



Division of Medical Services
Program Planning & Development

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TO: Arkansas Medicaid Health Care Providers – Developmental Day
Treatment Clinic Services

DATE: March 1, 2010

SUBJECT: Provider Manual Update Transmittal #115

Table with 4 columns: REMOVE Section, REMOVE Date, INSERT Section, INSERT Date. Lists updates for sections 214.210, 214.500, 215.200, 217.000, 217.100, 217.700, 217.800, 218.000, 220.200, and 220.210.

Explanation of Updates

Section 214.210 is updated to include clarification on the required use of form DMS-640 for referral and prescription of occupational, physical and speech therapy services.

Section 214.500 is a new section, added to include benefit limit information for beneficiaries age 21 years and older.

Section 215.200 is updated to remove outdated information.

Section 217.000 is updated to change the section title and to update information and wording changes in descriptive terms as appropriate.

Section 217.100 is a new section, added to supply additional information on required documentation for extended benefit requests.

Section 217.700 is a new section, added to outline procedures for requesting benefit extensions for therapy services for beneficiaries age 21 years and older.

Section 217.800 is a new section, added to include documentation requirements for benefit extensions for beneficiaries age 21 and over.

Section 218.000 is updated with a title change and to incorporate minor wording changes in descriptive terms as appropriate.

Section 220.200 is updated to remove a reference to availability of the standardized available form in C#2.

Section 220.210 is updated to remove a reference to availability of the standardized available form in E #8 and F#9.

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 501-682-8323 (Local); 1-800-482-5850, extension 2-8323 (Toll-Free) or to obtain access to these numbers through voice relay, 1-800-877-8973 (TTY Hearing Impaired).

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.

Thank you for your participation in the Arkansas Medicaid Program.

Roy Jeffus, Director

TOC required

214.210 Occupational, Physical and Speech Therapy

3-1-10

Optional services available through DDTCS include occupational, physical and speech therapy and evaluation as an essential component of the plan of care for an individual accepted for developmental disabilities services. Therapy services are not included in the core services and are provided in addition to the core services. Procedural and benefit differences are based on the beneficiaries age (under age 21 and over age 21 yrs).

- A. The DDTCS client's primary care physician (PCP) or attending physician must refer a client for evaluation for occupational, physical or speech therapy services. For clients under the age of 21, the use of form DMS-640 is required. [View or print form DMS-640](#). The DDTCS client's primary care physician (PCP) or attending physician must also prescribe occupational, physical and/or speech therapy services and again, for clients under the age of 21, the use of an additional form DMS-640 is required for the prescription. The prescribed therapy must be included in the individual's DDTCS plan of care. A copy of the prescription must be maintained in the beneficiary's records. The original prescription is to be maintained by the physician. After the initial referral and initial prescription, subsequent referrals and prescriptions for continued therapy may be made at the same time using the same DMS-640 for clients under age 21. Instructions for completion of form DMS-640 are located on the back of the form. Medicaid will accept an electronic signature provided it is compliance with Arkansas Code 25-31-103.
- B. Therapies in the DDTCS Program may be provided only to individuals whose plan of care includes one of the three levels of care (early intervention, pre-school or adult development). Medicaid does not cover optional therapy services furnished by a DDTCS provider as "stand-alone" services. To ensure quality care, group therapy sessions are limited to no more than four persons in a group.
 1. When a DDTCS provider renders therapy services in conjunction with a DDTCS core service, therapy services must be billed by the DDTCS provider according to billing instructions in Section II of this manual.
 2. DDTCS providers may not bill under the Medicaid Occupational, Physical and Speech Therapy Program for therapy services available in the DDTCS Program and provided to DDTCS clients.
 3. Therapy services may not be provided during the same time period DDTCS core services are provided.
- C. Arkansas Medicaid applies the following therapy benefits to all therapy services provided in the DDTCS program:
 1. Medicaid will reimburse up to four (4) occupational, physical and speech therapy evaluation units (1 unit = 30 minutes) per discipline, per state fiscal year (July 1 through June 30) without authorization. Additional evaluation units for beneficiaries under age 21 will require an extended therapy request.
 2. Medicaid will reimburse up to four (4) occupational, physical and speech therapy units (1 unit = 15 minutes) daily, per discipline, without authorization. Additional daily therapy units will require an extended therapy request for beneficiaries under age 21.
 3. All requests for extended therapy services must comply with sections 217.000 through 217.100 for beneficiaries under age 21.

4. All requests for benefit extensions for therapy services provided in the DDTCS program to beneficiaries age 21 years and over must comply with sections 217.700 through 217.800.
- D. Make-up therapy sessions are covered for beneficiaries under age 21 in the event a therapy session is canceled or missed, if determined medically necessary and prescribed by the beneficiary's PCP. A make-up therapy session requires a separate prescription from the original previously received. Form DMS-640 must be used by the PCP for make-up therapy session prescriptions for beneficiaries under age 21.
- E. 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. The licensed therapist must be present and engaged in student oversight during the entirety of any encounter.

214.500 Occupational, Physical and Speech Therapies Provided in the DDTCS Program For Beneficiaries 21 Years of Age and Older 3-1-10

- A. Medicaid will reimburse up to four (4) occupational, physical and speech therapy evaluation units (1 unit = 30 minutes) per discipline, for an eligible beneficiary, per state fiscal year (July 1 through June 30).
- B. Medicaid will reimburse up to four (4) occupational, physical and speech therapy units (1 unit = 15 minutes) daily, per discipline, for an eligible beneficiary.
- C. All requests for benefit extensions for therapy services for beneficiaries over age 21 must comply with sections 217.700 through 217.800.

215.200 Establishing Medical Necessity for Optional Services 3-1-10

- A. Occupational, physical and speech therapy services for Medicaid beneficiaries under age 21 require a *referral* from the client's primary care physician (PCP) or attending physician if the individual is exempt from mandatory PCP referral requirements. The *referral* for occupational, physical and speech therapy services must be renewed every six months. The PCP or attending physician is responsible for determining medical necessity for therapy treatment.
- B. A written *prescription* for therapy services is required and is valid for one year unless the prescribing physician specifies a shorter period.

217.000 Procedures for Requesting Extended Therapy Services for Occupational, Physical and Speech Therapy (Evaluation or Treatment) for Beneficiaries Under Age 21 3-1-10

- A. Requests for benefit extension of therapy services for beneficiaries under age 21 must be mailed to the Arkansas Foundation for Medical Care, Inc. (AFMC). [View or print the Arkansas Foundation for Medical Care, Inc. contact information.](#) The request must meet the medical necessity requirement, and adequate documentation must be provided to support this request.
 1. Requests for benefit extensions of therapy services are considered only after a claim is denied because a regular benefit is exceeded.

2. The request must be received by AFMC within 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 denial for exceeded benefits. Do not send a claim.
 4. AFMC 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, include credentials and date the request. An electronic signature is accepted provided it is in compliance with Arkansas Code 25-31-103. All applicable records that support the medical necessity of the request should be attached.
- C. AFMC will approve, deny, or ask for additional information, within 30 calendar days of receiving the request. AFMC reviewers will simultaneously advise the provider and the beneficiary when a request is denied. Approved requests will be returned to the provider with an authorization number that is required to be submitted with the billing for the approved services in order to obtain Medicaid payment.

217.100 Documentation Requirements for Extended Therapy Benefits for Beneficiaries Under 21

3-1-10

- A. To request extended therapy services, all applicable documentation that support the medical necessity of extended benefits are 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.

217.700 Procedures for Requesting Extended Benefits for Occupational, Physical and Speech Therapy Provided in the DDTCS Program (Evaluation or Treatment) for Beneficiaries Over Age 21

3-1-10

- A. Requests for extended benefits for therapy services provided in the DDTCS program for beneficiaries over age 21 must be mailed to the Arkansas Foundation for Medical Care, Inc. (AFMC). [View or print the Arkansas Foundation for Medical Care, Inc. contact information](#). The request must meet the medical necessity requirement, and adequate documentation must be provided to support this request.
1. Requests for extended DDTCS benefits for therapy services are considered only after a claim is denied because a regular benefit is exceeded.
 2. The request must be received by AFMC within 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 denial for exceeded benefits. Do not send a claim.
 4. AFMC 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, include credentials and date the request. 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.
- C. AFMC will approve, deny, or ask for additional information, within 30 calendar days of their receiving the request. AFMC reviewers will simultaneously advise the provider and the beneficiary when a request is denied. Approved requests will be returned to the provider with an authorization number that is required to be submitted with the billing for the approved services in order to obtain Medicaid payment.

217.800 Documentation Requirements for Benefit Extensions for Beneficiaries Over age 21 3-1-10

- A. To request extended therapy services, all applicable documentation supporting the medical necessity of extended benefits are 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.

218.000 Administrative Reconsideration of Extended Therapy Services Denial 3-1-10

- A. A request for administrative reconsideration of an extended therapy service request denial must be in writing and sent to AFMC within 30 calendar days of the denial. The request must include a copy of the denial letter and additional supporting documentation.
- B. 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 AFMC with 35 calendar days of a denial will be deemed timely. A request received later than 35 calendar days of a denial will be considered on an individual basis. Reconsideration requests must be mailed and will not be accepted via facsimile or email.

220.200 Speech-Language Therapy Guidelines for Retrospective Review for Beneficiaries Under Age 21 3-1-10

- A. Speech-language 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 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 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 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.

B. 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, if the child is 12 months or age or younger, gestational age.
5. Standardized test results, including all subtest scores, if applicable. Test results should be adjusted for prematurity (less than 37 weeks gestation) if the child is age 12 months or younger, 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 his or her native language; if not, an explanation must be provided in the evaluation.
8. Signature and credentials of the therapist performing the evaluation.

C. Feeding/Swallowing/Oral Motor:

1. Can be formally or informally assessed.
2. Must have an in-depth functional profile on oral motor structures and function. This profile is a description of a child's oral motor structure that specifically notes how the structure is impaired and justifies the medical necessity of feeding/swallowing/oral motor therapy services.
3. If swallowing problems and/or signs of aspiration are noted, a formal medical swallow study must be submitted.

D. Voice

A medical evaluation is a prerequisite for voice therapy.

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 entry with a full signature and credentials.
8. Graduate students must have the supervising SLP co-sign progress notes.

220.210 Accepted Tests for Speech-Language Therapy

3-1-10

Tests used must be norm referenced, standardized, age appropriate and specific to the therapy provided. The following list of tests is not all-inclusive. When using a test not listed below, the provider must include documentation in the evaluation to support the reliability and validity of the test. This additional information will be used as reference information if the chart is selected by Medicaid for review. An explanation of why a test from the approved list could not be used to evaluate the child must also be included. The *Mental Measurement Yearbook (MMY)* is the standard reference to determine the reliability and validity of the test(s) administered in an evaluation. Providers should refer to the *MMY* for additional information regarding specific tests. The following definitions of terms are applied to the lists of accepted tests:

- **Standard:** Evaluations that are used to determine deficits.
 - **Supplemental:** Evaluations that are used to identify deficits and support other results. Supplemental tests may not supplant standard tests.
 - **Clinical observations:** Clinical observations always have a supplemental role in the evaluation and should 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.
- A. Speech-Language Tests – Standardized
1. Preschool Language Scale, Third Ed. (PLS-3)
 2. Preschool Language Scale, Fourth Ed. (PLS-4)
 3. Test of Early Language Development, Third Ed. (TELD-3)
 4. Peabody Picture Vocabulary Test, Third Ed. (PPVT-3)
 5. Clinical Evaluation of Language Fundamentals – Preschool (CELF-P)
 6. Clinical Evaluation of Language Fundamentals, Third Ed. (CELF-3)
 7. Clinical Evaluation of Language Fundamentals, Fourth Ed. (CELF-4)
 8. Communication Abilities Diagnostic Test (CADeT)
 9. Test of Auditory Comprehension of Language, Third Ed. (TACL-3)
 10. Comprehensive Assessment of Spoken Language (CASL)
 11. Oral and Written Language Scales (OWLS)
 12. Test of Language Development – Primary, Third Ed. (TOLD-P:3)
 13. Test of Word Finding, Second Ed. (TWF-2)
 14. Test of Auditory Perceptual Skills, Revised (TAPS-R)
 15. Language Processing Test, Revised (LPT-R)
 16. Test of Pragmatic Language (TOPL)
 17. Test of Language Competence, Expanded Ed. (TLC-E)
 18. Test of Language Development – Intermediate, Third Ed. (TOLD-I:3)
 19. Fullerton Language Test for Adolescents, Second Ed. (FLTA)
 20. Test of Adolescent and Adult Language, Third Ed. (TOAL-3)
 21. Receptive One-Word Picture Vocabulary Test, Second Ed. (ROWPVT-2)
 22. Expressive One-Word Picture Vocabulary Test, 2000 Ed. (EOWPVT)

23. Comprehensive Receptive and Expressive Vocabulary Test, Second Ed. (CREVT-2)
 24. Kaufman Assessment Battery for Children (KABC)
 25. Receptive-Expressive Emergent Language Test, Third Edition (REEL-3)
- B. Speech Language Tests – Supplemental
1. Receptive/Expressive Emergent Language Test, Second Ed. (REEL-2)
 2. Nonspeech Test for Receptive/Expressive Language
 3. Rossetti Infant-Toddler Language Scale (RITLS)
 4. Mullen Scales of Early Learning (MSEL)
 5. Reynell Developmental Language Scales
 6. Illinois Test of Psycholinguistic Abilities, Third Ed. (ITPA-3)
 7. Social Skills Rating System – Preschool & Elementary Level (SSRS-1)
 8. Social Skills Rating System – Secondary Level (SSRS-2)
 9. Kaufman Speech Praxis Test (KSPT)
- C. Literacy/Comprehension – Supplemental
1. The Clinical Assessment of Literacy and Language
 2. The Literacy Comprehension Test 2
 3. Test of Reading Comprehension 3 (TORC3)
- D. Written Language/Comprehension – Supplemental
1. Test of Written Language 3 (TWL3)
- E. Birth to Age 3:
1. A (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.
 2. Two language tests must be reported with at least one of these being a global norm-referenced standardized test with good reliability and 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 the child's functional hearing ability must be included as a part of the therapy evaluation report.
 7. Non-school-age children must be evaluated annually.
 8. If the provider indicates that 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.
 9. Children must be evaluated at least annually. Children (birth to age 2) in the Child Health Management Services (CHMS) Program must be evaluated every 6 months.
- F. Ages 3 to 21:

1. A (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 and 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.
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.
10. IQ scores are required on all children who are school age and receiving language therapy. **Exception: IQ scores are not required for children under ten (10) years of age.**