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| 200.000 Developmental Day Treatment Clinic Services (DDTCS) GENERAL INFORMATION |  |
| 201.000 Arkansas Medicaid Participation Requirements for Developmental Day Treatment Clinic Services (DDTCS) Providers | 11-1-09 |

DDTCS providers must meet the Provider Participation and enrollment requirements contained within Section 140.000 of this manual as well as the following criteria to be eligible to participate in the Arkansas Medicaid Program:

1. Each provider of DDTCS must be licensed as a Developmental Day Treatment clinic by the Division of Developmental Disabilities Services (DDS), Arkansas Department of Human Services.

B. A copy of the current license must accompany the provider application and the Medicaid contract.

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| 201.100 Providers of DDTCS Services in Arkansas and Bordering States | 10-13-03 |

Developmental day treatment clinic services (DDTCS) providers in Arkansas and the six bordering states (Louisiana, Mississippi, Missouri, Oklahoma, Tennessee and Texas) may be enrolled as routine services providers if they meet all Arkansas Medicaid participation requirements outlined above.

DDTCS providers may furnish and claim reimbursement for covered services in the Arkansas Medicaid Program subject to benefit limits and coverage restrictions set forth in this manual. Claims must be filed according to the specifications in this manual.

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| 201.200 DDTCS Providing Occupational, Physical, or Speech Therapy | 8-15-08 |

Optional services available through DDTCS include occupational, physical and speech therapy and evaluation as an essential component of the plan of care for an individual accepted for developmental disabilities services. Therapy services are not included in the core services and are provided in addition to the core services (see Sections 214.210 and 215.200 of this manual for additional requirements for provision of therapy services).

A DDTCS facility may contract with or employ qualified therapy practitioners. Effective for dates of service on and after October 1, 2008, the individual therapy practitioner who actually performs a service on behalf of the DDTCS facility must be identified on the claim as the performing provider when the DDTCS facility bills for that service. This action is taken in compliance with the federal Improper Payments Information Act of 2002 (IPIA), Public Law 107-300 and the resulting Payment Error Rate Measurement (PERM) program initiated by the Centers for Medicare and Medicaid Services (CMS).

If the facility contracts with a qualified therapy practitioner, the criteria for group providers of therapy services apply (See Section 201.100 of the Occupational, Physical, Speech Therapy Services manual). The qualified therapy practitioner who contracts with the facility must be enrolled with Arkansas Medicaid. The contract practitioner who performs a service must be listed as the performing provider on the claim when the facility bills for that service.

If the facility employs a qualified therapy practitioner, that practitioner has the option of either enrolling with Arkansas Medicaid or requesting a Practitioner Identification Number ([View or print form DMS-7708](../../Forms/DMS-7708.doc)). The employed practitioner who performs a service must be listed as the performing provider on the claim when the facility bills for that service.

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| 202.000 Documentation Requirements |  |
| 202.100 Documentation Requirements for All Medicaid Providers | 11-1-09 |

See Section 141.000 for the documentation that is required for all Medicaid providers.

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| 202.200 Clinical Records DDTCS Providers Must Keep | 10-1-17 |

A. Providers must establish and maintain medical records for each beneficiary that include documentation of medical necessity for DDTCS services and a plan of care.

B. For each beneficiary who is under 18, the record must include the result of the annual developmental screen performed by the Department of Human Services’ Third-Party Vendor or an approved medical diagnosis exemption of the developmental screen in accordance with the Provider Manual Governing Independent Assessments and Developmental Screens.

C. Sufficient written documentation for each beneficiary record must support the medical or remedial therapy services provided. This requirement applies to core services and optional services. Refer to Sections 214.000 through 214.210 of this manual for description of services.

D. Service documentation for each DDTCS beneficiary must, at a minimum, include the following items.

1. The specific services furnished daily,

2. The date and actual beginning and ending time of day the services were performed daily,

3. Name(s) and title(s) of the person(s) providing the service(s) daily,

4. The relationship of the daily services to the goals and objectives described in the beneficiary’s individualized plan of care, and

5. At a minimum, weekly progress notes, signed or initialed by the person providing the service(s), describing each beneficiary’s status with respect to his or her goals and objectives.

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| 202.300 Electronic Signatures | 10-8-10 |

Medicaid will accept electronic signatures provided the electronic signatures comply with Arkansas Code § 25-31-103 et seq.

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| 203.000 Referral to First Connections Program Pursuant to Part C of the Individuals with Disabilities Education Act (IDEA) | 10-1-17 |

DDS is the lead agency responsible for the general administration and supervision of the programs and activities utilized to carry out the provisions of Part C of the IDEA. First Connections is the DDS program in Arkansas that administers, monitors, and carries out all Part C of IDEA activities and responsibilities for the state. The First Connections program ensures that appropriate early intervention services are available to all infants and toddlers from birth to thirty-six (36) months of age (and their families) that are suspected of having a developmental delay.

Each DDTCS must, within two (2) working days of receipt of referral of an infant or toddler thirty-six (36) months of age or younger, present the family with DDS-approved information about the Part C program, First Connections, so that the parent/guardian can make an informed choice regarding early intervention options. Each DDTCS must maintain appropriate documentation of parent choice in the child record.

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| 204.000 Election to Provide Special Education Services in Accordance with Part B of the Individuals with Disabilities Education Act (IDEA) | 10-1-17 |

Local Education Agencies (LEA) have the responsibility to ensure that children, ages three (3) until entry into kindergarten, who have or are suspected of having a disability under Part B of IDEA (Part B), receive a Free Appropriate Public Education. The Arkansas Department of Education provides each DDTCS with the option of participating in Part B as a LEA. Participation as a LEA requires a DDTCS to provide special education and related services in accordance with Part B (Special Education Services) to all children with disabilities it is serving aged three (3) until entry into Kindergarten. A participating DDTCS is also eligible to receive a portion of the federal grant funds made available to LEAs under Part B in any given fiscal year.

Each DDTCS must therefore make an affirmative election to either provide or not provide Special Education Services to all children with disabilities it is serving aged three (3) until entry into kindergarten as follows:

A. Opt-in: A DDTCS that elects to provide Special Education Services to all children with disabilities it is serving aged three (3) until entry into Kindergarten must follow Arkansas Department of Education Procedural Requirements and Program Standards for Special Education and comply with Part B at all times. Failure by a DDTCS to provide all required Special Education Services in compliance with the above will result in a loss of Part B funds.

B. Opt-out: A DDTCS that elects not to provide Special Education Services to all children with disabilities it is serving aged three (3) until entry into kindergarten must perform the following:

1. Prior to delivering any services to a child age three (3) or older who has or is suspected of having a disability under Part B, the DDTCS must complete a Special Education Referral Form (or any successor form), and submit it to the appropriate LEA. The DDTCS will be responsible for maintaining documentation evidencing that a timely and properly completed referral was provided to the appropriate LEA.

2. The DDTCS must complete a Special Education Referral Form (or any successor form), and submit it to the appropriate LEA at least ninety (90) days prior to the third (3rd) birthday of any child who has or may have a disability under Part B that is being served by the DDTCS. The DDTCS will be responsible for maintaining documentation evidencing that a timely and properly completed referral was provided to the appropriate LEA.

3. For any child who has a disability under Part B served by the DDTCS that will be entering kindergarten in a calendar year, the DDTCS must complete a referral form and submit it to the LEA where the child will attend kindergarten by February 1 of that year. The DDTCS will be responsible for maintaining documentation evidencing that a timely and properly completed referral was provided to the appropriate LEA.

A DDTCS may change its election at any time; however, a decision to change will only be effective as of July 1st. A DDTCS must inform DDS of its intent to change its election no later than March 1st for its election to be effective as of July 1st of the same calendar year. Any decision to change an election received by DDS after March 1st will not be effective until July 1st of the next calendar year. Any time a DDTCS elects to cease providing Special Education Services, the DDTCS must complete a Special Education Referral Form (or any successor form) for each child age three (3) or older it is currently serving, and submit each one to the appropriate LEA.

[View or print the Arkansas Department of Education Special Education contact information.](../../Links/ADESpecialEd.doc)

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| 210.000 PROGRAM COVERAGE |  |
| 211.000 Introduction | 11-1-06 |

Medicaid assists eligible individuals to obtain medical care in accordance with the guidelines specified in Section I of this manual. Reimbursement may be made for covered developmental day treatment clinic services provided to Medicaid beneficiaries at qualified provider facilities.

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| 212.000 Scope | 10-1-17 |

A. Developmental day treatment clinic services in qualified facilities may be covered only when they are:

1. Provided to outpatients

2. Determined medically necessary for the beneficiary

3. Provided pursuant to a written prescription by a physician

4. Provided in accordance with an individualized written plan of care

B. Outpatients are individuals who travel to and from a treatment site on the same day, who do not reside in an intermediate care facility for individuals with intellectual disabilities (ICF/IID) and who are not inpatients of a hospital.

C. Please refer to Sections 215.000 through 216.100 of this manual for details regarding medical necessity and plans of care.

D. Beneficiaries who are enrolled in a program that is dually certified as a DDTCS and CHMS cannot be billed under both programs during the same enrollment period. An enrollment period is defined as the twelve (12) months of allowed billing after the developmental screen is administered and a prescription is written for CHMS or DDTCS services for the beneficiary.

Beneficiaries who continue to qualify for either DDTCS or CHMS during the enrollment period can transfer to another CHMS or DDTCS program based on parent choice. These beneficiaries do not have to undergo another developmental screen.

Beneficiaries who graduate or no longer qualify for DDTCS or CHMS before the end of the enrollment period must be referred to the third party vendor for a developmental screen and obtain a new prescription before they can be reenrolled in a DDTCS or CHMS program.

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| 213.000 Non-Covered Services | 10-13-03 |

Non-covered services include, but are not limited to:

A. Diagnosis and evaluation services, pre-school services and adult development services less than 1 hour in length,

B. Early intervention services less than 2 hours in length,

C. Supervised living services,

D. Educational services and

E. Services to inpatients.

A developmental day treatment clinic must provide only those services that the Division of Developmental Disabilities Services licenses the DDTCS clinic to provide.

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| 214.000 Coverage of DDTCS Services |  |
| 214.100 DDTCS Core Services | 10-13-03 |

A. Developmental Day Treatment Clinic Services (DDTCS) may be furnished only by DDS licensed comprehensive day treatment centers offering as core services:

1. Diagnosis and Evaluation and

2. Habilitation.

B. DDTCS core services are provided at three levels of care. The levels of care are:

1. Early Intervention,

2. Pre-School and

3. Adult Development.

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| 214.110 Diagnosis and Evaluation (D&E) | 10-1-17 |

Diagnosis and evaluation services (D&E) constitute the process of determining a person’s eligibility for habilitation services in one of the three levels of care.

D&E services are covered separately from DDTCS habilitation training services. D&E services are reimbursed on a per unit basis with one unit equal to one hour of service. The length of the service may not exceed one unit per date of service. The billable unit includes time spent administering the test, time spent scoring the test and/or time spent writing a test report.

D&E services are covered once each calendar year if the service is deemed medically necessary by a physician. For children in the early intervention and pre-school levels of care, the child must be determined to need D&E services by the developmental screen conducted in accordance with the Manual Governing Independent Assessments and Developmental Screens.

If the physician or DDTCS provider believes that the child has a significant developmental diagnosis, disability, or delay such that he or she does not need a developmental screen, the physician or DDTCS provider may send relevant documentation for review by the Third Party Assessor’s clinician. The Clinician will determine the necessity of a developmental screen.

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| 214.120 Habilitation | 10-1-17 |

A. Habilitation is instruction in areas of self-help, socialization, communication, or cognitive development; or to reinforce skills learned and practiced in occupational, physical, or speech therapy. Habilitation activities must be designed to teach habilitation goals and objectives specified in the client’s individualized plan of care. (Refer to Section 216.000 of this manual.)

B. Medicaid covers habilitation services only in clinical settings licensed by DDS and enrolled in Medicaid.

C. DDTCS providers must ensure that a noon meal is available to each Medicaid beneficiary who receives at least four hours of DDTCS core services in a day and who is unable to provide his or her own meal on the date of the core services.

1. When being responsible for providing his or her own meal is a component of a beneficiary’s plan of care, the provider may request the beneficiary furnish the meal.

2. A beneficiary may not be charged for a meal the facility provides, whether or not providing his or her own meal is included in the client’s individualized plan of care.

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| 214.130 Levels of Care |  |
| 214.131 Early Intervention | 7-15-12 |

Early intervention is a facility-based program designed to provide one-on-one direct training to the child *and* the parent or caregiver. The intent of early intervention is to work with parents and caregivers to assist them with training the child. The parent or caregiver of the child must participate in the programming to learn how to work with the child in the home.

A. To be eligible for early intervention services, the child must be an individual with a developmental disability or developmental delay and must not be school age. School age is defined as having reached the age of five years on or before the date set by the Arkansas Department of Education. A child reaching age five after that date is not considered school age until the next school year.

B. Early intervention services must include training the parent or caregiver in meeting the needs of the child and in meeting the goals of the care plan.

C. Coverage is limited to one encounter per day. An early intervention encounter includes the time spent on preparation and service documentation as well as the direct training. Each early intervention encounter must be two hours or more in duration. At each encounter, a minimum of one hour of direct training with the child and the parent or caregiver is required.

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| 214.132 Pre-School | 7-15-12 |

Pre-school service is a facility-based program designed to provide specialized services to children who have been diagnosed with a developmental disability or developmental delay and who are not school age. School age is defined as having reached the age of five years on or before the date set by the Arkansas Department of Education. A child reaching age five after that date is not considered school age until the next school year.

Services must be provided for the purpose of teaching habilitation goals as set forth in the plan of care. Services are established on a unit-of-service basis. Each unit of service equals one hour. A maximum of five units per day is allowed.

Time spent in transit from the person’s place of residence to the provider facility and from the facility back to the person’s place of residence is not included in the unit of service calculation.

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| 214.133 Adult Development | 7-15-12 |

Adult development is a facility-based program providing specialized habilitation services to adults who have been diagnosed with a developmental disability. Qualifying individuals must be between ages 18 and 21 with a diploma or certificate of completion, or age 21 and older.

A. Adult development services may include prevocational services that prepare a person for employment. Prevocational services:

1. May *not* be job-task oriented, but

2. May include such *habilitation* goals as compliance, attending, task completion, problem solving and safety, and

3. May be provided only to persons who are not expected to be able to join the general work force or to participate in a transitional sheltered workshop within one year (excluding supported employment programs).

B. Prevocational services may not be primarily directed at teaching specific job skills. All prevocational services must be listed in the plan of care as habilitation and may not address explicit employment objectives. The person’s compensation must be less than 50% of minimum wage in order for the training to qualify as prevocational services. Commensurate wage must be paid under a current Wage and Hour Sheltered Workshop Certificate.

C. Documentation must be maintained in each person’s file showing that the services are not available under a program funded under Section 110 of the Rehabilitation Act of 1973, as amended, or the Individuals with Disabilities Education Act of 1997.

Adult development services are established on a unit-of-service basis. Each unit of service equals one hour in the facility with a maximum of five units reimbursable per day.

Time spent in transit from the person’s place of residence to the provider facility and from the facility back to the person’s place of residence is not included in the unit of service calculation.

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| 214.200 DDTCS Optional Services |  |
| 214.210 Occupational, Physical and Speech Therapy | 7-1-17 |

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

A. The DDTCS client’s primary care physician (PCP) or attending physician must refer a client for evaluation for occupational, physical or speech therapy services. For clients under the age of 21, the use of form DMS-640 is required. [View or print form DMS-640](../../Forms/DMS-640.doc). The DDTCS client’s primary care physician (PCP) or attending physician must also prescribe occupational, physical and/or speech therapy services and again, for clients under the age of 21, the use of an additional form DMS-640 is required for the prescription. The prescribed therapy must be included in the individual’s DDTCS plan of care. A copy of the prescription must be maintained in the beneficiary’s records. The original prescription is to be maintained by the physician. After the initial referral and initial prescription, subsequent referrals and prescriptions for continued therapy may be made at the same time using the same DMS‑640 for clients under age 21. Instructions for completion of form DMS-640 are located on the back of the form. Medicaid will accept an electronic signature provided it is compliance with Arkansas Code 25‑31‑103.

B. Therapies in the DDTCS Program may be provided only to individuals whose plan of care includes one of the three levels of care (early intervention, pre-school or adult development). Medicaid does not cover optional therapy services furnished by a DDTCS provider as “stand-alone” services. To ensure quality care, group therapy sessions are limited to no more than four persons in a group.

1. When a DDTCS provider renders therapy services in conjunction with a DDTCS core service, therapy services must be billed by the DDTCS provider according to billing instructions in Section II of this manual.

2. DDTCS providers may not bill under the Medicaid Occupational, Physical and Speech Therapy Program for therapy services available in the DDTCS Program and provided to DDTCS clients.

3. Therapy services may not be provided during the same time period DDTCS core services are provided.

C. Arkansas Medicaid applies the following therapy benefits to all therapy services provided in the DDTCS program:

1. Medicaid will reimburse up to four (4) occupational, physical and speech therapy evaluation units (1 unit = 30 minutes) per discipline, per state fiscal year (July 1 through June 30) without authorization. Additional evaluation units for beneficiaries under age 21 will require an extended therapy request.

2. Medicaid will reimburse up to six (6) occupational, physical and speech therapy units (1 unit = 15 minutes) weekly, per discipline, without authorization. Additional daily therapy units will require an extended therapy request for beneficiaries under age 21.

3. All requests for extended therapy services must comply with Sections 217.000 through 217.100 for beneficiaries under age 21.

4. All requests for benefit extensions for therapy services provided in the DDTCS program to beneficiaries age 21 years and over must comply with Sections 217.700 through 217.800.

D. Make-up therapy sessions are covered for beneficiaries under age 21 in the event a therapy session is canceled or missed, if determined medically necessary and prescribed by the beneficiary’s PCP. A make-up therapy session requires a separate prescription from the original previously received. Form DMS-640 must be used by the PCP for make-up therapy session prescriptions for beneficiaries under age 21.

E. Therapy services carried out by an unlicensed therapy student may be covered only when the following criteria are met:

1. Therapies performed by an unlicensed student must be under the direction of a licensed therapist and the direction is such that the licensed therapist is considered to be providing the medical assistance.

2. The licensed therapist must be present and engaged in student oversight during the entirety of any encounter.

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| 214.500 Occupational, Physical and Speech Therapies Provided in the DDTCS Program For Beneficiaries 21 Years of Age and Older | 7-1-17 |

A. Medicaid will reimburse up to four (4) occupational, physical and speech therapy evaluation units (1 unit = 30 minutes) per discipline, for an eligible beneficiary, per state fiscal year (July 1 through June 30).

B. Medicaid will reimburse up to six (6) occupational, physical and speech therapy units (1 unit = 15 minutes) weekly, per discipline, for an eligible beneficiary.

C. All requests for benefit extensions for therapy services for beneficiaries over age 21 must comply with Sections 217.700 through 217.800.

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| 215.000 Establishing Medical Necessity for DDTCS |  |
| 215.100 Establishing Medical Necessity for Core Services | 10-1-17 |

Reimbursement for covered services will be approved only when the individual’s attending physician has determined DDTCS core services are medically necessary.

A. The physician must identify the individual’s medical needs that habilitation training can address.

B. To initiate DDTCS services the individual’s physician must issue a written prescription. The prescription for DDTCS is valid for one year unless the prescribing physician specifies a shorter period of time. The prescription must be renewed at least once a year for services to continue.

C. Each prescription must be dated and signed by the physician with his or her original signature to be considered a valid prescription.

D. For beneficiaries under age 18, the prescription must be based on the result of the developmental screen performed by DHS’ Third-Party Assessor, as well as the results of the D&E.

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

A. Occupational, physical and speech therapy services for Medicaid beneficiaries under age 21 require a *referral* from the client’s primary care physician (PCP) or attending physician if the individual is exempt from mandatory PCP referral requirements. The *referral* for occupational, physical and speech therapy services must be renewed every six months. The PCP or attending physician is responsible for determining medical necessity for therapy treatment.

B. A written *prescription* for therapy services is required and is valid for one year unless the prescribing physician specifies a shorter period.

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| 215.300 Definition of Developmental Diagnosis | 10-1-17 |

A. A developmental disability:

1. Is attributable to intellectual disability, cerebral palsy, spina bifida, Down syndrome, epilepsy or autism spectrum disorder.

a. Intellectual Disability – As established by scores of intelligence which fall two or more standard deviations below the mean of a standardized test of intelligence administered by a legally qualified professional; Infants/Preschool, 0-5 years - developmental scales, administered by qualified personnel authorized in the manual accompanying the instrument used, which indicate impairment of general functioning similar to that of developmentally disabled persons;

b. Cerebral Palsy – As established by the results of a medical examination provided by a licensed physician;

c. Spina Bifida – As established by the results of a medical examination provided by a licensed physician.

d. Down Syndrome – As established by the diagnosis of a licensed physician.

e. Epilepsy – As established by the results of a neurological and/or licensed physician;

f. Autism Spectrum Disorder – As established by the results of a team evaluation including at least a licensed physician and a licensed psychologist and a licensed Speech Pathologist;

NOTE: Each of these six conditions is sufficient for determination of eligibility independent of each other. This means that a person who is intellectually disabled does not have to have a diagnosis of autism spectrum disorder, epilepsy, spina bifida, down syndrome, or cerebral palsy. Conversely, a person who has autism spectrum disorder, cerebral palsy, epilepsy, spina bifida, or Down syndrome does not have to have an intellectual disability to receive services.

2. Is attributable to any other condition of a person found to be closely related to intellectual disability because it results in impairment of general intellectual functioning or adaptive behavior similar to those of persons with intellectual disability or requires treatment and services similar to those required for such persons. This determination must be based on the results of a team evaluation including at least a licensed Physician and a licensed Psychologist.

a. In the case of individuals being evaluated for service, eligibility determination shall be based upon establishment of intelligence scores which fall two or more standard deviations below the mean of a standardized test of intelligence OR, is attributable to any other condition found to be closely related to an intellectual disability because it results in impairment of general intellectual functioning or adaptive behavior similar to those of persons with an intellectual disability, or requires treatment and services similar to those required for such persons.

b. Persons age 5 and over will be eligible for services if their I.Q. scores fall two or more standard deviations below the mean of a standardized test.

c. For persons ages 3 to 5, eligibility is based on an assessment that reflects functioning on a level two or more standard deviations from the mean in two or more areas as determined by a standardized test.

d. For infants and toddlers 0-36 months, eligibility for DDS Services will be indicated by a 25% delay in two or more areas based on an assessment instrument which yields scores in months. The areas to be assessed include: cognition; communication; social/emotion; motor; and adaptive.

3. Is attributable to dyslexia resulting from intellectual disability, cerebral palsy, epilepsy spina bifida, Down syndrome or autism spectrum disorder as established by the results of a team evaluation including at least a licensed Physician and a licensed Psychologist.

NOTE: In the case of individuals being evaluated for service, eligibility shall be based upon their condition closely related to an intellectual disability by virtue of their adaptive behavior functioning.

B. The disability has continued or is expected to continue indefinitely.

C. The disability constitutes a substantial handicap to the beneficiary’s ability to function without appropriate support services.

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| 216.000 Plan of Care | 11-1-06 |

For each beneficiary who enters the DDTCS Program, an individualized plan of care must be developed. This consists of a written, individualized plan to improve the beneficiary’s condition. The plan of care must contain a written description of the treatment objectives for the beneficiary. It also must describe:

A. The treatment regimen—the specific medical and remedial services, therapies and activities that will be used to achieve the treatment objectives.

B. A schedule for service delivery—this includes the frequency and duration of each type of therapeutic session or encounter.

C. The job titles or credentials of personnel that will furnish each service.

D. A schedule for completing reevaluations of the beneficiary’s condition and updating the plan of care.

The plan of care may be authorized only by the physician determining that DDTCS services are medically necessary. The physician’s original personal signature and the date signed must be recorded on the plan of care. Delegation of this function or a stamped signature is not allowed.

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| 216.100 Periodic Review of Plan of Care | 11-1-06 |

DDTCS staff must periodically review the plan of care to assess the appropriateness of services, the beneficiary’s status with respect to treatment objectives and his or her need for continued participation in the program. The reviews must be performed at least every 90 days and documented in detail in the individual’s case file.

The beneficiary’s physician must authorize (by dated original signature) any revisions to the plan of care for any reason.

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| 217.000 Procedures for Requesting Extension of Benefits/Prior Approval for Therapy Services for Occupational, Physical and Speech Therapy (Evaluation or Treatment) | 10-1-17 |

A. Requests for extension of benefits/prior approval of therapy services for beneficiaries must be submitted to the Quality Improvement Organization (QIO) under the contract to the Arkansas Medicaid Program via mail, fax or electronically. [View or print the QIO contact information](../../Links/AFMC.doc). The request must meet the medical necessity requirement, and adequate documentation must be provided to support this request.

1. Requests will be considered when the initial prescription is written, with documentation that extended benefits are medically necessary and that outcomes can be achieved.

2. The request must be received by the QIO and processed before the provider may bill for extended benefits.

B. Form DMS-671, Request for Extension of Benefits for Clinical, Outpatient, Laboratory, and X-Ray Services, must be utilized for requests for extended therapy services. [View or print form DMS-671](../../Forms/DMS-671.doc). Consideration of requests requires correct completion of all fields on this form. The instructions for completion of this form are located on the back of the form. The provider must sign, include credentials and date the request. An electronic signature is accepted provided it is in compliance with Arkansas Code 25‑31‑103. All applicable records that support the medical necessity of the request should be attached.

C. The QIO will approve, deny, or ask for additional information, within 3 business days of receiving a completed request. QIO reviewers will simultaneously advise the provider and the beneficiary when a request is denied. Approved requests will be returned to the provider with an authorization number that is required to be submitted with the billing for the approved services in order to obtain Medicaid payment.

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| 217.100 Documentation Requirements for Extension of Benefits/Prior Approval of Therapy Benefits | 10-1-17 |

A. To request extension of benefits/prior approval of therapy services, all applicable documentation that support the medical necessity of extended benefits are required.

B. Documentation requirements are as follows. Clinical records must:

1. Be legible and include documentation supporting the medical necessity of the specific request and include expected outcomes.

2. Be signed (with credentials) by the performing provider.

3. Include the physician referral and prescription for additional therapy based on clinical records and progress reports furnished by the performing provider.

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| 218.000 Administrative Reconsideration of Extension of Benefits/Prior Approval of Therapy Services Denial | 10-1-17 |

A. A request for administrative reconsideration of a denial of a request for extension of benefits/prior approval of therapy must be in writing and sent to the QIO within 30 calendar days of the denial. The request must include a copy of the denial letter and additional supporting documentation.

B. The deadline for receipt of the reconsideration request will be enforced pursuant to Sections 190.012 and 190.013 of this manual. A request received by the QIO with 35 calendar days of a denial will be deemed timely. A request received later than 35 calendar days of a denial will be considered on an individual basis. Reconsideration requests must be mailed and will not be accepted via facsimile or email.

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| 218.100 Appeal Process | 10-1-17 |

When the Division of Medical Services (DMS) denies coverage of services, the beneficiary may request a fair hearing to appeal the denial of services from the Department of Human Services. (See DDS Policy 1076.)

The appeal request must be in writing and received by the appropriate office within thirty (30) days of the date of the denial notification. (See Sections 160.000 and 190.000.)

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| 219.000 Utilization Review | 11-1-06 |

A. The Utilization Review Section of the Arkansas Medicaid Program has the responsibility for assuring quality medical care for Medicaid beneficiaries and for protecting the integrity of state and federal funds supporting the Medical Assistance Program. Those responsibilities are mandated by federal regulations.

B. The Utilization Review team shall:

1. Conduct on-site medical audits for the purpose of verifying the nature and extent of services paid for by the Medicaid Program,

2. Research all inquiries from beneficiaries in response to the Explanation of Medicaid Benefits and

3. Retrospectively evaluate medical practice patterns and providers’ patterns by comparing each provider’s pattern to norms and limits set by all the providers of the same specialty. Prior authorization is not required for DDTCS core service or for occupational, physical and speech therapy services.

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| 220.000 Guidelines for Retrospective Review of Occupational, Physical and Speech Therapy Services | 10-1-17 |

Arkansas Medicaid conducts retrospective review of the first 90 minutes per week 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), 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. [View or print QIO contact information.](../../Links/AFMCretroPA.doc)

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.

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| 220.100 Occupational and Physical Therapy Guidelines | 10-1-17 |

A. Medical Necessity

Occupational and physical therapy services must be medically necessary to the treatment of the individual’s illness or injury. A diagnosis alone is not sufficient documentation to support the medical necessity of therapy. 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).

B. Evaluation and Report Components

To establish medical necessity, a comprehensive assessment in the suspected area of deficit must be performed. A comprehensive assessment must include:

1. Date of evaluation.

2. Child’s name and date of birth.

3. Diagnosis specific to therapy.

4. Background information including pertinent medical history; and, if the child is 12 months of age or younger, gestational age. The child should be tested in the child’s dominant language; if not, an explanation must be provided in the evaluation.

NOTE: To calculate a child’s gestational age, subtract the number of weeks born before 40 weeks of gestation from the chronological age. Therefore, a 7-month-old, former 28 week gestational age infant has a corrected age of 4 months according to the following equation:

7 months - [(40 weeks) - 28 weeks) / 4 weeks]

7 months - [(12) / 4 weeks]

7 months - [3]

4 months

5. Standardized test results, including all subtest scores, if applicable. 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.

6. If applicable, test results should be adjusted for prematurity (less than 37 weeks gestation) if the child is 12 months of age or younger, and this should be noted in the evaluation.

7. 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 (strengths and weaknesses).

8. An interpretation of the results of the evaluation, including recommendations for therapy/minutes per week.

9. A description of functional strengths and limitations, a suggested treatment plan and potential goals to address each identified problem.

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

C. Interpretation and Eligibility: Ages Birth to 21

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

2. Tests must be age appropriate for the child being tested.

3. All subtests, components and scores must be reported for all tests used for eligibility purposes.

4. Eligibility for therapy will be based upon a score of -1.5 standard deviations (SD) below the mean or greater in at least one subtest area or composite score on a norm-referenced, standardized test. When a -1.5 SD or greater is not indicated by the test, a criterion-referenced test along with informed clinical opinion must be included to support the medical necessity of 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 ”Accepted Tests” sections for a list of standardized tests accepted by the Arkansas Medicaid program.

7. Range of Motion: A limitation of greater than ten degrees and/or documentation of how deficit limits function.

8. Muscle Tone: Modified Ashworth Scale.

9. 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.

10. 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.

11. Children (birth to age 21) receiving services outside of the public schools must be evaluated annually.

12. Children (birth to age 2) in the Child Health Management Services (CHMS) program must be evaluated every 6 months.

13. Children (age three to 21) receiving services within public schools, as a part of an Individual Program Plan (IPP) or an Individual Education Plan (IEP), must have a full evaluation every three years; however, an annual update of progress is required.

D. Frequency, Intensity and Duration of Physical and/or Occupational Therapy Services

The 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 that are 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 performed safely and effectively.

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, then services should be discontinued and monitoring or establishment of a home program should be implemented.

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 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.

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| 220.110 Accepted Tests for Occupational Therapy | 3-15-12 |

To view the current list of accepted tests for Occupational Therapy, refer to Section 214.310 of the Occupational, Physical, Speech Therapy Services manual.

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| 220.120 Accepted Tests for Physical Therapy | 3-15-12 |

To view the current list of accepted tests for Physical Therapy, refer to Section 214.320 of the Occupational, Physical, Speech Therapy Services manual.

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| 220.200 Speech-Language Therapy Guidelines | 10-1-17 |

A. Medical Necessity

Speech-language therapy services must be medically necessary to the treatment of the individual’s illness or injury. A diagnosis alone is not sufficient documentation to support the medical necessity of therapy. 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).

B. Types of Communication Disorders

1. Language Disorders — Impaired comprehension and/or use of spoken, written and/or other symbol systems. This disorder may involve the following components: forms of language (phonology, morphology, syntax), content and meaning of language (semantics, prosody), function of language (pragmatics) and/or the perception/processing of language. Language disorders may involve one, all or a combination of the above components.

2. Speech Production Disorders — Impairment of the articulation of speech sounds, voice and/or fluency. Speech Production disorders may involve one, all or combination of these components of the speech production system.

An articulation disorder may manifest as an individual sound deficiency, i.e., traditional articulation disorder, incomplete or deviant use of the phonological system, i.e. phonological disorder, or poor coordination of the oral-motor mechanism for purposes of speech production, i.e. verbal and/or oral apraxia, dysarthria.

3. Oral Motor/Swallowing/Feeding Disorders — Impairment of the muscles, structures and/or functions of the mouth (physiological or sensory-based) involved with the entire act of deglutition from placement and manipulation of food in the mouth through the oral and pharyngeal phases of the swallow. These disorders may or may not result in deficits to speech production.

C. Evaluation and Report Components

1. STANDARDIZED SCORING KEY:

Mild: Scores between 84-78; -1.0 standard deviation

Moderate: Scores between 77-71; -1.5 standard deviations

Severe: Scores between 70-64; -2.0 standard deviations

Profound: Scores of 63 or lower; -2.0+ standard deviations

2. LANGUAGE: To establish medical necessity, results from a comprehensive assessment in the suspected area of deficit must be reported. (Refer to Section 220.200, part D, paragraphs 9-12 for required frequency of re-evaluations.) A comprehensive assessment for language disorder must include:

a. Date of evaluation.

b. Child’s name and date of birth.

c. Diagnosis specific to therapy.

d. Background information including pertinent medical history; and, if the child is 12 months of age or younger, gestational age. The child should be tested in the child’s dominant language; if not, an explanation must be provided in the evaluation.

NOTE: To calculate a child’s gestational age, subtract the number of weeks born before 40 weeks of gestation from the chronological age. Therefore, a 7-month-old, former 28 week gestational age infant has a corrected age of 4 months according to the following equation:

7 months - [(40 weeks) - 28 weeks) / 4 weeks]

7 months - [(12) / 4 weeks]

7 months - [3]

4 months

e. Results from an assessment specific to the suspected type of language disorder, including all relevant scores, quotients and/or indexes, if applicable. A comprehensive measure of language must be included for initial evaluations. Use of one-word vocabulary tests alone will not be accepted. (To view a current list of Accepted Tests for Speech-Language Therapy, refer to Section 214.410 of the Occupational, Physical, Speech Therapy Services Manual.)

f. If applicable, test results should be adjusted for prematurity (less than 37 weeks gestation) if the child is 12 months of age or younger, and this should be noted in the evaluation.

g. Oral-peripheral speech mechanism examination, which includes a description of the structure and function of the orofacial structures.

h. Formal or informal assessment of hearing, articulation, voice and fluency skills.

i. An interpretation of the results of the evaluation including recommendations for frequency and intensity of treatment.

j. A description of functional strengths and limitations, a suggested treatment plan and potential goals to address each identified problem.

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

3. SPEECH PRODUCTION (Articulation, Phonological, Apraxia): To establish medical necessity, results from a comprehensive assessment in the suspected area of deficit must be reported. (Refer to Section 220.200, part D, paragraphs 9-12 for required frequency of re-evaluations.) A comprehensive assessment for Speech Production (Articulation, Phonological, Apraxia) disorder must include:

a. Date of evaluation.

b. Child’s name and date of birth.

c. Diagnosis specific to therapy.

d. Background information including pertinent medical history; and, if the child is 12 months of age or younger, gestational age. The child should be tested in the child’s dominant language; if not, an explanation must be provided in the evaluation.

NOTE: To calculate a child’s gestational age, subtract the number of weeks born before 40 weeks of gestation from the chronological age. Therefore, a 7-month-old, former 28 week gestational age infant has a corrected age of 4 months according to the following equation:

7 months - [(40 weeks) - 28 weeks) / 4 weeks]

7 months - [(12) / 4 weeks]

7 months - [3]

4 months

e. Results from an assessment specific to the suspected type of speech production disorder, including all relevant scores, quotients and/or indexes, if applicable. All errors specific to the type of speech production disorder must be reported (e.g., positions, processes, motor patterns). (To view a current list of Accepted Tests for Speech-Language Therapy, refer to Section 214.410 of the Occupational, Physical, Speech Therapy Services Manual.)

f. If applicable, test results should be adjusted for prematurity (less than 37 weeks gestation) if the child is 12 months of age or younger, and this should be noted in the evaluation.

g. Oral-peripheral speech mechanism examination, which includes a description of the structure and function of orofacial structures.

h. Formal screening of language skills. Examples include, but are not limited to, the Fluharty-2, KLST-2, CELF-4 Screen or TTFC.

i. Formal or informal assessment of hearing, voice and fluency skills.

j. An interpretation of the results of the evaluation including recommendations for frequency and intensity of treatment.

k. A description of functional strengths and limitations, a suggested treatment plan and potential goals to address each identified problem.

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

4. SPEECH PRODUCTION (Voice): To establish medical necessity, results from a comprehensive assessment in the suspected area of deficit must be reported. (Refer to Section 220.200, part D, paragraphs 9-12 for required frequency of re-evaluations.) A comprehensive assessment for Speech Production (Voice) disorder must include:

a. A medical evaluation to determine the presence or absence of a physical etiology as a prerequisite for evaluation of voice disorder.

b. Date of evaluation.

c. Child’s name and date of birth.

d. Diagnosis specific to therapy.

e. Background information including pertinent medical history; and, if the child is 12 months of age or younger, gestational age. The child should be tested in the child’s dominant language; if not, an explanation must be provided in the evaluation.

NOTE: To calculate a child’s gestational age, subtract the number of weeks born before 40 weeks of gestation from the chronological age. Therefore, a 7-month-old, former 28 week gestational age infant has a corrected age of 4 months according to the following equation:

7 months - [(40 weeks) - 28 weeks) / 4 weeks]

7 months - [(12) / 4 weeks]

7 months - [3]

4 months

f. Results from an assessment relevant to the suspected type of speech production disorder, including all relevant scores, quotients and/or indexes, if applicable. (To view a current list of Accepted Tests for Speech-Language Therapy, refer to Section 214.410 of the Occupational, Physical, Speech Therapy Services Manual.)

g. If applicable, test results should be adjusted for prematurity (less than 37 weeks gestation) if the child is12 months of age or younger, and this should be noted in the evaluation.

h. Oral-peripheral speech mechanism examination, which includes a description of the structure and function of orofacial structures.

i. Formal screening of language skills. Examples include, but are not limited to, the Fluharty-2, KLST-2, CELF-4 Screen or TTFC.

j. Formal or informal assessment of hearing, articulation and fluency skills.

k. An interpretation of the results of the evaluation including recommendations for frequency and intensity of treatment.

l. A description of functional strengths and limitations, a suggested treatment plan and potential goals to address each identified problem.

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

5. SPEECH PRODUCTION (Fluency): To establish medical necessity, results from a comprehensive assessment in the suspected area of deficit must be reported. (Refer to Section 220.200, part D, paragraphs 9-12 for required frequency of re-evaluations.) A comprehensive assessment for Speech Production (Fluency) disorder must include:

a. Date of evaluation.

b. Child’s name and date of birth.

c. Diagnosis specific to therapy.

d. Background information including pertinent medical history; and, if the child is 12 months of age or younger, gestational age. The child should be tested in the child’s dominant language; if not, an explanation must be provided in the evaluation.

NOTE: To calculate a child’s gestational age, subtract the number of weeks born before 40 weeks of gestation from the chronological age. Therefore, a 7-month-old, former 28 week gestational age infant has a corrected age of 4 months according to the following equation:

7 months - [(40 weeks) - 28 weeks) / 4 weeks]

7 months - [(12) / 4 weeks]

7 months - [3]

4 months

e. Results from an assessment specific to the suspected type of speech production disorder, including all relevant scores, quotients and/or indexes, if applicable. (To view a current list of Accepted Tests for Speech-Language Therapy, refer to Section 214.410 of the Occupational, Physical, Speech Therapy Services Manual.)

f. If applicable, test results should be adjusted for prematurity (less than 37 weeks gestation) if the child is12 months of age or younger, and this should be noted in the evaluation.

g. Oral-peripheral speech mechanism examination, which includes a description of the structure and function of orofacial structures.

h. Formal screening of language skills. Examples include, but are not limited to, the Fluharty-2, KLST-2, CELF-4 Screen or TTFC.

i. Formal or informal assessment of hearing, articulation and voice skills.

j. An interpretation of the results of the evaluation including recommendations for frequency and intensity of treatment.

k. A description of functional strengths and limitations, a suggested treatment plan and potential goals to address each identified problem.

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

6. ORAL MOTOR/SWALLOWING/FEEDING: To establish medical necessity, results from a comprehensive assessment in the suspected area of deficit must be reported. (Refer to Section 220.200, part D, paragraphs 9-12 for required frequency of re-evaluations.) A comprehensive assessment for Oral Motor/Swallowing/Feeding disorder must include:

a. Date of evaluation.

b. Child’s name and date of birth.

c. Diagnosis specific to therapy.

d. Background information including pertinent medical history; and, if the child is 12 months of age or younger, gestational age. The child should be tested in the child’s dominant language; if not, an explanation must be provided in the evaluation.

NOTE: To calculate a child’s gestational age, subtract the number of weeks born before 40 weeks of gestation from the chronological age. Therefore, a 7-month-old, former 28 week gestational age infant has a corrected age of 4 months according to the following equation:

7 months - [(40 weeks) - 28 weeks) / 4 weeks]

7 months - [(12) / 4 weeks]

7 months - [3]

4 months

e. Results from an assessment specific to the suspected type of oral motor/swallowing/feeding disorder, including all relevant scores, quotients and/or indexes, if applicable. . (To view a current list of Accepted Tests for Speech-Language Therapy, refer to Section 214.410 of the Occupational, Physical, Speech Therapy Services Manual.)

f. f swallowing problems and/or signs of aspiration are noted, then include a statement indicating that a referral for a videofluoroscopic swallow study has been made.

g. If applicable, test results should be adjusted for prematurity (less than 37 weeks gestation) if the child is 12 months of age or younger, and this should be noted in the evaluation.

h. Formal or informal assessment of hearing, language, articulation, voice and fluency skills.

i. An interpretation of the results of the evaluation including recommendations for frequency and intensity of treatment.

j. A description of functional strengths and limitations, a suggested treatment plan and potential goals to address each identified problem.

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

D. Interpretation and Eligibility: Ages Birth to 21

1. LANGUAGE: Two language composite or quotient scores (i.e., normed or standalone) in the area of suspected deficit must be reported, with at least one being a norm-referenced, standardized test with good reliability and validity. (Use of two one-word vocabulary tests alone will not be accepted.)

a. For children age birth to three: criterion-referenced tests will be accepted as a second measure for determining eligibility for language therapy.

b. For children age three to 21, criterion-referenced tests will not be accepted as a second measure when determining eligibility for language therapy. (When use of standardized instruments is not appropriate, see Section 220.200, part D, paragraph 8).

c. Age birth to three: Eligibility for language therapy will be based upon a composite or quotient score that is -1.5 standard deviations (SD) below the mean or greater from a norm-referenced, standardized test, with corroborating data from a criterion-referenced measure. When these two measures do not agree, results from a third measure that corroborate the identified deficits are required to support the medical necessity of services.

d. Age three to 21: Eligibility for language therapy will be based upon 2 composite or quotient scores that are -1.5 standard deviations (SD) below the mean or greater. When -1.5 SD or greater is not indicated by both of these scores, a third standardized score indicating a -1.5 SD or greater is required to support the medical necessity of services.

2. ARTICULATION AND/OR PHONOLOGY: Two tests and/or procedures must be administered, with at least one being from a norm-referenced, standardized test with good reliability and validity.

Eligibility for articulation and/or phonological therapy will be based upon standard scores (SS) of -1.5 SD or greater below the mean from two tests. When -1.5 SD or greater is not indicated by both of these tests, corroborating data from accepted procedures can be used to support the medical necessity of services. (To view a current list of Accepted Tests for Speech-Language Therapy, refer to Section 214.410 of the Occupational, Physical, Speech Therapy Services Manual).

3. APRAXIA: Two tests and/or procedures must be administered, with at least one being a norm-referenced, standardized test with good reliability and validity.

Eligibility for apraxia therapy will be based upon standard scores (SS) of -1.5 SD or greater below the mean from two tests. When -1.5 SD or greater is not indicated by both of these tests, corroborating data from a criterion-referenced test and/or accepted procedures can be used to support the medical necessity of services. (To view a current list of Accepted Tests for Speech-Language Therapy, refer to Section 214.410 of the Occupational, Physical, Speech Therapy Services Manual.)

4. VOICE: Due to the high incidence of medical factors that contribute to voice deviations, a medical evaluation is a requirement for eligibility for voice therapy.

Eligibility for voice therapy will be based upon a medical referral for therapy and a functional profile of voice parameters that indicates a moderate or severe deficit/disorder.

5. FLUENCY: At least one norm-referenced, standardized test with good reliability and validity, and at least one supplemental tool to address affective components.

Eligibility for fluency therapy will be based upon an SS of -1.5 SD below the mean or greater on the standardized test.

6. ORAL MOTOR/SWALLOWING/FEEDING: An in-depth, functional profile of oral motor structures and function.

Eligibility for oral-motor/swallowing/feeding therapy will be based upon an in-depth functional profile of oral motor structures and function using a thorough protocol (e.g., checklist, profile) that indicates a moderate or severe deficit or disorder. When moderate or severe aspiration has been confirmed by videofluoroscopic swallow study, the patient can be treated for pharyngeal dysphagia via the recommendations set forth in the swallow study report.

7. All subtests, components and scores must be reported for all tests used for eligibility purposes.

8. When administration of standardized, norm-referenced instruments is inappropriate, the provider must submit an in-depth functional profile of the child’s communication abilities. An in-depth functional profile is a detailed narrative or description of a child’s communication behaviors that specifically explains and justifies the following:

a. The reason standardized testing is inappropriate for this child,

b. The communication impairment, including specific skills and deficits, and

c. The medical necessity of therapy.

d. Supplemental instruments from Accepted Tests for Speech-Language Therapy may be useful in developing an in-depth functional profile.

9. Children (birth to age 21) receiving services outside of the schools must be evaluated annually.

10. Children (birth to 24 months) in the Child Health Management Services (CHMS) Program must be evaluated every 6 months.

11. Children (age three to 21) receiving services within schools as part of an Individual Program Plan (IPP) or an Individual Education Plan (IEP) must have a full evaluation every three years; however, an annual update of progress is required.

12. Children (age three to 21) receiving privately contracted services, apart from or in addition to those within the schools, must have a full evaluation annually.

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

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 speech-language pathologist co-sign progress notes.

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| 220.210 Accepted Tests for Speech-Language Therapy | 3-15-12 |

To view a current list of accepted tests for Speech-Language Therapy, refer to Section 214.410 of the Occupational, Physical, Speech Therapy Services manual.

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| 220.220 Intelligence Quotient (IQ) Testing | 11-1-10 |

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

| Test | Abbreviation |
| --- | --- |
| Stanford-Binet | S-B |
| The Wechsler Preschool & Primary Scales of Intelligence, Revised | WPPSI-R |
| Slosson |  |
| Wechsler Intelligence Scale for Children, Third Edition | WISC-III |
| Kauffman Adolescent & Adult Intelligence Test | KAIT |
| Wechsler Adult Intelligence Scale, Third Edition | WAIS-III |
| Differential Ability Scales | DAS |
| Reynolds Intellectual Assessment Scales | RIAS |

B. Severe and Profound IQ Test/Non-Traditional — Supplemental — Norm-Reference

| Test | Abbreviation |
| --- | --- |
| Comprehensive Test of Nonverbal Intelligence | CTONI |
| Test of Nonverbal Intelligence — 1997 | TONI-3 |
| Functional Linguistic Communication Inventory | FLCI |

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| 221.000 Recoupment Process | 7-1-15 |

The Division of Medical Services (DMS), Utilization Review Section (UR) is required to initiate the recoupment process for all services denied by the Arkansas Medicaid programs’ contracted Quality Improvement Organization (QIO) for retrospective therapy reviews for not meeting the medical necessity requirement. Based on QIO findings during retrospective reviews, UR will initiate recoupment 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.

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| 240.000 PRIOR AUTHORIZATION | 10-1-17 |

Prior authorization is not required for DDTCS core service or for the first 90 minutes per week of occupational, physical and speech therapy services.

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| 250.000 REIMBURSEMENT |  |
| 251.000 Method of Reimbursement | 10-13-03 |

The reimbursement methodology for DDTCS services is a “fee schedule” methodology. Under the fee schedule methodology, reimbursement is made at the lower of the billed charge for each procedure or the maximum allowable for each procedure. The maximum allowable fee for a procedure is the same for all DDTCS providers.

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| 251.010 Fee Schedules | 12-1-12 |

Arkansas Medicaid provides fee schedules on the Arkansas Medicaid website. The fee schedule link is located at [https://www.medicaid.state.ar.us](https://www.medicaid.state.ar.us/) under the provider manual section. The fees represent the fee-for-service reimbursement methodology.

Fee schedules do not address coverage limitations or special instructions applied by Arkansas Medicaid before final payment is determined.

Procedure codes and/or fee schedules do not guarantee payment, coverage or amount allowed. Information may be changed or updated at any time to correct a discrepancy and/or error. Arkansas Medicaid always reimburses the lesser of the amount billed or the Medicaid maximum.

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| 252.000 Rate Appeal Process | 11-1-06 |

A provider may request reconsideration of a Program decision by writing to the Assistant Director, Division of Medical Services. This request must be received within 20 calendar days following the application of policy and/or procedure or the notification of the provider of its rate.

Upon receipt of the request for review, the Assistant Director will determine the need for a Program/Provider conference and will contact the provider to arrange a conference if needed. Regardless of the Program decision, the provider will be afforded the opportunity of a conference, for a full explanation of the factors involved and the Program decision.

Following review of the matter, the Assistant Director will notify the provider of the action to be taken by the Division within 20 calendar days of receipt of the request for review or the date of the Program/Provider conference.

If the provider disagrees with the decision made by the Assistant Director, the provider may appeal the question to a standing Rate Review Panel established by the Director of the Division of Medical Services. The Rate Review Panel will include one member of the Division of Medical Services, a representative of the provider association and a member of the Department of Health and Human Services (DHHS) management staff, who will serve as chairperson.

The request for review by the Rate Review Panel must be postmarked within 15 calendar days following the notification of the initial decision by the Assistant Director. The Rate Review Panel will meet to consider the question(s) within 15 calendar days after receipt of a request for such appeal. The panel will hear the question(s) and will submit a recommendation to the Director.

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| 260.000 BILLING PROCEDURES |  |
| 262.000 CMS-1500 Billing Procedures |  |
| 262.100 DDTCS Core Services Procedure Codes | 12-5-05 |

DDTCS core services are reimbursable on a per unit basis. Partial units are not reimbursable. Service time less than a full unit of service may not be rounded up to a full unit of service and may not be carried over to the next service date.

| Procedure Code | Required Modifier | Description |
| --- | --- | --- |
| T1015 | U4 | Early Intervention Services (1 unit equals 1 encounter of two hours or more; maximum of 1 unit per day.) |
| T1015 | — | Adult Development Services (1 unit equals 1 hour of service; maximum of 5 cumulative units per day.) |
| T1015 | U1 | Pre-School Services (1 unit equals 1 hour of service; maximum of 5 cumulative units per day.) |
| T1023 | UB | Diagnosis and Evaluation Services (not to be billed for therapy evaluations) (1 unit equals 1 hour of service; maximum of 1 unit per date of service.) |

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| 262.110 Occupational, Physical and Speech Therapy Procedure Codes | 7-1-17 |

DDTCS therapy services may be provided only outside the time DDTCS core services are furnished. The following procedure codes must be used for therapy services in the DDTCS Program for Medicaid beneficiaries of all ages.

A. Occupational Therapy Procedure Codes

| Procedure Code | Required Modifier(s) | Description |
| --- | --- | --- |
| 97003 | — | Evaluation for occupational therapy (30-minute unit; maximum of 4 units per state fiscal year, July 1 through June 30) |
| 97150 | U1, UB | Group occupational therapy by occupational therapy assistant (15-minute unit; maximum of 6 units per week, maximum of 4 clients per group) |
| 97150 | U2 | Group occupational therapy by Occupational Therapist (15-minute unit; maximum of 6 units per week, maximum of 4 clients per group) |
| 97530 | — | Individual occupational therapy by Occupational Therapist (15-minute unit; maximum of 6 units per week) |
| 97530 | UB | Individual occupational therapy by occupational therapy assistant (15-minute unit; maximum of 6 units per week) |

B. Physical Therapy Procedure Codes

| Procedure Code | Required Modifier(s) | Description |
| --- | --- | --- |
| 97001 | — | Evaluation for physical therapy (30-minute unit; maximum of 4 units per state fiscal year, July 1 through June 30) |
| 97110 | — | Individual physical therapy by Physical Therapist (15-minute unit; maximum of 6 units per week) |
| 97110 | UB | Individual physical therapy by physical therapy assistant (15-minute unit; maximum of 6 units per week) |
| 97150 | — | Group physical therapy by Physical Therapist (15-minute unit; maximum of 6 units per week, maximum of 4 clients per group) |
| 97150 | UB | Group physical therapy by physical therapy assistant (15‑minute unit; maximum of 6 units per week, maximum of 4 clients per group) |

C. Speech Therapy Procedure Codes

| Procedure Code | Required Modifier(s) | Description |
| --- | --- | --- |
| 92521 | UA | ⁂Evaluation of speech fluency (e.g. stuttering, cluttering) (maximum of four 30-minute units per state fiscal year, July 1 through June 30) |
| 92522 | UA | ⁂Evaluation of speech sound production (e.g. articulation, phonological process, apraxia, dysarthria) (maximum of four 30-minute units per state fiscal year, July 1 through June 30) |
| 92523 | UA | ⁂Evaluation of speech sound production (e.g. articulation, phonological process, apraxia, dysarthria) with evaluation of language comprehension and expression (e.g. receptive and expressive language) (maximum of four 30-minute units per state fiscal year, July 1 through June 30) |
| 92524 | UA | ⁂Behavioral and qualitative analysis of voice and resonance (maximum of four 30-minute units per state fiscal year, July 1 through June 30) |
| 92507 | — | Individual speech session by Speech Therapist (15-minute unit; maximum of 6 units per week) |
| 92507 | UB | Individual speech therapy by speech language pathology assistant (15-minute unit; maximum of 6 units per week) |
| 92508 | — | Group speech session by Speech Therapist (15-minute unit; maximum of 6 units per week, maximum of 4 clients per group) |
| 92508 | UB | Group speech therapy by speech language pathology assistant (15-minute unit; maximum of 6 units per week, maximum of 4 clients per group) |

NOTE: ⁂(…) This symbol, along with text in parentheses, indicates the Arkansas Medicaid description of the service. When using a procedure code with this symbol, the service must meet the indicated Arkansas Medicaid description.

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| 262.200 National Place of Service (POS) Codes | 7-1-07 |

Listed below is the National Place of Service (POS) Code for DDTCS procedures.

Electronic and paper claims now require the same National Place of Service code.

| Place of Service | POS Codes |
| --- | --- |
| Day Care Facility/DDTCS Clinic | 99 |

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| --- | --- |
| 262.300 Billing Instructions – Paper Only | 11-1-17 |

Bill Medicaid for professional services with form CMS-1500. The numbered items in the following instructions correspond to the numbered fields on the claim form. [View a sample form CMS-1500.](../../Forms/SampleCMS-1500.pdf)

Carefully follow these instructions to help the Arkansas Medicaid fiscal agent efficiently process claims. Accuracy, completeness, and clarity are essential. Claims cannot be processed if necessary information is omitted.

Forward completed claim forms to the Claims Department. [View or print the Claims Department contact information.](../../Links/Claims.doc)

NOTE: A provider delivering services without verifying beneficiary eligibility for each date of service does so at the risk of not being reimbursed for the services.

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| 262.310 Completion of the CMS-1500 Claim Form | 9-1-14 |

| Field Name and Number | | Instructions for Completion |
| --- | --- | --- |
| 1. (type of coverage) | | Not required. |
| 1a. INSURED’S I.D. NUMBER (For Program in Item 1) | | Beneficiary’s or participant’s 10-digit Medicaid or ARKids First-A or ARKids First-B identification number. |
| 2. PATIENT’S NAME (Last Name, First Name, Middle Initial) | | Beneficiary’s or participant’s last name and first name. |
| 3. PATIENT’S BIRTH DATE | | Beneficiary’s or participant’s date of birth as given on the individual’s Medicaid or ARKids First-A or ARKids First-B identification card. Format: MM/DD/YY. |
| SEX | | Check M for male or F for female. |
| 4. INSURED’S NAME (Last Name, First Name, Middle Initial) | | Required if insurance affects this claim. Insured’s last name, first name, and middle initial. |
| 5. PATIENT’S ADDRESS (No., Street) | | Optional. Beneficiary’s or participant’s completemailing address (street address or post office box). |
| CITY | | Name of the city in which the beneficiary or participant resides. |
| STATE | | Two-letter postal code for the state in which the beneficiary or participant resides. |
| ZIP CODE | | Five-digit zip code; nine digits for post office box. |
| TELEPHONE (Include Area Code) | | The beneficiary’s or participant’s telephone number or the number of a reliable message/contact/ emergency telephone. |
| 6. PATIENT RELATIONSHIP TO INSURED | | If insurance affects this claim, check the box indicating the patient’s relationship to the insured. |
| 7. INSURED’S ADDRESS (No., Street) | | Required if insured’s address is different from the patient’s address. |
| CITY | |  |
| STATE | |  |
| ZIP CODE | |  |
| TELEPHONE (Include Area Code) | |  |
| 8. RESERVED | | Reserved for NUCC use. |
| 9. OTHER INSURED’S NAME (Last name, First Name, Middle Initial) | | If patient has other insurance coverage as indicated in Field 11d, the other insured’s last name, first name, and middle initial. |
| a. OTHER INSURED’S POLICY OR GROUP NUMBER | | Policy and/or group number of the insured individual. |
| b. RESERVED | | Reserved for NUCC use. |
| SEX | | Not required. |
| c. RESERVED | | Reserved for NUCC use. |
| d. INSURANCE PLAN NAME OR PROGRAM NAME | | Name of the insurance company. |
| 10. IS PATIENT’S CONDITION RELATED TO: | |  |
| a. EMPLOYMENT? (Current or Previous) | | Check YES or NO. |
| b. AUTO ACCIDENT? | | Required when an auto accident is related to the services. Check YES or NO. |
| PLACE (State) | | If 10b is YES, the two-letter postal abbreviation for the state in which the automobile accident took place. |
| c. OTHER ACCIDENT? | | Required when an accident other than automobile is related to the services. Check YES or NO. |
| d. CLAIMS CODES | | The “Claim Codes” identify additional information about the beneficiary’s condition or the claim. When applicable, use the Claim Code to report appropriate claim codes as designated by the NUCC. When required to provide the subset of Condition Codes, enter the condition code in this field. The subset of approved Condition Codes is found at [www.nucc.org](http://www.nucc.org/) under Code Sets. |
| 11. INSURED’S POLICY GROUP OR FECA NUMBER | | Not required when Medicaid is the only payer. |
| a. INSURED’S DATE OF BIRTH | | Not required. |
| SEX | | Not required. |
| b. OTHER CLAIM ID NUMBER | | Not required. |
| c. INSURANCE PLAN NAME OR PROGRAM NAME | | Not required. |
| d. IS THERE ANOTHER HEALTH BENEFIT PLAN? | | When private or other insurance may or will cover any of the services, check YES and complete items 9, 9a and 9d. Only one box can be marked. |
| 12. PATIENT’S OR AUTHORIZED PERSON’S SIGNATURE | | Enter “Signature on File,” “SOF” or legal signature. |
| 13. INSURED’S OR AUTHORIZED PERSON’S SIGNATURE | | Enter “Signature on File,” “SOF” or legal signature. |
| 14. DATE OF CURRENT:  ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP) | | Required when services furnished are related to an accident, whether the accident is recent or in the past. Date of the accident.  Enter the qualifier to the right of the vertical dotted line. Use Qualifier 431 Onset of Current Symptoms or Illness; 484 Last Menstrual Period. |
| 15. OTHER DATE | | Enter another date related to the beneficiary’s condition or treatment. Enter the qualifier between the left-hand set of vertical, dotted lines.  The “Other Date” identifies additional date information about the beneficiary’s condition or treatment. Use qualifiers:  454 Initial Treatment  304 Latest Visit or Consultation  453 Acute Manifestation of a Chronic Condition  439 Accident  455 Last X-Ray  471 Prescription  090 Report Start (Assumed Care Date)  091 Report End (Relinquished Care Date)  444 First Visit or Consultation |
| 16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION | | Not required. |
| 17. NAME OF REFERRING PROVIDER OR OTHER SOURCE | | Referring physician’s name and title. DDTCS optional therapy services require primary care physician (PCP) referral. |
| 17a. (blank) | | Not required. |
| 17b. NPI | | Enter NPI of the referring physician. |
| 18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES | | When the serving/billing provider’s services charged on this claim are related to a beneficiary’s or participant’s inpatient hospitalization, enter the individual’s admission and discharge dates. Format: MM/DD/YY. |
| 19. ADDITIONAL CLAIM INFORMATION | For tracking purposes, DDTCS providers are required to enter one of the following therapy codes: | | |
| Code | Category | | |
| A | Individuals from birth through 2 years who are receiving therapy services under an Individualized Family Services Plan (IFSP) through the Division of Developmental Disabilities Services. | | |
| B | Individuals ages 0 through 5 years (if individual has not reached age 5 by September 15) who are receiving therapy services under an Individualized Plan (IP) through the Division of Developmental Disabilities Services. | | |
|  | **NOTE: This code is to be used only when all three of the following conditions are in place: 1) the individual receiving services has not attained age 5 by September 15 of the current school year, 2) the individual receiving services is receiving the services under an Individualized Plan and 3) the Individualized Plan is through the Division of Developmental Disabilities Services.** | | |
| When using code C or D, providers must also include the 4-digit LEA (local education agency) code assigned to each school district. For example: C1234 |  | | |
| C (and 4-digit LEA code) | Individuals ages 3 through 5 years (if individual has not reached age 5 by September 15) who are receiving therapy services under an Individualized Education Plan (IEP) through an education service cooperative. | | |
|  | **NOTE: This code is to be used only when all three of the following conditions are in place: 1) the individual receiving services is between the ages of 3 through 5 years and has not attained age 5 by September 15 of the current school year, 2) the individual receiving services is receiving the services under an Individualized Education Plan and 3) the Individualized Education Plan is through an education service cooperative.** | | |
| D (and 4-digit LEA code) | Individuals aged 5 (by September 15) to 21 years who are receiving therapy services under an Individualized Education Plan (IEP) through a school district. | | |
|  | **NOTE: This code is to be used only when all three of the following conditions are in place: 1) the individual receiving services is between the ages of 5 (by September 15 of the current school year) to 21 years, 2) the individual receiving services is receiving the services under an Individualized Education Plan and 3) the Individualized Education Plan is through a school district.** | | |
| E | Individuals aged 18 years and up who are receiving therapy services through the Division of Developmental Disabilities Services. | | |
| F | Individuals aged 18 years and up who are receiving therapy services through individual or group providers not included in any of the previous categories (A-E). | | |
| G | Individuals aged birth through 17 years who are receiving therapy/pathology services through individual or group providers not included in any of the previous categories (A-F). | | |
| 20. OUTSIDE LAB? | | Not required. |
| $ CHARGES | | Not required. |
| 21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY | | Enter the applicable ICD indicator to identify which version of ICD codes is being reported.  Use “9” for ICD-9-CM.  Use “0” for ICD-10-CM.  Enter the indicator between the vertical, dotted lines in the upper right-hand portion of the field.  Diagnosis code for the primary medical condition for which services are being billed. Use the appropriate International Classification of Diseases (ICD). List no more than 12 diagnosis codes. Relate lines A-L to the lines of service in 24E by the letter of the line. Use the highest level of specificity. |
| 22. RESUBMISSION CODE | | Reserved for future use. |
| ORIGINAL REF. NO. | | Any data or other information listed in this field does not/will not adjust, void or otherwise modify any previous payment or denial of a claim. Claim payment adjustments, voids and refunds must follow previously established processes in policy. |
| 23. PRIOR AUTHORIZATION NUMBER | | The prior authorization or benefit extension control number if applicable. |
| 24A. DATE(S) OF SERVICE | | The “from” and “to” dates of service for each billed service. Format: MM/DD/YY.  1. On a single claim detail (one charge on one line), bill only for services provided within a single calendar month.  2. Providers may bill on the same claim detail for two or more sequential dates of service within the same calendar month when the provider furnished equal amounts of the service on each day of the date sequence. |
| B. PLACE OF SERVICE | | Two-digit national standard place of service code. See Section 262.200 for codes. |
| C. EMG | | Enter “Y” for “Yes” or leave blank if “No.” EMG identifies if the service was an emergency. |
| D. PROCEDURES, SERVICES, OR SUPPLIES | |  |
| CPT/HCPCS | | Enter the correct CPT or HCPCS procedure code from Sections 262.100 through 262.110. |
| MODIFIER | | Enter the applicable modifier from Section 262.110. |
| E. DIAGNOSIS POINTER | | Enter the diagnosis code reference letter (pointer) as shown in Item Number 21 to relate to the date of service and the procedures performed to the primary diagnosis. When multiple services are performed, the primary reference letter for each service should be listed first; other applicable services should follow. The reference letter(s) should be A-L or multiple letters as applicable. The “Diagnosis Pointer” is the line letter from Item Number 21 that relates to the reason the service(s) was performed. |
| F. $ CHARGES | | The full charge for the service(s) totaled in the detail. This charge must be the usual charge to any client, patient, or other beneficiary of the provider’s services. |
| G. DAYS OR UNITS | | The units (in whole numbers) of service(s) provided during the period indicated in Field 24A of the detail. |
| H. EPSDT/Family Plan | | Enter E if the services resulted from a Child Health Services (EPSDT) screening/referral. |
| I. ID QUAL | | Not required. |
| J. RENDERING PROVIDER ID # | | Enter the 9-digit Arkansas Medicaid provider ID number of the individual who furnished the services billed for in the detail or |
| NPI | | Enter NPI of the individual who furnished the services billed for in the detail. |
| 25. FEDERAL TAX I.D. NUMBER | | Not required. This information is carried in the provider’s Medicaid file. If it changes, please contact Provider Enrollment. |
| 26. PATIENT’S ACCOUNT N O. | | Optional entry that may be used for accounting purposes; use up to 16 numeric or alphabetic characters. This number appears on the Remittance Advice as “MRN.” |
| 27. ACCEPT ASSIGNMENT? | | Not required. Assignment is automatically accepted by the provider when billing Medicaid. |
| 28. TOTAL CHARGE | | Total of Column 24F—the sum all charges on the claim. |
| 29. AMOUNT PAID | | Enter the total of payments previously received on this claim. Do not include amounts previously paid by Medicaid. \*Do not include in this total the automatically deducted Medicaid or co-payments. |
| 30. RESERVED | | Reserved for NUCC use. |
| 31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS | | The provider or designated authorized individual must sign and date the claim certifying that the services were personally rendered by the provider or under the provider’s direction. “Provider’s signature” is defined as the provider’s actual signature, a rubber stamp of the provider’s signature, an automated signature, a typewritten signature, or the signature of an individual authorized by the provider rendering the service. The name of a clinic or group is not acceptable. |
| 32. SERVICE FACILITY LOCATION INFORMATION | | If other than home or office, enter the name and street, city, state, and zip code of the facility where services were performed. |
| a. (blank) | | Not required. |
| b. (blank) | | Not required. |
| 33. BILLING PROVIDER INFO & PH # | | Billing provider’s name and complete address. Telephone number is requested but not required. |
| a. (blank) | | Enter NPI of the billing provider or |
| b. (blank) | | Enter the 9-digit Arkansas Medicaid provider ID number of the billing provider. |

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| 262.400 Special Billing Procedures | 11-1-06 |

Special billing procedures are not applicable to this program.