



Division of Medical Services
Program Development & Quality Assurance

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TO: Arkansas Medicaid Health Care Providers – Occupational, Physical,
Speech Therapy Services

DATE: August 1, 2011

SUBJECT: Provider Manual Update Transmittal #THERAPY-1-11

Table with 4 columns: REMOVE Section, REMOVE Date, INSERT Section, INSERT Date. Rows include updates for sections 203.000, 214.310, 214.320, and 262.310.

Explanation of Updates

Section 203.000 was updated to clarify language.
Sections 214.310 and 214.320 are updated to add Occupational and Physical Therapy tests.
Section 262.310 is updated to reflect the directions for completing field #19 of the CMS-1500 claim form.
The paper version of this update transmittal includes revised pages that may be filed in your provider manual.
If you have questions regarding this transmittal, please contact the HP Enterprise Services Provider Assistance Center at 1-800-457-4454 (Toll-Free) within Arkansas or locally and Out-of-State at (501) 376-2211.
If you need this material in an alternative format, such as large print, please contact our Americans with Disabilities Act Coordinator at 501-682-0593 (Local); 1-800-482-5850, extension 2-0593 (Toll-Free) or to obtain access to these numbers through voice relay, 1-800-877-8973 (TTY Hearing Impaired).
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.

Eugene I. Gessow, Director

TOC not required**203.000 Supervision****8-1-11**

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

214.310 Accepted Tests for Occupational Therapy**8-1-11**

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 used to further document deficits and support standardized results; any non-diagnostic tool that is a screening or is criterion-referenced, descriptive in design, a structured probe or an accepted clinical assessment procedure. Supplemental tests may not replace standardized tests.

- **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

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
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
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
NOTE: Although the MSEL is an accepted standardized test, it is felt by the Therapy Advisory Council (TAC) that an additional test should be administered.	
Peabody Developmental Motor Scales	PDMS
Peabody Developmental Motor Scales — 2	PDMS-2
Pediatric Evaluation of Disability Inventory	PEDI
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.	
Purdue Pegboard Test	
Range of Motion	ROM
Sensory Integration and Praxis Test	SIPT

Test	Abbreviation
Sensory Integration Inventory Revised	SII-R
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

B. Occupational Therapy Tests — Supplemental

Test	Abbreviation
Analysis of Sensory Behavior Inventory	
Battelle Developmental Inventory	BDI
Bay Area Functional Performance Evaluation	BaFPE
Brigance Developmental Inventory	BDI
Developmental Assessment of Young Children	DAYC
Early Learning Accomplishment Profile	E-LAP
Erhardt Developmental Prehension Assessment	EDPA
Functional Profile	
Goodenough Harris Draw a Person Scale Test	
Grip and Pinch Strength	
Hawaii Early Learning Profile	HELP
Jordan Left-Right Reversal Test	JLRRT
Knox Preschool Play Scale	
Learning Accomplishment Profile	LAP
Manual Muscle Test	MMT
Miller Assessment for Preschoolers	MAP
School Function Assessment	SFA
Sensorimotor Performance Analysis	SPA
Sensory Integration Inventory	SII

Test	Abbreviation
Social Skills Rating System	SSRS

214.320 Accepted Tests for Physical Therapy

8-1-11

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 used to further document deficits and support standardized results; any non-diagnostic tool that is a screening or is criterion-referenced, descriptive in design, a structured probe or an accepted clinical assessment procedure. Supplemental tests may not replace standardized tests.
- **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

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

NOTE: Although the MSEL is an accepted standardized test, it is felt by the Therapy Advisory Council (TAC) that an additional test should be administered.

Test	Abbreviation
Peabody Developmental Motor Scales	PDMS
Peabody Developmental Motor Scales, Second Edition	PDMS-2
Pediatric Balance Scale	PBS
Pediatric Evaluation of Disability Inventory	PEDI
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.	
Range of Motion — Functional Performance Impairments	ROM
Test of Infant Motor Performance	TIMP
Test of Gross Motor Development, Second Edition	TGMD-2
Toddler and Infant Motor Evaluation	

B. Physical Therapy Tests — Supplemental

Test	Abbreviation
Battelle Developmental Inventory	BDI
Bayley Scales of Infant Development, Second Edition	BSID-2
Brigance Developmental Inventory	BDI
Developmental Assessment for Students with Severe Disabilities, Second Edition	DASH-2
Developmental Assessment of Young Children	DAYC
Early Learning Accomplishment Profile	E-LAP
Hawaii Early Learning Profile	HELP
Learning Accomplishment Profile	LAP
Manual Muscle Test	MMT
Milani-Comparetti Developmental Examination	
Miller Assessment for Preschoolers	MAP
Neonatal Behavioral Assessment Scale	NBAS

C. Physical Therapy Tests — Piloted

Test	Abbreviation
Assessment for Persons Profoundly or Severely Impaired	APPSI

262.310

Completion of the CMS-1500 Claim Form

8-1-11

Field Name and Number	Instructions for Completion
1. (type of coverage)	Not required.

Field Name and Number	Instructions for Completion
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 SEX	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. 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) CITY STATE ZIP CODE TELEPHONE (Include Area Code)	Optional. Beneficiary's or participant's complete mailing address (street address or post office box). Name of the city in which the beneficiary or participant resides. Two-letter postal code for the state in which the beneficiary or participant resides. Five-digit zip code; nine digits for post office box. 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) CITY STATE ZIP CODE TELEPHONE (Include Area Code)	Required if insured's address is different from the patient's address.
8. PATIENT STATUS	Not required.
9. OTHER INSURED'S NAME (Last name, First Name, Middle Initial) a. OTHER INSURED'S POLICY OR GROUP NUMBER b. OTHER INSURED'S DATE OF BIRTH SEX c. EMPLOYER'S NAME OR SCHOOL NAME d. INSURANCE PLAN NAME OR PROGRAM NAME	If patient has other insurance coverage as indicated in Field 11d, the other insured's last name, first name, and middle initial. Policy and/or group number of the insured individual. Not required. Not required. Required when items 9 a-d are required. Name of the insured individual's employer and/or school. Name of the insurance company.

Field Name and Number	Instructions for Completion
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.
10d. RESERVED FOR LOCAL USE	Not used.
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. EMPLOYER'S NAME OR SCHOOL NAME	Not required.
c. INSURANCE PLAN NAME OR PROGRAM NAME	Not required.
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 9a through 9d.
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE	Not required.
13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE	Not required.
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.
15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE	Not required.
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 Therapy Services. Enter the referring physician's name.
17a. (blank)	The 9-digit Arkansas Medicaid provider ID number of the referring physician.
17b. NPI	Not required.

Field Name and Number	Instructions for Completion
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.
19. Reserved for Local Use	For tracking purposes, occupational, physical and speech therapy providers are required to enter one of the following therapy codes:
<u>Code</u>	<u>Category</u>
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? \$ CHARGES	Not required. Not required.
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY	Diagnosis code for the primary medical condition for which services are being billed. Up to three additional diagnosis codes can be listed in this field for information or documentation purposes. Use the International Classification of Diseases, Ninth Revision (ICD-9-CM) diagnosis coding current as of the date of service.
22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.	Reserved for future use. Reserved for future use.
23. PRIOR AUTHORIZATION NUMBER	The prior authorization or benefit extension control number if applicable.
24A. DATE(S) OF SERVICE	<p>The "from" and "to" dates of service for each billed service. Format: MM/DD/YY.</p> <ol style="list-style-type: none"> 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.
C. EMG	Not required.
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.

Field Name and Number	Instructions for Completion
E. DIAGNOSIS POINTER	Enter in each detail the single number—1, 2, 3, or 4—that corresponds to a diagnosis code in Item 21 (numbered 1, 2, 3, or 4) and that supports most definitively the medical necessity of the service(s) identified and charged in that detail. Enter only one number in E of each detail. Each DIAGNOSIS POINTER number must be only a 1, 2, 3, or 4, and it must be the only character in that field.
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 #	The 9-digit Arkansas Medicaid provider ID number of the individual who furnished the services billed for in the detail.
NPI	Not required.
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.
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. BALANCE DUE	From the total charge, subtract amounts received from other sources and enter the result.
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.

Field Name and Number	Instructions for Completion
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)	Not required.
b. (blank)	Enter the 9-digit Arkansas Medicaid provider ID number of the billing provider.
