficient justification for physical therapy services.
- C. 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.
- D. If a patient cannot be tested with a norm-referenced standardized test, then criterion-based testing or a functional description of the patient's gross and fine motor deficits may be

used. Documentation of the reason a standardized test cannot be used must be included in the evaluation.

- E. The mental measurement yearbook is the standard reference to determine reliability and validity.

#### 218.130 Other Objective Tests and Measures

11-1-05

- A. **Range of Motion:** A limitation of greater than ten degrees and/or documentation of how a deficit limits function.
- B. **Muscle Tone:** Modified Ashworth Scale.
- C. **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.
- D. **Transfer Skills:** Documented as the amount of assistance required to perform a transfer, such as maximum, moderate or minimal assistance. A deficit is defined as the inability to perform a transfer safely and independently.

#### 218.140 Retrospective Review of Progress Notes for Beneficiaries Under the Age of 21

11-1-05

Progress notes must be legible and contain:

- A. The patient's name.
- B. The date of service.
- C. The beginning and ending time of each therapy session.
- D. Objectives addressed during the session. (These must correspond directly to the plan of care.)
- E. Descriptions of the physical therapy modalities provided daily and the activities involved during each therapy session, along with a form measurement.
- F. The qualified physical therapist's full signature, dated and with credentials, on each entry.
- G. The supervising qualified physical therapist's co-signature when a graduate student performs the physical therapy

#### 218.150 Definitions of Terms

11-1-05

- A. **Standard:** Evaluations that are used to determine deficits.
- B. **Supplemental:** Evaluations that are used to justify deficits and support other results. Supplemental tests may not supplant standard tests.
- C. **Clinical observations:** Clinical observations always have a supplemental role in the evaluation, but they must always be included. Detail, precision and comprehensiveness of clinical observations are especially important when standard scores do not qualify the patient for therapy and the clinical notes constitute the primary justification of medical necessity.

#### 218.160 Accepted Tests for Physical Therapy

11-1-05

- A. Tests used must be norm-referenced, standardized, age appropriate and specific to the therapy provided.

- B. The lists of tests in sections 218.161 through 218.165 are not all-inclusive.
  1. When using a test not listed, the provider must document the reliability and validity of the test.
  2. The *Mental Measurement Yearbook* (MMY) is the standard reference to determine reliability/validity of the test(s) administered in an evaluation.
  3. An explanation why a test from the approved list could not be used to evaluate a patient must be included in the documentation.

**218.161**      **Norm Reference**      11-1-05

- A. Adaptive Areas Assessment
- B. Test of Gross Motor Development (TGMD-2)
- C. Peabody Developmental Motor Scales, Second Ed. (PDMS-2)
- D. Bruininks-Oseretsky Test of Motor Proficiency (BOT)
- E. Pediatric Evaluation of Disability Inventory (PEDI)
- F. Test of Gross Motor Development – 2 (TGMD-2)
- G. Peabody Developmental Motor Scales (PDMS)
- H. Alberta Infant Motor Scales (AIM)
- I. Toddler and Infant Motor Evaluation (TIME)
- J. Functional Independence Measure for Children (WeeFIM)
- K. Gross Motor Function Measure (GMFM)
- L. Adaptive Behavior Scale – School, Second Ed. (AAMR-2)
- M. Movement Assessment Battery for Children (Movement ABC)

**218.162**      **Physical Therapy – Supplemental**      11-1-05

- A. Bayley Scales of Infant Development, Second Ed. (BSID-2)
- B. Neonatal Behavioral Assessment Scale (NBAS)

**218.163**      **Physical Therapy Criterion**      11-1-05

- A. Developmental Assessment for Students with Severe Disabilities, Second Ed. (DASH-2)
- B. Milani-Comparetti Developmental Examination

**218.164**      **Physical Therapy – Traumatic Brain Injury (TBI) – Standardized**      11-1-05

- A. Comprehensive Trail-Making Test
- B. Adaptive Behavior Inventory

**218.165**      **Physical Therapy – Piloted**      11-1-05

Assessment of Persons Profoundly or Severely Impaired