Arkansas Department of Human Services

Division of Medical Services

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

DATE: **November 1, 2005**

SUBJECT: **Provider Manual Update Transmittal #61**

REMOVE		**INSERT**	
Section	**Date**	**Section**	**Date**
220.000 – 220.200	10-13-03	220.000 – 221.000	11-1-05

Explanation of Updates

Sections 220.000 and 220.100 have been revised to make minor wording changes and to add references to new sections of the manual.

Sections 220.110 and 220.120 are new sections added to the manual for informational purposes. This information includes a listing of tests recognized as acceptable tools for use in determining the need for occupational and physical therapy services.

Section 220.200 has been revised with minor wording changes and reorganization of text for clarity.

Sections 220.210 and 220.220 are new sections added to the manual for informational purposes. The information includes a listing of tests recognized as acceptable tools for use in determining the need for speech therapy services.

Section 221.000 is new section added to explain the recoupment process if a claim is denied based on findings during retrospective reviews.

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.

Roy Jeffus, Director

SECTION II - DEVELOPMENTAL DAY TREATMENT CLINIC SERVICES (DDTCS)

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220.000 Guidelines for Retrospective Review of Occupational, Physical and Speech Therapy Services 11-1-05

Arkansas Medicaid conducts retrospective review of occupational, physical and speech therapy services. The purpose of retrospective review is to promote effective, efficient and economical delivery of health care services.

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

Specific guidelines have been developed for occupational, physical and speech therapy retrospective reviews. These guidelines may be found in sections 220.100 through 220.220.

220.100 Occupational and Physical Therapy Guidelines for Retrospective Review 11-1-05

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 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 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:

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.

C. Standardized Testing:

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

2. Tests 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 -1.5 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 why 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 and validity.

   Refer to sections 220.110 and 220.120 for a list of standardized tests accepted by AFMC for retrospective reviews of occupational and physical therapy services.

D. Other Objective Tests and Measures:

1. Range of Motion: A limitation of greater than ten degrees and/or documentation of how 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 amount of assistance required to perform transfer, e.g., 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:

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 ensure 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 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 safe and effective.

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.

220.110 Accepted Tests for Occupational Therapy 11-1-05

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 here, the provider must include additional documentation to support the reliability and validity of the test. This additional information will be used as reference information if the chart is ever 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 *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.

Definitions:

STANDARD: Evaluations that are used to determine deficits.

SUPPLEMENTAL: Evaluations that are used to justify deficits and support other results. These should not "stand alone."

CLINICAL OBSERVATIONS: All clinical observations are supplemental but should be included with every evaluation, especially if standard scores do not qualify the child for therapy. They will be considered during reviews for medical necessity.

A. Fine Motor Skills – Standard

1. Peabody Developmental Motor Scales (PDMS, PDMS2)
2. Toddler and Infant Motor Evaluation (TIME)
3. Bruininks-Oseretsky Test of Motor Proficiency (BOMP)

B. Fine Motor Skills – Supplemental

1. Early Learning Accomplishment Profile (ELAP)
2. Learning Accomplishment Profile (LAP)
3. Mullen Scales of Early Learning, Infant/Preschool (MSEL)
4. Miller Assessment for Preschoolers (MAP)
5. Functional Profile
6. Hawaii Early Learning Profile (HELP)
7. Battelle Developmental Inventory (BDI)

8. Developmental Assessment of Young Children (DAYC)
9. Brigance Developmental Inventory (BDI)

C. Visual Motor – Standard

10. Developmental Test of Visual Motor Integration (VMI)
11. Test of Visual Motor Integration (TVMI)
12. Test of Visual Motor Skills
13. Test of Visual Motor Skills – R (TVMS)

D. Visual Perception – Standard

1. Motor Free Visual Perceptual Test
2. Motor Free Visual Perceptual Test – R (MVPT)
3. Developmental Test of Visual Perceptual 2/A (DTVP)
4. Test of Visual Perceptual Skills
5. Test of Visual Perceptual Skills (upper level) (TVPS)

E. Handwriting – Standard

1. Evaluation Test of Children's Handwriting (ETCH)
2. Test of Handwriting Skills (THS)
3. Children's Handwriting Evaluation Scale

F. Sensory Processing – Standard

1. Sensory Profile for Infants/Toddlers
2. Sensory Profile for Preschoolers
3. Sensory Profile for Adolescents/Adults
4. Sensory Integration and Praxis Test (SIPT)
5. Sensory Integration Inventory Revised (SII-R)

G. Sensory Processing – Supplemental

1. Sensory Motor Performance Analysis
2. Analysis of Sensory Behavior
3. Sensory Integration Inventory
4. DeGangi-Berk Test of Sensory Integration

H. Activities of Daily Living/Vocational/Other – Standard

1. 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 7½ year old with no disabilities. In this case, the scaled score is the most appropriate score to consider.

2. Adaptive Behavior Scale – School (ABS)
3. Jacobs Pre-vocational Assessment
4. Kohlman Evaluation of Daily Living Skills
5. Milwaukee Evaluation of Daily Living Skills
6. Cognitive Performance Test

7. Purdue Pegboard
8. Functional Independence Measure (FIM)
9. Functional Independence Measure – young version (WeeFIM)

I. Activities of Daily Living/Vocational/Other – Supplemental

1. School Function Assessment (SFA)
2. Bay Area Functional Performance Evaluation
3. Manual Muscle Test
4. Grip and Pinch Strength
5. Jordan Left-Right Reversal Test
6. Erhardy Developmental Prehension
7. Knox Play Scale
8. Social Skills Rating System
9. Goodenough Harris Draw a Person Scale

220.120 Accepted Tests for Physical Therapy 11-1-05

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 here, the provider must include additional documentation to support the reliability and validity of the test. This additional information will be used as reference information if the chart is ever 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 *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.

A. Norm Reference

1. Adaptive Areas Assessment
2. Test of Gross Motor Development (TGMD-2)
3. Peabody Developmental Motor Scales, Second Ed. (PDMS-2)
4. Bruininks-Oseretsky Test of Motor Proficiency (BOMP)
5. Pediatric Evaluation of Disability Inventory (PEDI)
6. Test of Gross Motor Development – 2 (TGMD-2)
7. Peabody Developmental Motor Scales (PDMS)
8. Alberta Infant Motor Scales (AIM)
9. Toddler and Infant Motor Evaluation (TIME)
10. Functional Independence Measure for Children (WeeFIM)
11. Gross Motor Function Measure (GMFM)
12. Adaptive Behavior Scale – School, Second Ed. (AAMR-2)
13. Movement Assessment Battery for Children (Movement ABC)

B. Physical Therapy – Supplemental

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

C. Physical Therapy Criterion

1. Developmental assessment for students with severe disabilities, Second Ed. (DASH-2)
2. Milani-Comparetti Developmental Examination

D. Physical Therapy – Traumatic Brain Injury (TBI) – Standardized

1. Comprehensive Trail-Making Test
2. Adaptive Behavior Inventory

E. Physical Therapy – Piloted

Assessment of Persons Profoundly or Severely Impaired

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

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 gestational age.
5. Standardized test results, including all subtest scores, if applicable. Test results should be adjusted for prematurity if the child is one year old 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. 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.

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 List of Accepted Tests 11-1-05

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 here, the provider must include additional documentation to support the reliability and validity of the test. This additional information will be used as reference information if the chart is ever 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 *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.

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)

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)

C. Birth to Age 3:

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

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.

D. Ages 3 to 21:

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

220.220 Intelligence Quotient (IQ) Testing 11-1-05

Children receiving language intervention therapy must have cognitive testing once they reach ten (10) years of age. This also applies to home-schooled children. If the IQ score is higher than the qualifying language scores, the child qualifies for language therapy; if the IQ score is lower than the qualifying language test scores, the child would appear to be functioning at or above the expected level. In this case, the child may be denied for language therapy. If a provider determines that therapy is warranted, an in-depth functional profile must be submitted. **However, IQ scores are not required for children under ten (10) years of age.**

A. IQ Tests – Traditional

1. Stanford-Binet (S-B)
2. The Wechsler Preschool & Primary Scales of Intelligence, Revised (WPPSI-R)
3. Slosson
4. Wechsler Intelligence Scale for Children, Third Ed. (WISC-III)
5. Kauffman Adolescent & Adult Intelligence Test (KAIT)
6. Wechsler Adult Intelligence Scale, Third Ed. (WAIS-III)

7. Differential Ability Scales (DAS)

B. Severe & Profound IQ Test/Non-Traditional – Supplemental – Norm Reference

1. Comprehensive Test of Nonverbal Intelligence (CTONI)
2. Test of Nonverbal Intelligence (TONI-3) – 1997
3. Functional Linguistic Communication Inventory (FLCI)

C. Articulation/Phonological Assessments – Norm Reference

1. Arizona Articulation Proficiency Scale, Third Ed. (Arizona-3)
2. Goldman-Fristoe Test of Articulation (GFTA)
3. Goldman-Fristoe Test of Articulation, Second Ed. (GFTA-2)
4. Khan-Lewis Phonological Analysis (KLPA)
5. Slosson Articulation Language Test with Phonology (SALT-P)
6. Bankston-Bernthal Test of Phonology (BBTOP)
7. Smit-Hand Articulation and Phonology Evaluation (SHAPE)
8. Comprehensive Test of Phonological Processing (CTOPP)
9. Assessment of Intelligibility of Dysarthric Speech (AIDS)
10. Weiss Comprehensive Articulation Test (WCAT)
11. Assessment of Phonological Processes – R (APPS-R)
12. Photo Articulation Test, Third Ed. (PAT-3)

D. Articulation/Phonological Assessments – Supplemental – Norm Reference

Test of Phonological Awareness (TOPA)

E. Voice/Fluency Assessments – Norm Reference

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

F. Auditory Processing Assessments – Norm Reference

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

G. Oral Motor – Supplemental – Norm Reference

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

H. Traumatic Brain Injury (TBI) Assessments – Norm Reference

1. Ross Information Processing Assessment – Primary
2. Test of Adolescent/Adult Word Finding (TAWF)
3. Brief Test of Head Injury (BTHI)
4. Assessment of Language-Related Functional Activities (ALFA)
5. Ross Information Processing Assessment, Second Ed. (RIPA-2)
6. Scales of Cognitive Ability for Traumatic Brain Injury (SCATBI)
7. Communication Activities of Daily Living, Second Ed. (CADL-2)

221.000 Recoupment Process 11-1-05

The Division of Medical Services (DMS), Utilization Review Section (UR) is required to initiate the recoupment process for all claims that Arkansas Foundation for Medical Care (AFMC), Arkansas' Quality Improvement Organization (QIO) has denied for not meeting the medical necessity requirement. Based on QIO findings during retrospective reviews, UR will initiate recoupments as appropriate.

Medicaid will send the provider an Explanation of Recoupment Notice that will include the claim date of service, Medicaid beneficiary name and ID number, service provided, amount paid by Medicaid, amount to be recouped, and the reason the claim has been denied.