



# Arkansas Department of Health and Human Services

## Division of Medical Services



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**TO:** Arkansas Medicaid Health Care Providers – Therapy

**DATE:** June 1, 2006

**SUBJECT:** Provider Manual Update Transmittal #56

<u>REMOVE</u>		<u>INSERT</u>	
Section	Date	Section	Date
201.300	10-13-03	201.300	6-1-06
204.000	10-13-03	204.000	6-1-06
214.300	11-1-05	214.300	6-1-06

**Explanation of Updates**

Section 201.300: The entire section has been changed and contains new information.

Section 204.000: New information has been added about the documentation and record keeping requirements that providers must adhere to, and, all occurrences of the word “recipient” have been changed to the word “beneficiary” or its appropriate form.

Section 214.300: Information has been added to the occupational and physical therapy retrospective review guidelines section to explain how often an evaluation should be administered to school-age children.

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

If you need this material in an alternative format, such as large print, please contact our Americans with Disabilities Act Coordinator at (501) 682-6789 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 OCCUPATIONAL, PHYSICAL, SPEECH THERAPY CONTENTS

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## 201.300

Providers in States **Not Bordering Arkansas**

6-1-06

- A. Providers in states not bordering Arkansas are called limited services providers because they may enroll in Arkansas Medicaid only after they have treated an Arkansas Medicaid beneficiary and have a claim to file, and because their enrollment automatically expires.
1. A non-bordering state provider may send a claim to Provider Enrollment and Provider Enrollment will forward by return mail a provider manual and a provider application and contract. [View or print Medicaid Provider Enrollment Unit contact information.](#)
  2. Alternatively, a non-bordering state provider may download the provider manual and provider application materials from the Arkansas Medicaid website, [www.medicaid.state.ar.us](http://www.medicaid.state.ar.us), and then submit its application and claim to the Medicaid Provider Enrollment Unit.
- B. Limited services providers remain enrolled for one year.
1. If a limited services provider treats another Arkansas Medicaid beneficiary during its year of enrollment and bills Medicaid, its enrollment may continue for one year past the newer claim's last date of service, if the provider keeps the enrollment file current.
  2. During its enrollment period the provider may file any subsequent claims directly to EDS.
  3. Limited services providers are strongly encouraged to submit claims through the Arkansas Medicaid website because the front-end processing of web-based claims ensures prompt adjudication and facilitates reimbursement.

## 204.000

## Required Documentation

6-1-06

- A. The provider must contemporaneously create and maintain records that completely and accurately explain all evaluations, care, diagnoses and any other activities of the provider in connection with its delivery of medical assistance to any Medicaid beneficiary.
- B. Beneficiary records must support the levels of service billed to Medicaid.
- C. Providers furnishing any Medicaid-covered good or service for which a prescription, admission order, physician's order, care plan or other order for service initiation, authorization or continuation is required by law, by Medicaid rule, or both, must obtain a copy of the aforementioned prescription, care plan or order within five (5) business days of the date it is written. Providers also must maintain a copy of each prescription, care plan or order in the beneficiary's medical record and follow all prescriptions, care plans, and orders as required by law, by Medicaid rule, or both.
- D. All records must be kept for a period of five (5) years from the ending date of service or until all audit questions, appeal hearings, investigations or court cases are resolved, whichever is longer. Failure to furnish medical records upon request may result in sanctions being imposed. (See Section I of this manual.)
- E. The provider must make available to the Division of Medical Services, its contractors and designees and the Medicaid Fraud Control Unit all records related to any Medicaid beneficiary. When records are stored off-premise or are in active use, the provider may certify, in writing, that the records in question are in active use or in off-premise storage and set a date and hour within three (3) working days, at which time the records will be made available. However, the provider will not be allowed to delay for matters of convenience, including availability of personnel.
- F. All documentation must be made available to representatives of the Division of Medical Services at the time of an audit conducted by the Medicaid Field Audit Unit. All documentation must be available at the provider's place of business. If an audit determines that recoupment is necessary, there will be only thirty (30) days after the date of the recoupment notice in which additional documentation will be accepted. Additional documentation will not be accepted at a later date.
- G. 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 6 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.
  5. Where applicable, an Individual Educational Plan (IEP) established pursuant to Part B of the Individuals with Disabilities Education Act.
  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.
- H. 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.
- I. 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.
- J. 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.
- K. 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.

## 214.300

**Occupational and Physical Therapy Guidelines for Retrospective Review**

6-1-06

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

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

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

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

- B. Evaluations:

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

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

- C. Standardized Testing:

1. Test used must be norm referenced, standardized and specific to the therapy provided.

2. Test must be age appropriate for the child being tested.
  3. Test results must be reported as standard scores, Z scores, T scores or percentiles. Age-equivalent scores and percentage of delay cannot be used to qualify for services.
  4. A score of -1.50 standard deviations or more from the mean in at least one subtest area or composite score is required to qualify for services.
  5. If the child cannot be tested with a norm-referenced, standardized test, criterion-based testing or a functional description of the child's gross/fine motor deficits may be used. Documentation of the reason a standardized test could not be used must be included in the evaluation.
  6. The Mental Measurement Yearbook (MMY) is the standard reference to determine reliability/validity. Refer to sections 214.310 and 214.320 for a list of standardized tests accepted by the Arkansas Foundation for Medical Care, Inc. (AFMC), for retrospective reviews.
- D. Other Objective Tests and Measures:
1. Range of Motion: A limitation of greater than ten degrees and/or documentation of how a deficit limits function.
  2. Muscle Tone: Modified Ashworth Scale.
  3. Manual Muscle Test: A deficit is a muscle strength grade of fair (3/5) or below that impedes functional skills. With increased muscle tone, as in cerebral palsy, testing is unreliable.
  4. Transfer Skills: Documented as the amount of assistance required to perform transfer, i.e., maximum, moderate, or minimal assistance. A deficit is defined as the inability to perform a transfer safely and independently.
- E. Frequency, Intensity and Duration of Physical and/or Occupational Therapy Services:
- The frequency, intensity and duration of therapy services should always be medically necessary and realistic for the age of the child and the severity of the deficit or disorder. Therapy is indicated if improvement will occur as a direct result of these services and if there is a potential for improvement in the form of functional gain.
1. Monitoring: May be used to insure that the child is maintaining a desired skill level or to assess the effectiveness and fit of equipment such as orthotics and other durable medical equipment. Monitoring frequency should be based on a time interval that is reasonable for the complexity of the problem being addressed.
  2. Maintenance Therapy: Services that are performed primarily to maintain range of motion or to provide positioning services for the patient do not qualify for physical or occupational therapy services. These services can be provided to the child as part of a home program implemented by the child's caregivers and do not necessarily require the skilled services of a physical or occupational therapist to be performed safely and effectively.
  3. Duration of Services: Therapy services should be provided as long as reasonable progress is made toward established goals. If reasonable functional progress cannot be expected with continued therapy, services should be discontinued and monitoring or establishment of a home program should be implemented.
- F. Progress Notes:
1. Child's name.
  2. Date of service.

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