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TO: **Arkansas Medicaid Health Care Providers - Hospital/Critical Access Hospital (CAH)/End Stage Renal Disease (ESRD)**

DATE: **November 1, 2005**

SUBJECT: **Provider Manual Update Transmittal #68**

REMOVE		**INSERT**	
Section	**Date**	**Section**	**Date**
		218.000 – 218.303	11-1-05

Explanation of Updates

Sections 218.000 through 218.303: These sections have been added to set forth Arkansas Medicaid's guidelines for retrospective review of occupational, physical and speech therapy services.

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.

Thank you for your participation in the Arkansas Medicaid Program.

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Roy Jeffus, Director

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

11-1-05

The Quality Improvement Organization (QIO), Arkansas Foundation for Medical Care, Inc. (AFMC), under contract with the Arkansas Medicaid Program, performs retrospective reviews of medical records to determine the medical necessity of services paid for by Medicaid.

AFMC has developed guidelines for retrospective review of occupational, physical and speech-language therapy services furnished to Medicaid beneficiaries under the age of 21. Those guidelines are included in this manual to assist providers in determining and documenting the medical necessity of occupational, physical and speech-language therapy services.

218.100 Guidelines for Retrospective Review of Occupational and Physical Therapy for Beneficiaries Under the Age of 21

11-1-05

A. Occupational and physical therapy services are services prescribed by a physician for the diagnosis and treatment of movement dysfunction.

B. 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
   a. Will result in a meaningful improvement of a condition or
   b. Will prevent a worsening of the condition.

C. A diagnosis alone is not sufficient documentation to support the medical necessity of therapy.

D. Assessment for physical or occupational therapy includes

1. A comprehensive evaluation of the patient's physical deficits and functional limitations,
2. The treatment(s) planned to address each identified problem and
3. Treatment goals and objectives.

218.101 Documenting Evaluations

11-1-05

Documentation of an annual evaluation must contain the following

A. Date of evaluation

B. Patient's name and date of birth

C. Diagnosis applicable to specific therapy

D. Background information including pertinent medical history (and gestational age when applicable)

E. Standardized test results, including all subtest scores, when applicable

F. Test results adjusted for prematurity, when applicable, when the child is one year old or younger

G. 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 patient's functional mobility skills.

H. Assessment of the results of the evaluation, including recommendations for frequency and intensity of treatment.

I. Signature and credentials of the therapist performing the evaluation.

218.102 Standardized Testing 11-1-05

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

1. Tests must be age appropriate for the child being tested.
2. Test results must be reported as standard scores, Z scores, T scores or percentiles.
3. Age-equivalent scores and percentage of delay do not justify the medical necessity of services.

B. A score of negative 1.50 standard deviations or more from the mean in at least one subtest area or composite score is required to qualify for services.

C. If the child cannot be tested with a norm-referenced, standardized test, criterion-based testing or a functional description of the patient's gross/fine motor deficits may be used. Documentation of the reason(s) that a standardized test could not be used must be included in the evaluation.

D. The *Mental Measurement Yearbook* (*MMY*) is the standard reference to determine reliability/validity. Refer to sections 217.112 through 217.119 for listings of the standardized tests accepted by AFMC.

218.103 Other Objective Tests and Measures 11-1-05

A. **Range of Motion**: A limitation of greater than ten degrees and/or documentation of how the 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 transfer, i.e., maximum, moderate or minimal assistance. A deficit is defined as the inability to perform a transfer safely and independently.

218.104 Progress Notes 11-1-05

Progress notes must be legible and include the following

A. Patient's name

B. Date of service

C. Time in and time out of each therapy session

D. Objectives addressed (should correspond to the plan of care)

E. Descriptions of specific therapy services provided and activities conducted during each therapy session, including progress measurements

F. Therapist's full signature and credentials for each date of service

G. Co-signature of supervising physical therapist or occupational therapist on graduate student's notes

218.105 Frequency, Intensity and Duration of Therapy Services 11-1-05

A. The frequency, intensity and duration of 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 there is a potential for functional improvement as a direct result of these services.

218.106 Duration of Services 11-1-05

A. Therapy services may be provided as long as reasonable progress is made toward established goals.

B. When reasonable functional progress cannot be expected with continued therapy, the provider must discontinue therapy services but may work with the patient's caregiver(s) to help establish an in-home maintenance therapy plan, with monitoring.

218.107 In-Home 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 routinely require the skilled services of a physical or occupational therapist to perform safely and effectively.

B. Such services can be provided to the child as part of a home program administered by the child's caregivers, with occasional monitoring by the therapist.

218.108 Monitoring In-Home Maintenance Therapy 11-1-05

A provider may monitor in-home maintenance therapy to ensure that the child is maintaining a desired skill level or to assess the effectiveness and fit of equipment, such as orthotics and durable medical equipment.

A. Monitoring frequency should be based on an interval that is reasonable for the complexity of the problem(s) being addressed.

B. If a hospital providing therapy services cannot monitor in-home maintenance therapy by seeing the patient in the outpatient hospital, the provider must ask the primary care physician (PCP) to refer the case to an individual or group provider in the Occupational, Physical and Speech Therapy Program or – when applicable to physical therapy – a Home Health provider.

218.110 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 the 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.

218.120 Accepted Tests for Occupational Therapy 11-1-05

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

B. The listing of tests in sections 218.121 through 218.129 is not all-inclusive.

C. When a test not listed is used, the provider must document the reliability and validity of the test.

1. The *MMY* is the standard reference for determining the reliability and validity of tests administered in an evaluation.

2. An explanation why a test from the approved list could not be used to evaluate the patient must also be included.

218.121 Fine Motor Skills – Standard 11-1-05

A. Peabody Developmental Motor Scales (PDMS, PDMS2)

B. Toddler and Infant Motor Evaluation (TIME)

C. Bruininks-Oseretsky Test of Motor Proficiency (BOMP)

218.122 Fine Motor Skills – Supplemental 11-1-05

A. Early Learning Accomplishment Profile (ELAP)

B. Learning Accomplishment Profile (LAP)

C. Mullen Scales of Early Learning, Infant/Preschool (MSEL)

D. Miller Assessment for Preschoolers (MAP)

E. Functional Profile

F. Hawaii Early Learning Profile (HELP)

G. Battelle Developmental Inventory (BDI)

H. Developmental Assessment of Young Children (DAYC)

I. Brigance Developmental Inventory (BDI)

218.123 Visual Motor – Standard 11-1-05

A. Developmental Test of Visual Motor Integration (VMI)

B. Test of Visual Motor Integration (TVMI)

C. Test of Visual Motor Skills

D. Test of Visual Motor Skills – R (TVMS)

218.124 Visual Perception – Standard 11-1-05

A. Motor Free Visual Perceptual Test

B. Motor Free Visual Perceptual Test – R (MVPT)

C. Developmental Test of Visual Perceptual 2/A (DTVP)

D. Test of Visual Perceptual Skills

E. Test of Visual Perceptual Skills (upper level) (TVPS)

218.125 Handwriting 11-1-05

A. Evaluation Test of Children's Handwriting (ETCH)

B. Test of Handwriting Skills (THS)

C. Children's Handwriting Evaluation Scale

218.126 Sensory Processing – Standard 11-1-05

A. Sensory Profile for Infants/Toddlers

B. Sensory Profile for Preschoolers

C. Sensory Profile for Adolescents/Adults

D. Sensory Integration and Praxis Test (SIPT)

E. Sensory Integration Inventory Revised (SII-R)

218.127 Sensory Processing – Supplemental 11-1-05

A. Sensory Motor Performance Analysis

B. Analysis of Sensory Behavior

C. Sensory Integration Inventory

D. DeGangi-Berk Test of Sensory Integration

218.128 Activities of Daily Living/Vocational/Other – Standard 7-1-05

A. Pediatric Evaluation of Disability Inventory (PEDI)

1. The PEDI can also be used for older children whose functional abilities fall below that expected of a 7½ year old with no disabilities.
2. When this is the case, the scaled score is the most appropriate score to consider.

B. Adaptive Behavior Scale – School (ABS)

C. Jacobs Pre-vocational Assessment

D. Kohlman Evaluation of Daily Living Skills

E. Milwaukee Evaluation of Daily Living Skills

F. Cognitive Performance Test

G. Purdue Pegboard

H. Functional Independence Measure (FIM)

I. Functional Independence Measure – young version (WeeFIM)

218.129 Activities of Daily Living/Vocational/Other – Supplemental 11-1-05

A. School Function Assessment (SFA)

B. Bay Area Functional Performance Evaluation

C. Manual Muscle Test

D. Grip and Pinch Strength

E. Jordan Left-Right Reversal Test

F. Erhardy Developmental Prehension

G. Knox Play Scale

H. Social Skills Rating System

I. Goodenough Harris Draw a Person Scale

218.130 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 218.131 through 218.135 are not all-inclusive.

C. When using a test not listed, the provider must document the reliability and validity of the test.

1. The *MMY* is the standard reference for determining the reliability and validity of tests administered in an evaluation.

2. An explanation why a test from the approved list could not be used to evaluate a patient must also be included.

218.131 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 (BOMP)

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)

218.132 Physical Therapy – Supplemental 11-1-05

A. Bayley Scales of Infant Development, Second Ed. (BSID-2)

B. Neonatal Behavioral Assessment Scale (NBAS)

218.133 Physical Therapy Criterion 11-1-05

A. Developmental assessment for students with severe disabilities, Second Ed. (DASH-2)

B. Milani-Comparetti Developmental Examination

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

A. Comprehensive Trail-Making Test

B. Adaptive Behavior Inventory

218.135 Physical Therapy – Piloted 11-1-05

Assessment of Persons Profoundly or Severely Impaired

218.200 Speech-Language Therapy Guidelines for Retrospective Review 11-1-05

218.201 Medical Necessity 11-1-05

A. A diagnosis alone is not sufficient documentation to support the medical necessity of therapy.

B. Assessment for speech-language therapy includes

1. A comprehensive evaluation of the patient's speech-language deficits and functional limitations,
2. Treatment(s) planned to address each identified problem and
3. Treatment goals and objectives.

C. The services must be considered under accepted standards of practice to be a specific and effective treatment for the patient's condition.

D. 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.

E. There must be reasonable expectation that therapy

1. Will result in a meaningful improvement of the condition or
2. Will prevent a worsening of the condition.

218.202 Documenting Evaluations 11-1-05

Documentation of a speech-language evaluation must include the following information

A. Patient's name and date of birth

B. Diagnosis specific to therapy

C. Background information including pertinent medical history and gestational age

D. Standardized test results, including all subtest scores when applicable

E. Adjustment of test results for prematurity, when applicable, when the child is one year old or younger

F. An assessment of the results of the evaluation, including recommendations for frequency and intensity of treatment

G. An explanation why the child was not tested in his or her native language, when such is the case

H. Signature and credentials of the therapist performing the evaluation

218.203 Feeding/Swallowing/Oral Motor 11-1-05

A. May be formally or informally assessed

B. Must have an in-depth functional profile on oral motor structures and function

C. An in-depth functional profile of oral motor structure and function is a description of a patient's oral motor structure that specifically

1. Notes how such structure is impaired in its function and
2. Justifies the medical necessity of feeding/swallowing/oral motor therapy services.

D. 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.

218.204 Voice 11-1-05

A medical evaluation is a prerequisite for voice therapy.

218.205 Progress Notes 11-1-05

Progress notes must be legible and must include the following information.

A. Patient's name

B. Date of service

C. Time in and time out of each therapy session

D. Objectives addressed (must directly correspond to the plan of care)

E. Descriptions of

1. Specific therapy services provided and
2. Activities conducted

F. Measurements of progress with respect to treatment goals and objectives

G. Therapist's full signature and credentials for each date of service

H. The supervising speech and language pathologist's co-signature on graduate students' progress notes

218.210 Accepted Tests 11-1-05

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

B. The listing of tests in sections 218.211 and 218.212 is not all-inclusive.

C. When using a test not listed in section 218.211 or 218.212, the provider must maintain documentation supporting the reliability and validity of the test used.

1. An explanation why a test from the approved list could not be used to evaluate a patient must be included in the documentation.

2. The *MMY* is the standard reference for determining the reliability and validity of test(s) administered in an evaluation.

218.211 Speech-Language Tests – Standardized 11-1-05

A. Preschool Language Scale, Third Ed. (PLS-3)

B. Preschool Language Scale, Fourth Ed. (PLS-4)

C. Test of Early Language Development, Third Ed. (TELD-3)

D. Peabody Picture Vocabulary Test, Third Ed. (PPVT-3)

E. Clinical Evaluation of Language Fundamentals – Preschool (CELF-P)

F. Clinical Evaluation of Language Fundamentals, Third Ed. (CELF-3)

G. Clinical Evaluation of Language Fundamentals, Fourth Ed. (CELF-4)

H. Communication Abilities Diagnostic Test (CADeT)

I. Test of Auditory Comprehension of Language, Third Ed. (TACL-3)

J. Comprehensive Assessment of Spoken Language (CASL)

K. Oral and Written Language Scales (OWLS)

L. Test of Language Development – Primary, Third Ed. (TOLD-P:3)

M. Test of Word Finding, Second Ed. (TWF-2)

N. Test of Auditory Perceptual Skills, Revised (TAPS-R)

O. Language Processing Test, Revised (LPT-R)

P. Test of Pragmatic Language (TOPL)

Q. Test of Language Competence, Expanded Ed. (TLC-E)

R. Test of Language Development – Intermediate, Third Ed. (TOLD-I:3)

S. Fullerton Language Test for Adolescents, Second Ed. (FLTA)

T. Test of Adolescent and Adult Language, Third Ed. (TOAL-3)

U. Receptive One-Word Picture Vocabulary Test, Second Ed. (ROWPVT-2)

V. Expressive One-Word Picture Vocabulary Test, 2000 Ed. (EOWPVT)

W. Comprehensive Receptive and Expressive Vocabulary Test, Second Ed. (CREVT-2)

X. Kaufman Assessment Battery for Children (KABC)

218.212 Speech-Language Tests – Supplemental 11-1-05

A. Receptive/Expressive Emergent Language Test, Second Ed. (REEL-2)

B. Nonspeech Test for Receptive/Expressive Language

C. Rossetti Infant-Toddler Language Scale (RITLS)

D. Mullen Scales of Early Learning (MSEL)

E. Reynell Developmental Language Scales

F. Illinois Test of Psycholinguistic Abilities, Third Ed. (ITPA-3)

G. Social Skills Rating System – Preschool & Elementary Level (SSRS-1)

H. Social Skills Rating System – Secondary Level (SSRS-2)

218.213 Birth to Three 11-1-05

A. Annual evaluation is required for children aged birth through 2 years who are receiving speech-language therapy.

B. To qualify for language therapy, a child must score negative 1.5 standard deviations (SD; standard score of 77) from the mean in two areas (expressive, receptive) or negative 2.0 SD (standard score of 70) from the mean in one area.

C. Two language tests must be reported.

1. At least one test must be a global, norm-referenced, standardized test with good reliability and validity.
2. The second test may be criterion referenced.

D. All subtests, components, and scores must be reported for all tests.

E. All sound errors must be reported for articulation, including positions and types of errors.

F. If phonological testing is used, a traditional articulation test must also be included with a standardized score.

G. Information regarding the patient's functional hearing ability must be included in the therapy evaluation report.

H. If the patient cannot complete a norm-referenced test, the provider must complete an in-depth functional profile of the patient's functional communication abilities.

1. An in-depth functional profile is a description of a patient's communication behaviors that
   a. Specifically notes where such communication behaviors are impaired and
   b. Justifies the medical necessity of therapy.
2. Standardized forms are available for the completion of an in-depth functional profile, but a standardized form is not required.

218.214 Ages 3 through 20 11-1-05

A. Negative 1.5 standard deviations (SD; standard score of 77) from the mean in two areas (expressive, receptive, articulation) or negative 2.0 SD (standard score of 70) from the mean in one area (expressive, receptive, articulation) is required to qualify for language therapy.

B. Two language tests must be reported.

1. At least one test must be a global, norm-referenced, standardized test with good reliability and validity.

2. Criterion-referenced tests are not accepted for this age group.

C. All subtests, components and scores must be reported for all tests.

D. All sound errors must be reported for articulation, including positions and types of errors.

E. If phonological testing is used, a traditional articulation test must also be completed with a standardized score.

F. Information regarding patient's functional hearing ability must be included in the therapy evaluation report.

G. Children who are not of school age or who do not attend public school must be evaluated annually.

H. School-aged children who attend public school and whose therapy is provided by the school must have a full evaluation every three years, with an annual update.

I. If the patient cannot complete a norm-referenced test, the provider must complete an in-depth functional profile of the patient's functional communication abilities.

1. An in-depth functional profile is a description of a patient's communication behaviors that specifically notes where such communication behaviors are impaired and justifies the medical necessity of therapy.

2. Standardized forms are available for the completion of an in-depth functional profile, but a standardized form is not required.

218.220 Intelligence Quotient (IQ) 11-1-05

A. Children receiving language intervention therapy must have cognitive testing once they reach ten (10) years of age, whether they are in public school or they are home-schooled.

B. Providers must maintain in their records the IQ scores of their patients who are 20 through 20 years of age and receiving language therapy.

C. Language therapy may be determined not medically necessary if a child's IQ is less than or equal to his or her language score, because the child is deemed to be functioning at or above the expected level.

1. If a provider determines that therapy is warranted despite the relationship of IQ to language score, the provider must complete an in-depth functional profile.

2. If the child's IQ is higher than his or her language scores, then the child qualifies for language therapy

D. Accepted IQ tests are listed in sections 218.221 through 218.228.

218.221 IQ Tests – Traditional 11-1-05

A. Stanford-Binet

B. The Wechsler Preschool & Primary Scales of Intelligence, Revised (WPPSI-R)

C. Slosson

D. Wechsler Intelligence Scale for Children, Third Ed. (WISC-III)

E. Kauffman Adolescent & Adult Intelligence Test (KAIT)

F. Wechsler Adult Intelligence Scale, Third Ed. (WAIS-III)

G. Differential Ability Scales (DAS)

218.222 Severe and Profound IQ Test/Non-Traditional – Supplemental 11-1-05

A. Comprehensive Test of Nonverbal Intelligence (CTONI)

B. Test of Nonverbal Intelligence (TONI-3) – 1997

C. Functional Linguistic Communication Inventory (FLCI)

218.223 Articulation/Phonological Assessments 11-1-05

A. Arizona Articulation Proficiency Scale, Third Ed. (Arizona-3)

B. Goldman-Fristoe Test of Articulation, Second Ed. (FGTA-2)

C. Khan-Lewis Phonological Analysis (KLPA)

D. Slosson Articulation Language Test with Phonology (SALT-P)

E. Bankston-Bernthal Test of Phonology (BBTOP)

F. Smit-Hand Articulation and Phonology Evaluation (SHAPE)

G. Comprehensive Test of Phonological Processing (CTOPP)

H. Assessment of Intelligibility of Dysarthric Speech (AIDS)

I. Weiss Comprehensive Articulation Test (WCAT)

J. Assessment of Phonological Processes – R (APPS-R)

K. Photo Articulation Test, Third Ed. (PAT-3)

218.224 Articulation/Phonological Assessments – Supplemental 11-1-05

Test of Phonological Awareness (TOPA)

218.225 Voice/Fluency Assessments 11-1-05

A. Stuttering Severity Instrument for Children and Adults (SSI-3)

B. Language Sample – A language sample with an in-depth profile of the percentage of stuttering and type of stuttering that occurs during conversational speech

218.226 Auditory Processing Assessments 11-1-05

Goldman-Fristoe-Woodcock Test of Auditory Discrimination (G-F-WTAD)

218.227 Oral Motor – Supplemental 11-1-05

Screening Test for Developmental Apraxia of Speech, Second Ed. (STDAS-2)

218.228 Traumatic Brain Injury (TBI) Assessments 11-1-05

A. Ross Information Processing Assessment – Primary

B. Test of Adolescent/Adult Word Finding (TAWF)

C. Brief Test of Head Injury (BTHI)

D. Assessment of Language-Related Functional Activities (ALFA)

E. Ross Information Processing Assessment, Second Ed. (RIPA)

F. Scales of Cognitive Ability for Traumatic Brain Injury (SCATBI)

G. Communication Activities of Daily Living, Second Ed. (CADL-2)

218.300 Retrospective Review of Paid Therapy Services 11-1-05

A. Retrospective review of a paid service is a two-fold process.

1. First, a reviewer must find
   a. Whether a service was medically necessary and
   b. Whether the scope, frequency and duration of the service were medically necessary.
2. Second, the reviewer must determine
   a. Whether the beneficiary received the services for which Medicaid paid and
   b. Whether the case record correctly documents the services reimbursed by Medicaid.

B. The record must contain primary care physician (PCP) referral documentation and a valid prescription (form DMS-640) covering the dates of service.

1. The referral and the prescription must be written, signed and dated by the PCP or attending physician.
2. The record must contain verification that referrals and prescriptions have been issued and maintained in accordance with the regulations in section 214.000 of this manual.

C. Each calendar quarter, AFMC selects and reviews a random sample of all the therapy services paid during the previous quarter.

1. Each provider under review receives a written request for copies of patient records and instructions for mailing them to AFMC.
2. Requested materials must be received by AFMC no later than the 30th day following the postmark date of the envelope containing the request for records.

D. AFMC's tracking system automatically generates notifications to providers that their records have been received.

218.301 Medical Necessity Review 11-1-05

A. Initial screening determines whether case records contain sufficient documentation to complete a medical necessity review.

B. Documentation passing the initial screening is reviewed in detail by a registered nurse to determine medical necessity.

C. When the nurse reviewer determines that therapy services were medically necessary, he or she proceeds to the utilization portion of the review.

D. When a nurse reviewer cannot determine that the therapy services were medically necessary, he or she must refer the record to a therapist whose professional discipline is the same as the therapy services under review (i.e., a physical therapist reviews physical therapy claims, an occupational therapist reviews occupational therapy claims, etc.).

1. The therapist may, on his or her own authority, approve the services in question; however, if the therapist cannot approve them, he or she must refer the case to the Associate Medical Director (AMD).

2. The therapist may recommend that the AMD deny all or some of the paid services under review.

E. The AMD has the final authority to approve or deny.

F. If the AMD's decision is to partially or completely deny the services, AFMC forwards written notification to the provider, the beneficiary and the referring physician.

1. Denial notifications are case-specific and state the AMD's rationale for the decision.

2. The provider and the beneficiary are given written instructions for requesting a reconsideration review or a fair hearing.

218.302 Utilization Review 11-1-05

A. When medical necessity is established, the nurse reviewer proceeds to the utilization portion of the retrospective review.

1. He or she compares the paid claims data to the medical records obtained from the provider, in order to verify that

a. The proper coding was used wherever required,

b. Beginning and ending times correspond to billed units and are documented,

c. Written descriptions correctly identify each service that was paid for by Medicaid and

d. The performing therapist signed off on each therapy session and dated his or her signature each time.

2. When the documentation submitted supports the paid services, the nurse reviewer approves the services as billed and paid.

B. When the provider's documentation does not appear to support the paid services, the nurse reviewer must refer the records to a therapist whose professional discipline is that of the services under review.

1. The therapist may approve the services as billed or recommend that the AMD deny some or all of the services.

2. If the AMD's decision is to partially or completely deny the services, AFMC forwards written notification to the provider, the beneficiary and the referring physician.

a. Denial letters are case specific and state the AMD's rationale for the decision.

b. Notification includes instructions for requesting reconsideration.

218.303 Reconsideration Review 11-1-05

A. When AFMC denies all or part of a previously paid claim on retrospective review, the therapy provider may request reconsideration of that decision by submitting additional information.

B. Additional information submitted for reconsideration must reach AFMC by the 30th day following the postmark date on the envelope bearing the denial notification.

1. A therapist whose professional discipline is that of the denied service reviews the additional information.

2. The therapist reviewing a case being reconsidered will not be the same therapist who reviewed the case initially.

C. If the additional documentation enables the therapist to approve the services, he or she will reverse the previous denial.

D. If the case documentation still appears insufficient to allow the therapist to approve the services, he or she must refer the case to a physician advisor for final determination.

1. The physician advisor will not be an AMD who denied the services during the first review.

2. The therapist provides a written recommendation to the physician advisor.

E. The physician advisor reconsidering the case may uphold or reverse all or part of the previous decision.

1. A written notification of the outcome of each reconsideration review is mailed to all parties.

2. Notification includes the physician advisor's case-specific rationale for upholding or overturning AFMC's initial determination.