



Division of Medical Services

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MEMORANDUM

TO: Interested Persons and Providers

FROM: Elizabeth Pitman, Director, Division of Medical Services

DATE: March 12, 2026

SUBJ: Arkansas Medicaid Reimbursement for Physical and Occupational Therapy in Clinic-Based Settings

As a part of the Arkansas Administrative Procedure Act process, attached for your review and comment are proposed rule revisions.

Public comments must be submitted in writing at the above address or at the following email address: ORP@dhs.arkansas.gov Please note that public comments submitted in response to this notice are considered public documents. A public comment, including the commenter's name and any personal information contained within the public comment, will be made publicly available and may be seen by various people.

If you have any comments, please submit those comments no later than April 12, 2026.

All DHS proposed rules, public notices, and recently finalized rules may also be viewed at: [Proposed Rules & Public Notices](#).

NOTICE OF RULE MAKING

The Department of Human Services (DHS) announces for a public comment period of thirty (30) calendar days a notice of rulemaking for the following proposed rule under one or more of the following chapters, subchapters, or sections of the Arkansas Code: §§20-76-201, 20-77-107, and 25-10-129. The projected effective date of the rule is July 1, 2026, if approved. There is no fiscal impact.

The Division of Medical Services (DMS) issues a rule to implement Act 103 of 2025. This rule allows adult Medicaid Beneficiaries, twenty-one (21) years of age and older, to receive rehabilitative occupational and physical therapy in clinic settings. Effective for dates of service on or after July 1, 2026, adult rehabilitative occupational and physical therapy services are limited to twelve (12) visits. There is a maximum of two (2) units of therapy evaluations per discipline per State Fiscal Year (July 1 through June 30). Extensions of the benefit limit will be provided if medically necessary. Implementation requires a revision to the Arkansas Medicaid State Plan and issuance of a new provider manual, Rehabilitative Occupational Therapy and Physical Therapy Services, which explains coverage and reimbursement rules. Corresponding revisions are issued for the Nurse Practitioner and Physician provider manuals.

The proposed rule is available for review at the Department of Human Services (DHS) Office of Policy and Rules, 2nd floor Donaghey Plaza South Building, 7th and Main Streets, P. O. Box 1437, Slot S295, Little Rock, Arkansas 72203-1437. You may also access and download the proposed rule at [ar.gov/dhs-proposed-rules](https://www.ark.gov/dhs-proposed-rules).

Public comments can be submitted in writing at the above address or at the following email address: ORP@dhs.arkansas.gov. All public comments must be received by DHS no later than April 12, 2026. Please note that public comments submitted in response to this notice are considered public documents. A public comment, including the commenter's name and any personal information contained within the public comment, will be made publicly available and may be seen by various people.

A public hearing will be held online by remote access. Public comments may be submitted at the hearing. The details for attending the online public hearing appear at [ar.gov/dhspublichearings](https://www.ark.gov/dhspublichearings).

If you need this material in a different format, such as large print, contact the Office of Policy and Rules at 501-320-6428. The Arkansas Department of Human Services is in compliance with Titles VI and VII of the Civil Rights Act and is operated, managed and delivers services without regard to religion, disability, political affiliation, veteran status, age, race, color or national origin. 4502292178

Elizabeth Pitman, Director
Division of Medical Services

TOC not required

- 214.800 Occupational, Physical, and Speech-Language Therapy** 4-4-247-1-26
- A. Medicaid covers occupational, physical, and speech-language therapy services for eligible beneficiaries under age twenty-one (21) in the Child Health Services (EPSDT) Program by qualified occupational, physical, or speech-language therapy providers. -Therapy services are not covered as nurse practitioner services. -The following is provided for the nurse practitioner's information.
- B. Occupational, Physical, and Speech-Language therapies are covered for beneficiaries in the ARKids First A and ARKids--B program ~~benefits~~.
- C. Therapy services for individuals age twenty-one (21) and older are only covered when provided ~~through the following Medicaid Programs: Adult Developmental Day Treatment (ADDT), Hospital/Critical Access Hospital (CAH), Rehabilitative Hospital, Home Health, Hospice and Physician. Refer to these Medicaid provider manuals for conditions of coverage and benefit limits as follows:~~
1. Habilitative therapy services provided in an Adult Developmental Day Treatment (ADDT) center; or
 2. Rehabilitative Therapy services when provided in accordance with the **Rehabilitative Occupational Therapy and Physical Therapy Services Manual**.
- D. All habilitative therapy services for beneficiaries under age twenty-one (21) require a referral for evaluation utilizing the form DMS-640 and a separate form DMS-640 for the written prescription from the patient's primary care physician-provider (PCP) or attending physician-provider if the beneficiary is exempt from PCP Managed Care Program requirements. -A referral for habilitative therapy services must be renewed every twelve (12) months. -After the initial referral using the form DMS-640 and initial prescription, utilizing a separate form DMS-640, subsequent referrals and prescriptions for continued therapy may be made at the same time using the same DMS-640. -The prescription for treatment is valid for one year unless the prescribing physician specifies a shorter period.
- E. The PCP or attending physician-provider must complete and sign the DMS-640 for beneficiaries under age twenty-one (21) receiving habilitative therapy.
- F. The PCP or attending physician must initiate a referral and prescription for rehabilitative therapy for beneficiaries over age twenty-one (21) using the DMS-640A. -An original signature is required when making a referral or prescribing a therapy service. -An electronic signature is acceptable on either document, provided it is in compliance with Arkansas Code Ann. 25-31-103. -A copy of the prescription-DMS-640A must be maintained in the beneficiary's records maintained by the therapy provider. -The original prescription-DMS-640A is to be maintained by the physician prescribing PCP or attending provider. **View or print form DMS-640 (for beneficiaries under age twenty-one (21)).**
- FG.** -For range of benefits, see the following procedure codes: **View or print the procedure codes for therapy services**.
- H.** Extended habilitative therapy services may be provided based on medical necessity, for Medicaid beneficiaries under age twenty-one (21).
- I.** Rehabilitative Occupational, Therapy and pPhysical, and speech-language therapies Therapy Services are subject to the benefit limit of twelve (12) outpatient hospital visits per state fiscal year (SFY) and two (2) evaluation units per SFY for beneficiaries age twenty-one (21) years of age and over. -Benefit Eextensions may be provided for rehabilitative therapy services, based on medical necessity, ~~for Medicaid beneficiaries 21 years of age~~

and over when provided within a covered program. Extension of the benefit is automatic for patients whose primary diagnosis for the service is one of the following: malignant neoplasm, HIV/AIDS, renal failure, Opioid Use Disorder when the treatment is part of a Medication Assisted Treatment Plan, or pregnancy.

MARKY-UP

TOC not required**203.210 Physician's Role in the Occupational, Physical, and Speech-Language Therapy Program**

7-1-269

Medicaid covers occupational therapy, physical therapy, and speech-language therapy services when provided to eligible Medicaid beneficiaries under age twenty-one (21) in the Child Health Services (EPSDT) Program by qualified occupational, physical, or speech-language therapy providers. Occupational evaluations and occupational therapy services are payable only to a qualified occupational therapist. Speech-language therapy evaluations may be performed by the physician; however, treatment for speech-language therapy disorders must be referred to a qualified speech-language therapist. Physical therapy evaluations may be performed by the physician and physical therapy sessions may be performed by the qualified physician. Physical therapy treatment may also be referred to a qualified physical therapist.

Occupational therapy, physical therapy, and speech-language therapy pathology services ONLY are covered for beneficiaries in the ARKids First-B Program benefits.

All occupational, physical, and speech-language therapy evaluations and treatment services must be medically necessary and require a referral from the beneficiary's primary care physician provider (PCP) or the attending physician provider if the beneficiary is exempt from PCP Managed Care Program requirements. Therapy treatment services also require a prescription written by the physician-PCP or attending provider who refers the patient to the therapist for specified services. For beneficiaries under age twenty-one (21), form DMS-640 must be used for the initial referral for evaluation and a separate DMS-640 is required for the prescription. View or print form DMS-640. For beneficiaries receiving rehabilitative therapy services, form DMS-640A must be used. An electronic signature is accepted provided it is in compliance with Arkansas Code Ann. § 25-31-103. The physician must maintain the original Therapy and Day Habilitation Services for Medicaid Eligible Beneficiaries Prescription/Referral form DMS-640-DMS-640 or DMS-640A form for each prescription in the beneficiary's medical records. The therapy provider must retain a copy of the DMS-640 or DMS-640A in their established beneficiary medical chart/record. After the initial referral using the form DMS-640 or DMS-640A and initial prescription utilizing a separate form DMS-640 or DMS-640A, subsequent referrals and prescriptions for continued therapy may be made at the same time using the same DMS-640 or DMS-640A.

Therapy services for individuals over age twenty-one (21) age twenty-one (21) and over are only covered when provided through the following Medicaid Programs: Adult Developmental Day Treatment (ADDT) services, Hospital/Critical Access Hospital (CAH), Rehabilitative Hospital, Home Health, Hospice, and Physician. Refer to these Medicaid provider manuals for conditions of coverage and benefit limits, as follows:

- A. Habilitative therapy provided in an Adult Developmental Day Treatment (ADDT) center;
- B. Rehabilitative therapy when provided in accordance with the **Rehabilitative Occupational Therapy, Physical Therapy and Speech-Language Pathology Manual**.

SECTION II – REHABILITATIVE OCCUPATIONAL THERAPY AND PHYSICAL THERAPY SERVICES

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200.000 REHABILITATIVE OCCUPATIONAL THERAPY AND PHYSICAL THERAPY SERVICES GENERAL INFORMATION

Providers of Rehabilitative Occupational Therapy and Physical Therapy services for beneficiaries twenty-one (21) years of age or older must meet the provider participation and enrollment requirements contained within Section 140.000 of this manual. Providers must also meet the participation requirements of the applicable service discipline in Section 201.100 of this manual. Reimbursement is conditional upon compliance with this manual, manual update transmittals, and official program correspondence.

- A. Beneficiaries younger than twenty-one (21) years of age who require rehabilitative therapy services are covered under the **Occupational Therapy, Physical Therapy and Speech-Language Pathology program manual.**
- B. Beneficiaries twenty-one (21) years of age or older who require rehabilitative physical therapy in the home setting are covered under the **Home Health program manual.**
- C. Beneficiaries twenty-one (21) years of age or older who require rehabilitative physical or occupational therapy while under Hospice care are also covered under the **Home Health program manual.**

200.200 Individual Service Provider Participation Requirements

7-1-26

Individual providers of rehabilitative occupational therapy and physical therapy services must meet the following requirements to be eligible to participate in the Medicaid Program:

- A. Complete the provider participation and enrollment requirements contained within Section 140.000 of this manual to enroll as a Medicaid provider; and
- B. Meet the credentialing, experience, training, and other qualification requirements of their applicable service discipline contained within Section 202.000 of this manual.
- C. Occupational Therapists enrolling as individuals or group providers are categorized as limited risk providers. For providers in the “limited” risk category, DHS must:
 - 1. Verify that the provider meets any applicable federal regulations or state requirements for their provider type prior to making an enrollment determination.
 - 2. Conduct license verifications, including state licensure verifications in states other than where the provider is enrolling, in accordance with 42 CFR 455.412; and
 - 3. Conduct database checks on a pre- and post-enrollment basis to ensure that providers initially meet and continue to meet the enrollment criteria for their provider type, in accordance with 42 CFR 455.436.
- D. Physical Therapists enrolling as individual or group providers are categorized as moderate risk providers. For providers in the “moderate” risk category, DHS must:
 - 1. Perform the “limited” screening requirements described in Paragraph C above; and
 - 2. Conduct on-site visits in accordance with 42 CFR 455.432.

200.300 Group Service Provider Participation Requirements

7-1-26

- A. Group providers of rehabilitative occupational therapy and physical therapy services must meet the following requirements to be eligible to participate in the Arkansas Medicaid Program:
 - 1. Complete the provider participation and enrollment requirements contained within Section 140.000 of this manual to enroll as a Medicaid provider; and
 - 2. Each individual therapist and therapy assistant who provides services on behalf of the group must complete the individual provider participation and enrollment requirements for their applicable service discipline contained within Sections 201.100 and 202.000 of this manual.

- B. Group providers must identify the individual licensed practitioner enrolled with Medicaid who performed the service as the rendering provider on their billing claim for each covered service.

200.400 Service Providers in Arkansas and Bordering States **7-1-26**

Providers of rehabilitative occupational therapy and physical therapy services in Arkansas and the six (6) bordering states (Louisiana, Mississippi, Missouri, Oklahoma, Tennessee, and Texas) may enroll as Arkansas Medicaid service providers if they meet the enrollment requirements specified in Sections 201.100, 201.200 and 202.000, as well as the provider enrollment requirements in Section 140.000 of this Manual, as applicable.

200.500 Service Providers in States Not Bordering Arkansas **7-1-26**

Providers of rehabilitative occupational therapy and physical therapy services in states not bordering Arkansas may enter into a single case agreement and enroll as a limited Arkansas Medicaid service provider to a single Arkansas Medicaid-eligible beneficiary. A separate single case agreement must be entered into for each Arkansas Medicaid-eligible beneficiary before the out of state provider may bill for services provided to that beneficiary. A provider will retain their limited-service provider status for one (1) year after the most recent claim's last date of service. **View or print the provider enrollment and contract package (Application Packet).**

200.600 Rehabilitative Occupational Therapy and Physical Therapy Service Provider Participation Requirements **7-1-26**

200.700 Occupational Therapy Provider Participation Requirements **7-1-26**

200.800 Occupational Therapist Participation Requirements **7-1-26**

Individuals must meet one (1) of the following requirements to enroll in Medicaid as an occupational therapist:

- A. Be licensed by the Arkansas State Medical Board to practice occupational therapy in the State of Arkansas;
- B. Hold compact privileges from the Arkansas State Medical Board to practice occupational therapy in the State of Arkansas; or
- C. If enrolling to perform occupational therapy services for an Arkansas Medicaid beneficiary outside the State of Arkansas, hold either:
 - 1. A current license to practice as an occupational therapist in the state where services are being performed; or
 - 2. Compact privileges to practice occupational therapy from the licensing board in the state where services are being performed.

200.900 Occupational Therapy Assistant Participation Requirements **7-1-26**

Individuals must meet one (1) of the following requirements to enroll in Medicaid as an occupational therapy assistant:

- A. Be licensed by the Arkansas State Medical Board to practice occupational therapy as an occupational therapy assistant in the State of Arkansas;

- B. Hold compact privileges from the Arkansas State Medical Board to practice occupational therapy as an occupational therapy assistant in the State of Arkansas; or
- C. If enrolling to perform occupational therapy assistant services for an Arkansas Medicaid beneficiary outside the State of Arkansas, hold either:
 - 1. A current license to practice as an occupational therapy assistant in the state where services are being performed; or
 - 2. Compact privileges to practice as an occupational therapy assistant from the licensing board in the state where services are being performed.

201.000 Physical Therapy Provider Participation Requirements **7-1-26**

201.100 Physical Therapist Participation Requirements **7-1-26**

Individuals must meet one (1) of the following requirements to enroll in Medicaid as a physical therapist:

- A. Be licensed by the Arkansas State Board of Physical Therapy to practice physical therapy in the State of Arkansas;
- B. Hold compact privileges from the Arkansas State Board of Physical Therapy to practice physical therapy in the State of Arkansas; or
- C. If enrolling to perform physical therapy services for an Arkansas Medicaid beneficiary outside the State of Arkansas, hold either:
 - 1. A current license to practice as a physical therapist in the state where services are being performed; or
 - 2. Compact privileges to practice physical therapy from the licensing board in the state where services are being performed.

201.200 Physical Therapy Assistant Participation Requirements **7-1-26**

Individuals must meet one (1) of the following requirements to enroll in Medicaid as a physical therapy assistant:

- A. Be licensed by the Arkansas State Board of Physical Therapy to practice physical therapy as a physical therapy assistant in the State of Arkansas;
- B. Hold compact privileges from the Arkansas State Board of Physical Therapy to practice physical therapy as a physical therapy assistant in the State of Arkansas; or
- C. If enrolling to perform physical therapy assistant services for an Arkansas Medicaid beneficiary outside the State of Arkansas, hold either:
 - 1. A current license to practice as a physical therapy assistant in the state where services are being performed; or
 - 2. Compact privileges to practice as a physical therapy assistant from the licensing board in the state where services are being performed.

201.300 Services by an Unlicensed Student **7-1-26**

Rehabilitative occupational therapy and physical therapy services carried out by an unlicensed student may be covered only when a licensed provider of the service is present and engaged in student oversight during the entirety of the encounter. The licensed provider is considered to be providing the service under this condition.

201.400 Supervision 7-1-26

- A. A physical or occupational therapist is responsible for the quality of work performed by each therapy assistant under the therapist's supervision.
1. A supervising therapist 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. A therapist must conduct an in-person observation of each therapy assistant they supervise throughout a service session at least once every thirty (30) calendar days.
 3. A therapist must review the treatment plan and progress notes of each therapy session provided by a therapy assistant they supervise at least once every thirty (30) calendar days.
- B. A therapist must review and approve all written documentation completed by a therapy assistant under their supervision prior to the filing of claims for the service(s) provided.
1. Each page of progress note entries must be signed by the supervising therapist with their 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. All supervision activities must be documented and available for review in the beneficiary's service record.
- C. A physical or occupational therapist may not supervise more than five (5) therapy assistants at any given time.

201.500 Documentation Requirements 7-1-26**201.600 Documentation Requirements for all Medicaid Providers 7-1-26**

See Section 140.000 of this manual for the documentation that is required for all Medicaid Program providers.

201.700 Rehabilitative Occupational Therapy and Physical Therapy Services Documentation Requirements 7-1-26

- A. Rehabilitative occupational therapy and physical therapy service providers are required to maintain the following documentation in each beneficiary's service record:
1. A written referral for rehabilitative occupational therapy or physical therapy evaluation services, or both, signed and dated within the past twelve (12) months (unless the prescription specifies a shorter period) by the beneficiary's primary care provider, attending physician, or certified nurse practitioner. (see Section 212.200, below)
 2. A written prescription for rehabilitative occupational therapy or physical therapy treatment services, or both, signed and dated by the beneficiary's primary care provider, attending physician, or certified nurse practitioner within the past twelve (12) months (unless the prescription specifies a shorter period). (See Section 212.300)
 3. The evaluation and treatment prescription may be obtained at the same time and provided on the same prescription signed by the beneficiary's PCP or attending physician or nurse practitioner.

4. A treatment plan for the prescribed rehabilitative occupational therapy or physical therapy services, or both, developed and signed by a provider licensed in the prescribed discipline(s) or the prescribing provider.
 5. Rehabilitative occupational therapy or physical therapy services delivery documentation, which must include for each individual session:
 - a. The beneficiary's name;
 - b. The date and the beginning and ending times of each therapy session;
 - c. A description of the specific services provided, and the activities rendered during each therapy session which includes the goal(s) or objective(s) the specific service or activity is designed to address;
 - d. The rendering service provider's full name, his or her credentials, and his or her signature for each therapy session; and
 - e. At least weekly progress notes signed or initialed by the supervising provider overseeing the therapy services, describing the beneficiary's progress towards the goals and objectives lined out in the Plan of Care.
 6. All evaluation reports, progress notes, and related correspondence.
 7. Discharge notes and summary, if applicable.
- B. Providers of rehabilitative occupational therapy and physical therapy services must maintain:
1. Verification of their required qualifications. Refer to Section 202.000 of this manual; and
 2. Any written contract between the individual provider and the group provider on behalf of which they provide services.
- C. Group providers of rehabilitative occupational therapy and physical therapy services must maintain appropriate employment, certification, and licensure records for individuals employed or contracted by the group to provide occupational therapy or physical therapy services the group's behalf. If an individual practitioner provides services to a group provider pursuant to a contract, a copy of the contractual agreement must be maintained.

201.800 Electronic Signatures**7-1-26**

The Arkansas Medicaid Program will accept electronic signatures in compliance with the Arkansas Electronic Records and Signatures Act found at Arkansas Code § 25-31-103 et seq.

210.000 PROGRAM COVERAGE**210.100 Introduction****7-1-26**

The Arkansas Medicaid Program will reimburse enrolled providers for covered rehabilitative occupational therapy and physical therapy services (also referred to as "rehabilitative therapy services) when such services are provided pursuant to a plan of care to Medicaid-eligible individuals twenty-one (21) years of age and older. Medicaid reimbursement for medically necessary rehabilitative therapy service claims is conditional upon compliance with this manual, manual update transmittals, and official program correspondence.

Rehabilitative therapy services are medically necessary services designed to help beneficiaries regain or improve physical skills lost due to illness or injury. Key elements include intensive therapy with skilled therapist involvement and primary care provider, attending physician, or certified nurse practitioner oversight focused on restoring independence.

Sources for information about other outpatient occupational therapy, physical therapy, and speech-language pathology services available through Medicaid, are listed in Section 201.000 of this manual.

210.200 Beneficiary Eligibility Requirements **7-1-26**

210.300 Referral to Evaluate **7-1-26**

- A. Rehabilitative therapy evaluation services require a written referral signed by the beneficiary's primary care provider, attending physician, or certified nurse practitioner, as appropriate.
1. The original referral must be maintained by the referring provider.
 2. A copy of the referral must be maintained in the beneficiary's service record by the rehabilitative therapy provider.
- B. An evaluation referral and a prescription for rehabilitative therapy treatment may be prescribed simultaneously by the appropriate practitioner listed in (A) above. It is not required for the beneficiary to return to the referring or prescribing practitioner if both evaluation and treatment are medically necessary and ordered by the practitioner.

210.400 Treatment Prescription **7-1-26**

- A. Rehabilitative therapy services require a written prescription signed by the beneficiary's primary care or attending physician or certified nurse practitioner.
1. The original prescription must be maintained by the prescribing provider.
 2. A copy of the prescription must be maintained in the rehabilitative therapy provider's beneficiary's service record.
- B. A prescription for rehabilitative therapy services is valid for the shorter of:
1. The length of time specified on the prescription; or
 2. One (1) year.
- C. The prescription must demonstrate the medical necessity of rehabilitative therapy services.
1. The beneficiary's diagnosis must clearly establish and support the prescribed rehabilitative occupational therapy or physical therapy services, or both.
 2. The prescription diagnosis codes and nomenclature must comply with the coding conventions and requirements established in the International Classification of Diseases Clinical Modification for the edition certified by the Arkansas Medicaid Program for the beneficiary's dates of service.
 3. Some diagnosis codes are not specific enough to identify the medical necessity for rehabilitative occupational therapy and physical therapy services and shall not be used. (View ICD codes.)

210.500 Rehabilitative Therapy Services Comprehensive Evaluation **7-1-26**

- A. Rehabilitative therapy services must be medically necessary as demonstrated by the results of a comprehensive evaluation in the suspected area(s) of deficit.
1. A diagnosis alone is not sufficient documentation to demonstrate medical necessity.
 2. The comprehensive evaluation must indicate the following:
 - a. The provision of rehabilitative occupational therapy or physical therapy

- services, or both, will be an effective treatment for the beneficiary's condition under accepted standards of practice;
- b. The prescribed rehabilitative therapy services are of a level of complexity, or the beneficiary's condition is such that the services can only be safely and effectively performed by or under the supervision of a licensed occupational therapist or physical therapist, as appropriate; and
- c. There is a reasonable expectation the rehabilitative therapy services will result in meaningful improvement or prevent a worsening of the beneficiary's condition.
- 3. The frequency, intensity, and duration of the prescribed rehabilitative therapy services must be medically necessary based on the results of the comprehensive evaluation and realistic for the age and physical condition of the beneficiary.
- B. Each comprehensive evaluation must include an evaluation report with the following information. There is not a required order or format in which the evaluation report must be prepared:
 - 1. The beneficiary's name, age, and date of birth;
 - 2. The prescribing providers name and credentials;
 - 3. The diagnosis specific to the service(s) and suspected area(s) of deficit;
 - 4. Background information on the beneficiary including pertinent medical history;
 - 5. One (1) or more standardized evaluations of the beneficiary specific to the suspected area(s) of deficit, including all relevant scores, quotients, and indexes, if applicable;
 - a. Each comprehensive evaluation used to establish medical necessity for rehabilitative occupational therapy and physical therapy services must include objective information describing the beneficiary's gross and fine motor abilities and deficits, such as range of motion measurements, manual muscle testing, muscle tone, or a narrative description of the beneficiary's functional mobility skills.
 - b. If administration of a standardized evaluation instrument is inappropriate or unavailable, an in-depth narrative of the functional profile describing the beneficiary's abilities and deficits may be used as a substitute for a standardized evaluation. The narrative must include the following:
 - i. The reason a standardized evaluation is inappropriate, or cannot be used with the beneficiary;
 - ii. The beneficiary's functional impairment(s), including specific skills and deficits;
 - iii. A list of supplemental assessments, evaluations, tools, and tests conducted to document deficits and develop the in-depth functional profile; and
 - iv. The rationale, contributing factors, and specific results of any supplemental assessments, evaluations, tools, tests, clinical observation, and clinical analysis procedures conducted that indicate rehabilitative therapy services are medically necessary for the beneficiary.
 - 6. An interpretation of the results of the standardized evaluation and in-person clinical observations, including recommendations for the frequency, duration, and intensity of the rehabilitative therapy services;
 - 7. A description of the functional strengths and limitations of the beneficiary, a suggested treatment plan, and goals to address each identified problem; and
 - 8. The dated signature and credentials of the qualified practitioner that performed the standardized evaluation.

- C. All aspects of a comprehensive evaluation for rehabilitative therapy services, including the administration of the standardized evaluation, must be communicated and conducted in the beneficiary's primary or preferred language.
- D. Supplemental screeners, evaluations, tools, assessments, clinical observation, and clinical analysis procedures used as part of the comprehensive evaluation to support the qualifying standardized evaluation may not be used to replace the qualifying standardized evaluation except as provided in Section 212.400(B)(5)(c).

210.600 Non-Covered Services

7-1-26

A beneficiary who has been admitted as an inpatient to a hospital or is residing in a nursing care facility is not eligible for occupational therapy or physical rehabilitative therapy services under this manual.

210.700 Covered Services

7-1-26

- A. Arkansas Medicaid will only reimburse those services listed in Section 222.100 through 222.500 of this manual, as well as corresponding manual update transmittals, and relevant official program correspondence. Covered services are subject to all applicable limits.
- B. Covered services are only reimbursable if medically necessary.
- C. Please refer to the **Home Health program manual** for patients twenty-one (21) years of age and older who are receiving physical rehabilitative therapy in the home setting.
- D. Please refer to the **Home Health program manual** for patients twenty-one (21) years of age and older who are receiving physical or occupational rehabilitative therapy while under Hospice care.

210.800 Rehabilitative Occupational Therapy and Physical Therapy Evaluation and Treatment Planning Services

7-1-26

- A. A provider may be reimbursed for medically necessary rehabilitative therapy evaluation and treatment planning services. Rehabilitative therapy evaluation and treatment planning services are a component of the process for determining a beneficiary's eligibility for rehabilitative therapy treatment services and developing the treatment plan.
- B. Need for rehabilitative therapy services is demonstrated by a referral from the beneficiary's primary care provider or attending physician or nurse practitioner validating the medical necessity of the services.
- C. The treatment plan must be developed and signed by an enrolled provider who is licensed in the prescribed service discipline or by the beneficiary's primary care provider or attending physician or nurse practitioner. The treatment plan must include functional, measurable, and specific goals for each individual beneficiary.
- D. Medically necessary rehabilitative therapy evaluation and treatment planning services are reimbursed on a per-unit basis according to complexity. The billable unit includes time spent administering and scoring a standardized evaluation, clinical observation, administering supplemental tests and tools, writing a comprehensive evaluation report, along with time spent developing the treatment plan. **View or print billable occupational therapy and physical therapy evaluation and treatment planning complexity codes and descriptions.**

210.900 Rehabilitative Therapy Treatment Services

7-1-26

- A. An enrolled provider may be reimbursed for rehabilitative therapy treatment services. Rehabilitative occupational therapy or physical therapy treatment services must be medically necessary in accordance with Section 212.400 of this manual.
- B. A group rehabilitative therapy provider may contract with or employ its practitioners. The group provider must identify the individual therapist or therapy assistant as the performing provider on the claim according to their respective therapy discipline when the group therapy provider bills the Arkansas Medicaid Program for rehabilitative therapy services. The individual therapist or therapy assistant performing the rehabilitative therapy must be enrolled with the Arkansas Medicaid Program and the criteria for individual providers of therapy services shall apply. See Section 202.000 of this manual.
- C. All rehabilitative therapy treatment services furnished by a therapy provider must be provided according to a treatment plan developed by a licensed therapist. All rehabilitative therapy treatment services must be provided, documented, and billed in accordance with this manual.
- D. Medically necessary rehabilitative therapy services are covered for up to twelve (12) rehabilitative therapy visits in combination with outpatient hospital and rehabilitative hospital services per state fiscal year (SFY). A maximum of two (2) units of therapy evaluation per discipline per SFY is also allowed. See Section 225.000 of this manual regarding how to request an extension of benefits. Refer to Section 223.000 of this manual regarding rehabilitative therapy services via telecommunication.
 - 1. **View or print the billable occupational therapy codes and descriptions.**
 - 2. **View or print the billable physical therapy codes and descriptions.**

211.000 Telemedicine Services**7-1-26**

- A. An enrolled provider may be reimbursed for medically necessary rehabilitative therapy services delivered through telemedicine.
 - 1. Rehabilitative therapy evaluation and treatment planning services may not be conducted through telemedicine. The evaluation and treatment planning services must be performed using traditional in-person methods.
 - 2. The plan of care and beneficiary service record for treatment services delivered by telemedicine must include the following:
 - a. A detailed assessment of the beneficiary that determines they are an appropriate candidate for rehabilitative therapy treatment service delivery by telemedicine based on the beneficiary's age and functioning level;
 - b. A detailed explanation of all on-site assistance or participation procedures the therapist or speech-language pathologist is implementing to ensure the effectiveness of service delivery via telemedicine. The detailed explanation must ensure:
 - i. The effectiveness of telemedicine service delivery is equivalent to face-to-face service delivery; and
 - ii. Telemedicine service delivery will address the unique needs of the beneficiary.
 - c. A plan and estimated timeline for returning service delivery to in-person if the beneficiary is not adequately progressing towards goals and outcomes using telemedicine service delivery.
 - 3. All telemedicine services must be delivered in accordance with the Arkansas Telemedicine Act, found at Ark. Code Ann § 17-80-401 et seq.
- B. The service provider is responsible for ensuring service delivery through telemedicine is equivalent to in-person service delivery.

1. The service provider is responsible for ensuring the calibration of clinical instruments and the proper functioning of telecommunications equipment.
 2. Rehabilitative therapy services delivered through telemedicine must be delivered in a synchronous manner, meaning through real-time interaction between the practitioner and beneficiary via a telecommunication link.
 3. A store and forward telecommunication method of service delivery where either the beneficiary or practitioner records and stores data in advance for the other party to review at a later time is prohibited as a service delivery mechanism. Correspondence, faxes, emails, and other non-real time interactions may supplement synchronous telemedicine service delivery.
 4. Telemedicine services must be provided using HIPAA compliant technology and in a manner that ensures the beneficiary's privacy is protected as required by HIPAA, HITECH, or other applicable privacy laws.
- C. Services delivered through telemedicine are reimbursed in the same manner as in-person service delivery. **View or print the billable telecommunication codes and descriptions.**

220.000 **BENEFIT LIMITS**

220.100 **Extension of Benefits for Rehabilitative Therapy Services** **7-1-26**

- A. Rehabilitative therapy services are subject to the outpatient services benefit limit of twelve (12) visits per state fiscal year (SFY), regardless of service location. The outpatient services benefit limit includes:
1. Outpatient hospital services provided in an acute care/general hospital, a rehabilitative hospital or both;
 2. Treatment and therapy services;
 3. Services that Medicaid covers separately when furnished in conjunction with one another *and* that occur during the same outpatient encounter count against this benefit limit as only *one* non-emergency outpatient hospital service.
- B. Requests for extension of this benefit are considered for patients who require supportive treatment for maintaining life.
- C. Extension of this benefit is automatic for patients whose primary diagnosis for the service furnished is in the following list:
1. Malignant neoplasm (**View ICD Codes.**)
 2. HIV infection and AIDS (**View ICD Codes.**)
 3. Renal failure (**View ICD Codes.**)
 4. Pregnancy (**View ICD Codes.**)
- D. For range of benefits, see the following procedure codes: **View or print the procedure codes for therapy services.**
- E. Requests for benefit extensions for rehabilitative therapy services for beneficiaries twenty-one (21) years of age or older must comply with Section 216.300.

220.200 **Process for Requesting Extended Rehabilitative Therapy Services** **7-1-26**

- A. Requests for extended rehabilitative therapy services must be submitted to **DHS or its designated vendor** via the provider portal.

- B. The request must meet medical necessity requirements for the services provided, and adequate documentation must be submitted to support the request.
1. A request for extended rehabilitative therapy services is considered only after a claim is denied because regular benefits were exceeded.
 2. The request must be received within ninety (90) calendar days of the date of the denial for exceeding benefits. 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. The provider must submit a copy of the Medical Assistance Remittance and Status Report (RA) reflecting the denial for exceeding benefits with the extension request. Do not send a claim.
 4. Requests for extension submitted by facsimile (FAX) or email will not be accepted for review.
- C. Form DMS-671, "Request for Extension of Benefits for Clinical, Outpatient, Diagnostic Laboratory, and Radiology/Other Services," must be used when requesting extended rehabilitative therapy services. **View or print Form DMS-671.** Correct completion of all fields on this form is required for consideration of the request. The instructions for completion of this form are located on the back of the form. The provider must sign, include his or her credentials, and date the Form DMS-671. All relevant documentation that supports the medical necessity of the request must be attached to be considered.

220.300 Request for Extension of Benefits Documentation Requirements

7-1-26

A request for extension of benefits must include, at a minimum, the:

- A. PCP or attending provider referral and prescription for the amount of service requested;
- B. Documentation to demonstrate the medical necessity of the request for extension of benefits. Appropriate documentation may include without limitation: comprehensive evaluation(s), diagnosis(es), clinical records, or progress reports; and
- C. Signature of the performing provider, including credentials, and date signed.

220.400 Review Process for Request for Extension of Benefits

7-1-26

- A. Requests for extension of benefits are initially screened for completeness and researched to determine the beneficiary's eligibility for Medicaid.
- B. All documentation submitted with the request is reviewed by an appropriately licensed clinician.
 1. If the reviewing clinician determines the documentation demonstrates the medical necessity of the request, then an approval letter is mailed to the requesting provider the following business day;
 2. If the reviewing clinician determines the documentation does not demonstrate medical necessity, the request is referred to a physician for review.
 - a. If the reviewing physician determines the documentation demonstrates medical necessity, an approval letter is mailed to the requesting provider the following business day.
 - b. If the reviewing physician determines the documentation does not demonstrate medical necessity, then a denial letter that includes the physician's rationale for denial of the request is mailed to the provider and the beneficiary the following business day.

3. A provider may request an administrative reconsideration of any denial of a request for extension of benefits in accordance with Section 227.000 of this manual.

220.500 Administrative Reconsideration and Appeals

7-1-26

- A. Medicaid allows only one (1) reconsideration of an adverse decision. Reconsideration requests of denied benefit extensions or prior authorizations must be submitted in accordance with Section 160.000 of Section I of this manual.
- B. When the state Medicaid agency or its designee denies a reconsideration request or issues any adverse decision, the beneficiary or provider may appeal and request a fair hearing. A request for a fair hearing must be submitted in accordance with Sections 160.000, 190.000, and 191.000 of Section I of this manual.

230.000 REIMBURSEMENT

230.100 Method of Reimbursement

- A. Rehabilitative occupational therapy and physical therapy services use fee schedule reimbursement methodology. Under the fee schedule methodology, reimbursement is made at the lower of the billed charge for the service or maximum allowable reimbursement for the service under the Arkansas Medicaid Program.
 1. A full unit of service must be rendered in order to bill a unit of service.
 2. Partial units of service may not be rounded up and are not reimbursable.
- B. The maximum group size for rehabilitative occupational therapy or physical therapy services is four (4) beneficiaries.

230.200 Fee Schedules

7-1-26

- A. The Arkansas Medicaid Program provides fee schedules on the Arkansas Medicaid website. **View or print the occupational therapy and physical therapy services fee schedule.**
- B. Fee schedules do not address coverage limitations or special instructions applied by the Arkansas Medicaid Program before final payment is determined.
- C. Fee schedules and **therapy category codes** do not guarantee payment, coverage, or the reimbursement amount. Fee schedule and procedure code information may be changed or updated at any time to correct a discrepancy or error.

AMOUNT, DURATION AND SCOPE OF
SERVICES PROVIDED

Revised: January-July 1, 2021-2026

CATEGORICALLY NEEDY

11. Physical Therapy and Related Services

Speech-Language Pathology services and qualified Speech-Language Pathologists meet the requirements set forth in 42 CFR 440.110. Speech-Language Pathology Assistants work under the supervision of the Speech-Language Pathologist in accordance with the State's licensing and supervisory requirements.

Physical Therapy services and qualified Physical Therapists meet the requirements set forth in 42 CFR 440.110. Physical Therapy assistants work under the supervision of the Physical Therapist in accordance with the State's licensing and supervisory requirements.

Occupational Therapy services and qualified Occupational Therapists meet the requirements set forth in 42 CFR 440.110. Occupational Therapy assistants work under the supervision of the Occupational Therapist in accordance with the State's licensing and supervisory requirements.

Audiology services and qualified Audiologists meet the requirements set forth in 42 CFR 440.110.

A. Occupational, Physical and Speech-Language Therapy in Adult Developmental Day Treatment (ADDT) clinics

1. Refer to Attachment 3.1-A, Item 4.b. (15) for therapy services for recipients-beneficiaries under age twenty-one (21).

2. For recipients-beneficiaries over age twenty-one (21) years old and over, effective for dates of services on or after July 1, 2017, individual and group therapy are limited to six (6) units per week per discipline. **For recipients-beneficiaries over aged 21 and over, Speech-language therapy** evaluations are limited to four (4) units per State Fiscal Year (July 1 through June 30). Extensions of the benefit limit will be provided if medically necessary.

3. For recipients-beneficiaries over age twenty-one (21) years old and over, effective for dates on or after January 1, 2021, physical therapy evaluations are limited to two (2) units per State Fiscal Year (July 1 through June 30). For recipients-beneficiaries over aged 21 and over, effective for dates on or after January 1, 2021, occupational therapy evaluations are limited to two (2) units per State Fiscal Year (July 1 through June 30). Extensions of the benefit limit for the evaluation will be provided if medically necessary.

B. Speech-Language Therapy

Speech Generating Device (SGD) Evaluation - Effective for dates of service on or after September 1, 1999, **Speech Generating Device (SGD)** evaluation is covered for eligible Medicaid recipients-beneficiaries of all ages. One **SGD** evaluation may be performed every

three years based on medical necessity. The benefit limit may be extended for individuals under age 21.

C. Adult Rehabilitative Occupational and Physical Therapy in a clinic setting

For beneficiaries twenty-one (21) years old and over, effective for dates on or after January 1/July 1, 2026, adult rehabilitative occupational and physical therapy services are limited to twelve (12) visits. There is a with a maximum of two (2) units of therapy evaluations per discipline per State Fiscal Year (July 1 through June 30). Extensions of the benefit limit will be provided if medically necessary.

~~TN:20-0021~~ ~~Approval:11-9-2020~~ ~~Effective Date:1-1-2021~~

~~Supersedes TN:18-0008~~

MARK-UP

AMOUNT, DURATION AND SCOPE OF
SERVICES PROVIDED
2021-2026

Revised: January-July 1,

MEDICALLY NEEDY

11. Physical Therapy and Related Services

Speech-Language Pathology services and qualified Speech-Language Pathologists meet the requirements set forth in 42 CFR 440.110. Speech-Language Pathology Assistants work under the supervision of the Speech-Language Pathologist in accordance with the State's licensing and supervisory requirements.

Physical Therapy services and qualified Physical Therapists meet the requirements set forth in 42 CFR 440.110. Physical Therapy assistants work under the supervision of the Physical Therapist in accordance with the State's licensing and supervisory requirements.

Occupational Therapy services and qualified Occupational Therapists meet the requirements set forth in 42 CFR 440.110. Occupational Therapy assistants work under the supervision of the Occupational Therapist in accordance with the State's licensing and supervisory requirements.

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A. A. Occupational, Physical and Speech-Language Therapy in Adult Developmental Day Treatment (ADDT) clinics

1. Refer to Attachment 3.1-A, Item 4.b. (15) for therapy services for recipients-beneficiaries under age twenty-one (21).

2. For recipients-beneficiaries over age twenty-one (21) years old and over, effective for dates of services on or after July 1, 2017, individual and group therapy are limited to six (6) units per week per discipline. **For recipients-beneficiaries over aged 21 and over, speech-language therapy evaluations are limited to four (4) units per State Fiscal Year (July 1 through June 30). Extensions of the benefit limit will be provided if medically necessary.**

3. **For recipients-beneficiaries over age twenty-one (21) years old and over, effective for dates on or after January 1, 2021, physical therapy evaluations are limited to two (2) units per State Fiscal Year (July 1 through June 30). For recipients-beneficiaries over aged 21 and over, effective for dates on or after January 1, 2021, Occupational therapy evaluations are limited to two (2) units per State Fiscal Year (July 1 through June 30).**

AB. Speech-Language Therapy

Speech Generating Device (SGD) Evaluation - Effective for dates of service on or after September 1, 1999, **Speech Generating Device (SGD) evaluation** is covered for eligible

Medicaid ~~recipients~~ beneficiaries of all ages. One **SGD** evaluation may be performed every three (3) years based on medical necessity. The benefit limit may be extended for individuals under age 21.

C. Adult Rehabilitative Occupational and Physical Therapy in a clinic setting

For beneficiaries twenty-one (21) years old and over, effective for dates on or after ~~January~~ July 1, 2026, adult rehabilitative occupational and physical therapy services are limited to twelve (12) visits. There is ~~visits with a~~ maximum of two (2) units of therapy evaluations per discipline per State Fiscal Year (July 1 through June 30). Extensions of the benefit limit will be provided if medically necessary.

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MARK-UP