SECTION II - REHABILITATIVE HOSPITAL GENERAL INFORMATION CONTENTS

200.000 REHABILITATIVE HOSPITAL GENERAL INFORMATION

201.000 Arkansas Medicaid Participation Requirements for Rehabilitative Hospitals 10-13-03

Rehabilitative Hospital 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:

A. An in-state hospital must be licensed by the Arkansas Department of Health as a Rehabilitative Hospital. An out-of-state hospital must be licensed by the appropriate licensing agency within its home state as a Rehabilitative Hospital. A copy of the current license must accompany the provider application and Medicaid contract.

B. A hospital must be certified as a Rehabilitative Hospital Title XVIII (Medicare) provider in its home state. A copy of the current Medicare Certification must accompany the Medicaid application and contract.

201.001 Electronic Signatures 10-8-10

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

201.010 Providers in Arkansas and Bordering States 10-13-03

Rehabilitative Hospital 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.

201.011 Routine Services Provider 10-13-03

A. A provider may be enrolled in the program as a regular provider of all inpatient and outpatient hospital covered services if they meet all Arkansas Medicaid participation requirements outlined above.

B. Reimbursement may be available for all Rehabilitative Hospital services covered in the Arkansas Medicaid Program.

C. Claims must be filed according to the specifications in this manual.

201.020 Providers in Non-Bordering States 10-13-03

Rehabilitative Hospital providers in non-bordering states may be enrolled only as limited services providers.

201.021 Non-Bordering Out-of-State Limited Services Providers 3-1-11

A. Non-bordering out-of-state limited services providers may enroll in the Arkansas Medicaid program to provide prior authorized or emergency services only.

Emergency services are inpatient or outpatient hospital services that a prudent layperson with an average knowledge of health and medicine would reasonably believe are necessary to prevent death or serious impairment of health and which, because of the danger to life or health, must be obtained at the most accessible hospital available and equipped to furnish those services.
Source: 42 U.S. Code of Federal Regulations §422.2 and §424.101.

Prior authorized services are those that are medically necessary and are not available in Arkansas. Each request for these services must be made in writing, forwarded to Utilization Review Section and approved before the service is provided. To enroll, a non-bordering state provider must download an Arkansas Medicaid application and contract from the Arkansas Medicaid website and submit the application, contract and claim to Arkansas Medicaid Provider Enrollment. A provider number will be assigned upon approval of the application and contract. **View or print Utilization Review contact information**. **View or print the provider enrollment and contract package (Application Packet).** **View or print Medicaid Provider Enrollment Unit contact information.**

B. Non-bordering out-of-state limited services provider claims will be manually reviewed prior to processing to ensure that only emergency or prior authorized services are approved for payment. These claims should be mailed to the Arkansas Division of Medical Services, Program Communications Unit. **View or print Arkansas Division of Medical Services Program Communications contact information**.

202.000 Medical Records Rehabilitative Hospitals are Required to Keep 10-13-03

Rehabilitative hospitals are required to keep the following records and, upon request, furnish the records to authorized representatives of the Arkansas Division of Medical Services, the State

Medicaid Fraud Control Unit and representatives of the Department of Health and Human Services and the Centers for Medicare and Medicaid Services:

A. History and physical examination at time of admission

B. Chief complaint at time of admission, including admitting diagnosis

C. Tests and results during hospitalization

D. Progress notes by attending physician

E. Signature or initials of patient's physician after each visit

F. Physician's orders

G. Nurses' notes

H. Operative report (if applicable)

I. Tissue report (if applicable)

J. Discharge orders

K. Pharmacy and drug records

L. Discharge summary

M. All Utilization Review (UR) documentation made by the UR coordinator and/or physician advisor during patient's hospitalization.

202.100 Reserved 11-1-09

203.000 Physician's Role in Rehabilitative Hospital Services 10-13-03

Rehabilitative hospital services are covered by Medicaid for eligible beneficiaries when medically necessary. The care and treatment of the patient must be under the direction of a licensed practitioner (physician or dentist with hospital staff affiliation).

If a stay is determined to be medically unnecessary by the QIO, the Medicaid Peer Review Committee or the Medical Director for the Medicaid Program, Medicaid will not reimburse the physician or the hospital and the patient may not be billed.

210.000 PROGRAM COVERAGE

211.000 Introduction and Definitions 10-13-03

Rehabilitative services are medical or remedial services recommended by a physician or other licensed practitioner of the healing arts, within the scope of his or her practice under State law, for maximum reduction of physical or mental disability and restoration of an individual to his or her best possible functional level.

Medicaid coverage is based on medical necessity.

A patient is an individual who is receiving needed professional services that are directed by a licensed practitioner of the healing arts toward the maintenance, improvement, or protection of health, or lessening of illness, disability or pain.

An inpatient is a patient who has been admitted to a medical institution as an inpatient on recommendation of a physician or dentist and who:

A. Receives room, board and professional services in the institution for a 24-hour period or longer, or

B. Is expected by the institution to receive room, board and professional services in the institution for a 24-hour period or longer even though it later develops that the patient dies, is discharged or is transferred to another facility and does not actually stay in the institution for 24 hours.

C. An outpatient is a patient of an organized medical facility, or distinct part of that facility, who is expected by the facility to receive and who does receive professional services for less than a 24-hour period regardless of the hour of admission, whether or not a bed is used, or whether or not the patient remains in the facility past midnight.

D. Rehabilitative hospital services must be furnished in accordance with a written plan of treatment. Services must be given in accordance with orders of practitioners who are authorized by the medical staff to order the services, and the orders must be incorporated in the patient's record.

212.000 Rehabilitative Hospital Inpatient Services

212.100 Scope 10-13-03

Inpatient hospital services are items and services ordinarily furnished by the hospital for care and treatment of inpatients and are provided under the direction of a licensed practitioner (physician or dentist with staff affiliation) of a facility maintained primarily for treatment and care of injured, disabled or sick persons. Such inpatient services must be medically justified, documented, certified and re-certified by the Quality Improvement Organization (QIO) and may be reimbursed by Medicaid if provided on a Medicaid covered day.

A Medicaid covered day is a day for which the beneficiary is Medicaid eligible, the patient's inpatient benefit has not been exhausted, the inpatient stay is medically necessary, the day is not part of a hospital stay for a non-payable procedure or non-authorized procedure and the claim is on time.

212.200 Covered Services 10-13-03

Medicaid coverage of inpatient services is by the day. Coverage includes all services provided by the inpatient facility either directly or by arrangement with other facilities or vendors.

212.300 Exclusions 12-15-14

A. Medicaid does not cover services that are not necessary to treat an illness or an injury, such as:

1. Beauty shop
2. Cots for visitors
3. Meals for visitors
4. Television
5. Telephone
6. Guest tray

B. Medicaid does not cover the following as rehabilitative hospital inpatient services:

1. Private duty nurse
2. Take home drugs and supplies
3. Private room (unless ordered by a physician's statement as medically necessary)

C. Medicaid does not cover services that are cosmetic, experimental, not medically necessary or that are not generally accepted by the medical profession. Medicaid does not cover services that are not documented by diagnoses that certify medical necessity. Arkansas Medicaid has identified some ICD diagnosis codes that do not certify medical necessity. See Section 242.200 for diagnosis codes that are covered by Arkansas Medicaid.

212.400 Therapeutic Leave 10-13-03

The Arkansas Medicaid Program allows a maximum of 7 days per beneficiary per SFY for therapeutic leave for patients in an acute care/general or rehabilitative hospital. Therapeutic leave will be allowed when it is prescribed as a part of the treatment and/or discharge planning.

The following documentation is required when providing therapeutic leave:

A. The purpose of the therapeutic leave (the leave must be listed in the plan of care along with the objectives, goals and frequency of this therapy)

B. The destination or location (the place where the beneficiary will go for this therapy must be recorded, as well as the date and time of departure and return and the person(s) responsible for the beneficiary during the leave period)

C. A therapeutic leave evaluation (documentation must be in a form that provides unquestionable support to the plan of care objectives and goals)

D. Progress notes (progress notes must provide periodic statements that track a beneficiary's actions and reactions and must clearly reveal the beneficiary's achievements or regressions)

A Medicaid beneficiary who has been admitted to the hospital may not leave the hospital and receive Medicaid covered outpatient services prior to being discharged. Unless a patient has been discharged from the hospital and is no longer considered an inpatient, the patient is not eligible for outpatient services covered by Medicaid. For example, a patient may not be prescribed therapeutic leave for 8 hours per day in order to receive day treatment services through a Community Mental Health Center. Even though a patient is on therapeutic leave from an acute/general hospital, he or she is still considered an inpatient.

213.000 Rehabilitative Hospital Inpatient Limitation

213.010 Inpatient Hospital Services Benefit Limit 8-1-21

A. There is no benefit limit for acute care/general and rehabilitative hospital inpatient services for beneficiaries under age twenty-one (21) in the Child Health Services (EPSDT) Program. Inpatient services must be approved by the QIO as medically necessary.

B. The benefit limit for acute care/general and rehabilitative hospital inpatient services is twenty-four (24) paid inpatient days per state fiscal year (July 1 through June 30) for Medicaid beneficiaries aged twenty-one (21) and older.

C. When a beneficiary turns twenty-one (21) during an inpatient stay, the dates of service on or after his/her 21st birthday must be billed separately.

D. Arkansas Medicaid covers up to four (4) days of inpatient services with no certification requirement. If a beneficiary is not discharged before or during the fifth day, additional days are covered only if certified. The Medicaid Utilization Management Program (MUMP) determines covered inpatient lengths of stay in acute care/general and rehabilitative hospitals, in and out of state. See Sections 213.100 and 213.110 for MUMP certification request procedures.

E. Included in the total of paid inpatient days are any days covered by primary third-party resources (except Medicare and Railroad Retirement) for which Medicaid receives a secondary-payer claim that it adjudicates as paid. A Medicaid-secondary claim that adjudicates as a paid claim is counted toward the inpatient benefit limit.

1. Medicaid, when it is secondary to a third-party resource other than Medicare or Railroad Retirement, covers only the difference between the primary resource's remittance and Medicaid's per diem or maximum allowable fee for Medicaid-covered services reimbursed by the primary resource.

2. Even when the Medicaid paid amount is $0.00 because the third-party payment equals or exceeds Medicaid's per diem, the days thus paid are counted toward the benefit limit.

F. Extension of the 24-day inpatient benefit is available under the Medicaid Utilization Management Program (MUMP).

213.100 Medicaid Utilization Management Program (MUMP) 8-1-21

The Medicaid Utilization Management Program (MUMP) determines covered inpatient lengths of stay in general and rehabilitative hospitals, in state and out-of-state. The MUMP does not apply to lengths of stay in psychiatric facilities.

Length-of-stay determinations are made by the Quality Improvement Organization (QIO), under contract to the Arkansas Medicaid Program.

213.110 MUMP Applicability 8-1-21

A. Medicaid covers up to four (4) days of inpatient service with no certification requirement, except in the case of a transfer (see part B, below). If a patient is not discharged before or during the fifth day of hospitalization, additional days are covered only if certified by DHS or its designated vendor. **View or print contact information for how to submit the request.**

B. When a patient is transferred from one hospital to another, the stay must be certified from the first day.

213.120 MUMP Exemptions 10-13-03

A. Individuals in all Medicaid eligibility categories and all age groups, except clients under age 1, are subject to this policy. Medicaid beneficiaries under age 1 at the time of admission are exempt from the MUMP policy for dates of service before their first birthday.

B. MUMP policy does not apply to inpatient stays for bone marrow, liver and heart transplant procedures.

213.150 Retroactive Eligibility 8-1-21

A. If eligibility is determined while the patient is still an inpatient, the hospital may contact DHS or its designated vendor to request post-certification of inpatient days beyond the first four (4) days (or all days if the admission was by transfer) and a concurrent certification of additional days, if needed. **View or print contact information for how to submit the request.**

B. If eligibility is determined after discharge the hospital may contact DHS or its designated vendor for post-certification of inpatient days beyond the first four (4) days (or all days if the admission was by transfer). If certification sought is for a stay longer than thirty (30) days, the provider must submit the entire medical record for review. **View or print contact information for how to submit the request.**

213.160 Third Party and Medicare Primary Claims 8-1-21

A. If a provider has not requested Medicaid Utilization Management Program (MUMP) certification of inpatient days because there is apparent coverage by insurance or Medicare Part A, but the other payer has denied the claim for non-covered service, lost eligibility, benefits exhausted, etc., post-certification required by the MUMP may be obtained by sending a copy of the third-party payer's denial notice to DHS or its designated vendor. **View or print contact information for how to submit the request.**

B. If a third-party insurer pays the provider for an approved number of days, Medicaid will not grant an extension for days beyond the number of days approved by the private insurer.

213.170 Requests for Reconsideration 8-1-21

Reconsideration reviews of denied extensions may be expedited by submitting the medical record to DHS or its designated vendor. **View or print contact information for how to submit the request.**

213.180 Post Payment Review 10-13-03

A post payment review of a random sample is conducted on all admissions, including inpatient stays *of four days or less*, to ensure that medical necessity for the services is substantiated.

214.000 Outpatient Rehabilitative Hospital Services

214.100 Coverage 10-13-03

For the purposes of reimbursement determination and benefit limitation, outpatient rehabilitative hospital services are divided into two types of service:

A. Non-emergency services—treatment/exam room, staffing and disposable supplies.

B. Therapy and treatment services

The following are covered outpatient rehabilitative hospital therapy and treatment services:

1. Respiratory therapy:
Respiratory therapy is covered separately from other services and does not include non-emergency services.

2. Physical, occupational and speech therapy and evaluations:
Coverage of occupational, physical and speech therapy and therapy evaluation includes coverage of non-emergency services.

214.110 Venipuncture for Collection of Specimen 10-13-03

Venipuncture for collection of specimen is included in the coverage of the lab test.

214.120 Benefit Limits for Outpatient Hospital Services 10-1-15

A. Individuals under age 21 in the Child Health Services (EPSDT) program are not benefit limited.

B. Medicaid beneficiaries aged 21 and older are limited to a total of 12 outpatient hospital visits a year. This yearly limit is based on the state fiscal year (July 1–June 30) and includes acute care/general and rehabilitative hospitals. Outpatient visits for occupational, physical and speech therapy and evaluations are counted as outpatient visits. If a patient receives two or more treatment/therapy services during a single visit or encounter, the

encounter only counts once against the outpatient hospital benefit. Extensions of benefits are considered for patients who require supportive treatment for maintaining life.

C. The Arkansas Medicaid Program exempts the following primary diagnoses from the extension of benefit requirements. Extensions of the outpatient hospital benefit are automatic for the diagnoses listed below.

1. Malignant Neoplasm: **(View ICD codes.)**
2. HIV infection and AIDS: **(View ICD codes.)**
3. Renal failure: **(View ICD codes.)**
4. Pregnancy: **(View ICD codes.)**

214.130 Benefit Limit for Occupational, Physical, and Speech-Language Therapies For Beneficiaries 21 Years of Age and Older 1-1-21

A. Occupational, physical, and speech-language therapies are subject to the benefit limit of 12 outpatient hospital visits per state fiscal year (SFY), as explained in Section 214.120, for beneficiaries age 21 and over.

1. Outpatient therapy services, as well as other outpatient services, furnished by acute care hospitals and rehabilitative hospitals are combined when tallying utilization of this benefit.
2. This limit does not apply to eligible Medicaid beneficiaries under the age of 21 (see Sections 216.110 – 216.111).
3. Outpatient occupational, physical, and speech-language therapy services for beneficiaries over age 21 require a referral from the beneficiary's primary care physician (PCP) unless the beneficiary is exempt from PCP Program requirements; if exempt from PCP, a referral from their attending physician is required.

B. For range of benefits see the following procedure codes: **View or print the procedure codes for therapy services**.

C. All requests for benefit extensions for therapy services for beneficiaries over age 21 must comply with Sections 215.120 through 215.130.

214.300 Exclusions—Outpatient 10-13-03

The following are non-covered outpatient hospital services:

A. Take home drugs and supplies

B. Durable medical equipment

C. Services not reasonable or necessary for the treatment of an illness or injury, including services not properly documented as medically necessary

215.120 Benefit Extension Requests 7-1-22

A. The Medicaid Program's diagnostic laboratory services benefit limit and radiology/other services benefit limit each apply to the outpatient setting.

1. Diagnostic laboratory services benefits are limited to five hundred dollars ($500) per State Fiscal Year (SFY: July 1 through June 30), and radiology/other services benefits are limited to five hundred dollars ($500) per SFY.
2. Radiology/other services include without limitation diagnostic X-rays, ultrasounds, and electronic monitoring/machine tests, such as electrocardiograms (ECG or EKG).

3. Diagnostic laboratory services and radiology/other services defined as Essential Health Benefits by the U.S. Preventive Services Task Force (USPSTF) are exempt from counting toward either of the two new annual caps.

View or print the essential health benefit procedure codes.

B. Requests to extend benefits for outpatient rehabilitative hospital visits, diagnostic laboratory services, and radiology/other services must be mailed to DHS or its designated vendor.

View or print contact information for how to submit the request.

Benefit extension requests are considered only after a claim has been filed and denied because the benefit is exhausted.

C. A copy of the Medical Assistance Remittance and Status Report reflecting the claim's denial for exhausted benefits must accompany the request for review. Do not send a claim.

D. Additional information needed to process a benefit extension may be requested from the provider. Failures to provide requested additional information within the specified timeline will result in technical denials, reconsiderations of which are not available.

E. A benefit extension request must be received within ninety (90) calendar days of the date of the benefits-exhausted denial.

F. Correspondence regarding benefit extension requests and requests for reconsideration of denied benefit extension requests does not constitute documentation or proof of timely claim filing.

215.121 Request for Extension of Benefits for Clinical, Outpatient, Diagnostic Laboratory, and Radiology/Other Services, Form DMS-671 — 7-1-22

A. The Medicaid Program's diagnostic laboratory services benefit limit, and radiology/other services benefit limit each apply to the outpatient setting.

1. Diagnostic laboratory services benefits are limited to five hundred dollars ($500) per State Fiscal Year (SFY: July 1 through June 30), and radiology/other services benefits are limited to five hundred dollars ($500) per SFY.

2. Radiology/other services include without limitation diagnostic X-rays, ultrasounds, and electronic monitoring/machine tests, such as electrocardiograms (ECG or EKG).

3. Diagnostic laboratory services and radiology/other services defined as Essential Health Benefits by the U.S. Preventive Services Task Force (USPSTF) are exempt from counting toward either of the two new annual caps.

View or print the essential health benefit procedure codes.

B. Consideration of requests for benefit extensions requires correct completion of all fields of Form DMS-671, "Request for Extension of Benefits for Clinical, Outpatient, Diagnostic Laboratory, and Radiology/Other Services." **View or print Form DMS-671.**

C. The request date and the signature of the provider's authorized representative are required on the form. Both stamped and electronic signatures are accepted.

D. Dates of service must be listed in chronological order on Form DMS-671. When requesting benefit extension for more than four (4) encounters, use a separate form for each set of encounters.

E. Enter a valid ICD diagnosis code and brief narrative description of the diagnosis.

F. Enter a valid revenue code or procedure code (and modifiers, when applicable) and a brief narrative description of the procedure.

G. Enter the number of units of service requested under the extension.

215.122 Documentation Requirements 7-1-22

A. The Medicaid Program's diagnostic laboratory services benefit limit and radiology/other services benefit limit each apply to the outpatient setting.

1. Diagnostic laboratory services benefits are limited to five hundred dollars ($500) per State Fiscal Year (SFY: July 1 through June 30), and radiology/other services benefits are limited to five hundred dollars ($500) per SFY.
2. Radiology/other services include without limitation diagnostic X-rays, ultrasounds, and electronic monitoring or machine tests, such as electrocardiograms (ECG or EKG).
3. Diagnostic laboratory services and radiology/other services defined as Essential Health Benefits by the U.S. Preventive Services Task Force (USPSTF) are exempt from counting toward either of the two new annual caps.

B. Records supporting the medical necessity of extended benefits must be submitted with benefit extension requests.

C. Clinical records must:

1. Be legible and include records supporting the specific request;
2. Be signed by the performing provider;
3. Include clinical, outpatient, and emergency room records for the dates of service (in chronological order);
4. Include related diabetic and blood pressure flow sheets;
5. Include current medication list for date of service;
6. Include the obstetrical record related to current pregnancy (if applicable); and
7. Include clinical indication for diagnostic laboratory and radiology/other services ordered with a copy of orders for diagnostic laboratory and radiology/other services signed by the physician

D. Diagnostic laboratory and radiology/other reports must include:

1. Clinical indication for diagnostic laboratory and radiology/other services ordered;
2. Signed orders for diagnostic laboratory and radiology/other services;
3. Results signed by the performing provider; and
4. Current and all previous ultrasound reports, including biophysical profiles and fetal non-stress tests if applicable.

215.123 Provider Notification of Benefit Extension Determinations 8-1-21

A benefit extension approval or denial—or request for additional information—will be returned to the provider within thirty (30) calendar days.

A. Reviewers will simultaneously advise the provider and the beneficiary when a request is denied.

B. Provider notification of benefit extension approval includes:

1. The procedure code approved,

2. The total number of units approved for the procedure code,
3. The benefit extension control number and
4. The approved beginning and ending dates of service.

215.124 Reconsideration of Benefit Extension Denials 2-1-05

A. Medicaid allows only one reconsideration of a denied benefit extension request.

B. Reconsideration requests that do not include all required documentation will be automatically denied.

C. Requests to reconsider benefit extension denials must be received by AFMC within 30 calendar days of the date of the denial notice. When requesting reconsideration:

1. Return all previously submitted documentation and pertinent additional information to justify the medical necessity of additional services.
2. Include a copy of the **NOTICE OF ACTION** denial letter with the resubmission.

215.130 Appealing an Adverse Action 2-1-05

A. When the state Medicaid agency or its designee denies a benefit extension request, the beneficiary may appeal the denial and request a fair hearing.

B. An appeal request must be in writing and must be received by the Appeals and Hearings Section of the Department of Human Services (DHS) within 30 days of the date on the letter from DMS explaining the denial. **View or print the Department of Human Services, Appeals and Hearings Section contact information.**

216.000 Retrospective Review of Occupational, Physical and Speech Therapy Services for Beneficiaries Under Age 21 8-1-21

DHS or its designated vendor performs retrospective reviews of medical records to determine the medical necessity of services paid for by Medicaid. **View or print contact information for retrospective reviews.**

Specific guidelines have been developed for retrospective review of occupational, physical and speech-language therapy services furnished to Medicaid beneficiaries under the age of twenty-one (21). Those guidelines are included in this manual to assist providers in determining and documenting medical necessity. The guidelines are found in Sections 216.100 through 216.108.

216.100 Occupational and Physical Therapy Guidelines for Retrospective Review for Beneficiaries Under the Age of 21 7-1-20

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 insufficient 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 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 twelve (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 forty (40) weeks of gestation from the chronological age. Therefore, a 7-month-old, former 28-week gestational age infant has a corrected age of four (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 thirty-seven (37) weeks gestation) if the child is twelve (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; and
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 (1) 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 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 Arkansas Medicaid for retrospective reviews.
7. Range of Motion: A limitation of greater than ten (10) degrees or documentation of how a 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 the 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 Twenty-one (21)) receiving services outside of the public schools must be evaluated annually.
12. Children (birth to age two (2)) in the Early Intervention Day Treatment (EIDT) program must be evaluated every six (6) months.
13. Children (age three (3) to twenty-one (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 (3) years; however, an annual update of progress is required.

D. Frequency, Intensity, and Duration of Physical 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 if reasonable progress is made toward established goals. If reasonable, functional progress cannot be expected with continued therapy, services should be discontinued and monitoring, or establishment of a home program, should be implemented.

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; and
8. Graduate students must have the supervising physical therapist or occupational therapist co-sign progress notes.

216.101 Reserved 11-1-10

216.102 Reserved 11-1-10

216.103 Reserved 11-1-10

216.104 Reserved 11-1-10

216.105 Reserved 11-1-10

216.106 Reserved 11-1-10

216.107 In-Home Maintenance Therapy 11-1-05

A. Services that are performed primarily to maintain range of motion or to provide positioning services for the patient do not routinely require the skilled services of a physical or occupational therapist to perform safely and effectively.

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

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

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

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

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

216.110 Therapy Services For Beneficiaries Under Age 21 In Child Health Services (EPSDT) 1-1-21

Outpatient occupational, physical, and speech-language therapy services require a referral from the beneficiary's primary care physician (PCP) unless the beneficiary is exempt from PCP Program requirements. If the beneficiary is exempt from the PCP process, referrals for therapy services are required from the beneficiary's attending physician. All therapy services for beneficiaries under the age of 21 years require referrals and prescriptions be made utilizing the "Occupational, Physical and Speech Therapy for Medicaid Eligible Beneficiaries Under Age 21"

form DMS-640. A prescription for therapy services is valid for the length of time specified by the prescribing physician, up to one year. Providers of therapy services are responsible for obtaining renewed PCP referrals every twelve (12) months. The PCP or attending physician is responsible for determining medical necessity for therapy treatment.

Arkansas Medicaid applies the following therapy benefits to all therapy services in the Child Health Services (EPSDT) program for children under age 21:

A. For range of benefits, see the following procedure codes: **View or print the procedure codes for therapy services**.

B. All requests for extended therapy services for beneficiaries under age 21 must comply with Sections 216.112 through 216.116.

216.111 Occupational, Physical, and Speech-Language Therapy Services For Beneficiaries Age 18 and Under In ARKids First – B 1-1-21

Occupational, physical, and speech-language therapy services are covered for beneficiaries in the ARKids First-B program benefits at the same level as the Arkansas Medicaid.

For range of benefits, see the following procedure codes: **View or print the procedure codes for therapy services**. All requests for extended therapy services must comply with the guidelines located within the **Occupational, Physical, and Speech-Language Therapy Provider Manual**.

216.112 Process for Requesting Extended Therapy Services for Beneficiaries Under Twenty-One (21) Years of Age 7-1-22

A. Requests for extended therapy services for beneficiaries under twenty-one (21) years of age must be submitted to DHS or its designated vendor.

View or print contact information for how to submit the request.

The request must meet the medical necessity requirement, and adequate documentation must be provided to support this request.

1. Requests for extended therapy services are considered only after a claim is denied due to regular benefits exceeded.
2. The request must be received within ninety (90) calendar days of the date of the benefits-exceeded denial. The count begins on the next working day after the date of the Remittance and Status Report (RA) on which the benefits-exceeded denial appears.
3. Submit a copy of the Medical Assistance Remittance and Status Report reflecting the claim's benefits-exceeded denial with the request. Do not send a claim.

B. Form DMS-671 "Request for Extension of Benefits for Clinical, Outpatient, Diagnostic Laboratory, and Radiology/Other Services", must be utilized for requests for extended therapy services. **View or print Form DMS-671**. 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 form. An electronic signature is accepted, provided it complies with Arkansas Code Annotated §25-31-103. All applicable documentation that supports the medical necessity of the request must be attached.

C. DHS or its designated vendor will approve, deny, or ask for additional information within thirty (30) calendar days of receiving the request. 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.

216.113 Documentation Requirements 1-1-09

A. To request extended therapy services, all applicable documentation that supports 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 specific request.
2. Be signed 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.

216.114 Extended Therapy Services Review Process 8-1-21

View or print contact information to obtain the DHS or designated vendor step-by-step process for an extended therapy services review.

216.115 Administrative Reconsideration 1-1-09

A request for administrative reconsideration of the denial of services must be in writing and sent to AFMC within 30 calendar days of the denial. The request must include a copy of the denial letter, all previously submitted documentation and pertinent additional supporting documentation to justify the medical necessity of additional services.

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 AFMC within 35 calendar days of a denial will be deemed timely. Reconsideration requests must be mailed and will not be accepted via facsimile or email.

216.116 Appealing an Adverse Action 1-1-09

When the state Medicaid agency or its designee denies an extended therapy request, the beneficiary or the provider may appeal the decision and request a fair hearing.

An appeal request must be in writing and must be received by the Appeals and Hearings Section of the Department of Human Services (DHS) within 30 days of the date on the letter from DMS explaining the denial. **View or print the Department of Human Services, Appeals and Hearings Section contact information.**

216.120 Accepted Tests for Occupational Therapy 3-15-12

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

216.130 Accepted Tests for Physical Therapy 3-15-12

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

216.200 Speech-Language Therapy Guidelines for Retrospective Review for Beneficiaries Under Age 21 7-1-20

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 insufficient 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 or use of spoken, written, 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), or the perception/processing of language. Language disorders may involve one (1), all, or a combination of the above components.
2. Speech Production Disorders — Impairment of the articulation of speech sounds, voice, or fluency. Speech Production disorders may involve one (1), all, or a 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 or oral apraxia, dysarthria.
3. Oral Motor/Swallowing/Feeding Disorders — Impairment of the muscles, structures, 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 sixty-three (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 216.200, part D, paragraphs 9-12 for required frequency of re-evaluations.) A comprehensive assessment for a 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 twelve (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 forty (40) weeks of gestation from the chronological age. Therefore, a 7-month-old, former 28-week gestational age infant has a corrected age of four (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, 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. (For a list of accepted tests, refer to Section 214.410 of the Occupational, Physical, and Speech-Language Therapy Services Manual.);

f. If applicable, test results should be adjusted for prematurity (less than thirty-seven (37) weeks gestation) if the child is twelve (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; and

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 216.200, 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 twelve (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 forty (40) weeks of gestation from the chronological age. Therefore, a 7-month-old, former 28-week gestational age infant has a corrected age of four (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, or indexes, if applicable. All errors specific to the type of speech production disorder must be reported (e.g., positions, processes, motor patterns). (For a list of accepted tests, refer to Section 214.410 of the Occupational, Physical, and Speech-Language Therapy Services Manual.);

f. If applicable, test results should be adjusted for prematurity (less than thirty-seven (37) weeks gestation) if the child is twelve (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, and

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 216.200, 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 twelve (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 forty (40) weeks of gestation from the chronological age. Therefore, a 7-month-old, former 28-week gestational age infant, has a corrected age of four (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, or indexes, if applicable. (For a list of accepted tests, refer to Section 214.410 of the Occupational, Physical, and Speech-Language Therapy Services Manual.);

g. If applicable, test results should be adjusted for prematurity (less than thirty-seven (37) weeks gestation) if the child is twelve (12) 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; and

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 216.200, 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 twelve (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 forty (40) weeks of gestation from the chronological age. Therefore, a 7-month-old, former 28-week gestational age infant, has a corrected age of four (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, or indexes, if applicable. (For a list of accepted tests, refer to Section 214.410 of the Occupational, Physical, and Speech-Language Therapy Services Manual.);

f. If applicable, test results should be adjusted for prematurity (less than thirty-seven (37) weeks gestation) if the child is twelve (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, 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; and

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 216.200, 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 twelve (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 forty (40) weeks of gestation from the chronological age. Therefore, a 7-month-old, former 28-week gestational age infant, has a corrected age of four (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, or indexes, if applicable. (For a list of accepted tests, refer to Section 214.410 of the Occupational, Physical, and Speech-Language Therapy Services Manual.);

    f. If swallowing problems 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 thirty-seven (37) weeks gestation) if the child is twelve (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; and

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

D. Interpretation and Eligibility: Ages Birth to 21

1. LANGUAGE: Two (2) language composite or quotient scores (i.e., normed or standalone) in the area of suspected deficit must be reported, with at least one (1) being a norm-referenced, standardized test with good reliability and validity. (Use of two (2) one-word vocabulary tests alone will not be accepted.)

    a. For children age birth to three (3): criterion-referenced tests will be accepted as a second measure for determining eligibility for language therapy.

    b. For children age three (3) to twenty-one (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

216.200, part D, paragraph 8).

c. Age birth to three (3): 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 (2) 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 (3) to twenty-one (21): Eligibility for language therapy will be based upon two (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 scores, a third standardized score indicating a -1.5 SD or greater is required to support the medical necessity of services.

2. ARTICULATION OR PHONOLOGY: Two (2) tests or procedures must be administered, with at least one (1) being from a norm-referenced, standardized test with good reliability and validity.

   Eligibility for articulation or phonological therapy will be based upon standard scores (SS) of -1.5 SD or greater below the mean from two (2) tests. When -1.5 SD or greater is not indicated by both tests, corroborating data from accepted procedures can be used to support the medical necessity of services (For a list of accepted tests, refer to Section 214.410 of the Occupational, Physical, and Speech-Language Therapy Services Manual.)

3. APRAXIA: Two (2) tests or procedures must be administered, with at least one (1) 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 (2) tests. When -1.5 SD or greater is not indicated by both tests, corroborating data from a criterion-referenced test or accepted procedures can be used to support the medical necessity of services. (For a list of accepted tests, refer to Section 214.410 of the Occupational, Physical, and Speech-Language 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 (1) norm-referenced, standardized test with good reliability and validity, and at least one (1) 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 feeding difficulties 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 Section 214.410 of the Occupational, Physical, and Speech-Language Therapy Services Manual may be useful in developing an in-depth, functional profile.

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

10. Children (age birth to twenty-four (24) months) in the Early Intervention Day Treatment (EIDT) Program must be evaluated every six (6) months.

11. Children (age three (3) to twenty-one (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 (3) years; however, an annual update of progress is required.

12. Children (age three (3) to twenty-one (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 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 the entry with a full signature and credentials; and

8. Graduate students must have the supervising speech-language pathologist co-sign progress notes.

216.210 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.

216.220 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 documented. 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

220.000 PRIOR AUTHORIZATION 10-13-03

Prior authorization does not apply to rehabilitative hospital services.

230.000 REIMBURSEMENT

231.000 Method of Reimbursement for Rehabilitative Hospital Inpatient Services 10-13-03

Reimbursement for rehabilitative hospital inpatient services is by per diem.

232.000 Method of Reimbursement of Outpatient Hospital Services 10-13-03

Medicaid reimbursement for outpatient services is by fee schedule at the lesser of the amount billed or the Medicaid allowable.

232.010 Fee Schedules 12-1-12

Arkansas Medicaid provides fee schedules on the Arkansas Medicaid website. The fee schedule link is located at **https://medicaid.mmis.arkansas.gov/** 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.

233.000 Rate Appeal Process 10-13-03

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 for a conference, if he or she so wishes, 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 decision of the Assistant Director, Division of Medical Services is unsatisfactory, the provider may then appeal the question to a standing Rate Review Panel established by the Director of the Division of Medical Services which will include one member of the Division of Medical Services, a representative of the provider association and a member of the Department of Human Services (DHS) Management Staff, who will serve as chairman.

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, Division of Medical Services. The Rate Review Panel will meet to consider the question(s) within 15 calendar days after receipt of a request for such appeal. The question(s) will be heard by the panel and a recommendation will be submitted to the Director of the Division of Medical Services.

240.000 BILLING PROCEDURES

241.000 Introduction to Billing 7-1-20

Rehabilitative Hospital providers who submit paper claims must use the CMS-1450 claim form, which also is known as the UB-04 claim form.

A Medicaid claim may contain only one (1) billing provider's charges for services furnished to only one (1) Medicaid beneficiary.

Section III of every Arkansas Medicaid provider manual contains information about available electronic claim options.

242.000 CMS-1450 (UB-04) Billing Procedures

242.100 Procedure Codes 2-1-22

View or print the procedure codes and modifiers for Rehabilitative Hospital services.

HCPCS procedure code must be billed on a paper claim with the manufacturer's invoice attached.

242.110 Non-Emergency Services 11-1-17

The procedure codes are as follows:

National Code	Revenue Code Description
459*	**Other non-emergency services:** includes room charges and all non-physician covered services. This service room charge includes supplies, drugs and injections. This code can be billed one (1) time only per claim.

*Revenue code

242.120 Therapy Procedure Codes

242.121 CPT Procedure Codes: Therapy 2-1-22

The CPT procedure codes that are payable to a rehabilitative hospital are as follows:

View or print the procedure codes and modifiers for Rehabilitative Hospital services.

242.122 Procedure Codes Requiring Modifiers 1-1-21

Treatment and therapy procedure codes may not be billed in conjunction with revenue code T1015. Medicaid reimbursement for a treatment/therapy room is included in the therapy reimbursement. **View or print the procedure codes for therapy services**.

242.200 Non-Covered Diagnosis Codes

242.210 Reserved 10-1-18

242.220 Diagnoses for Services not Covered for Under Age 21 in a Rehabilitative Hospital 10-1-15

Coverage of well-child and preventive services for children under age 21 in the Child Health Services (EPSDT) Program does not permit the use of the following ICD-9-CM diagnosis codes. The diagnosis codes in this table may be used when appropriate in regard to patients aged 21 and older.

(View ICD codes.)	Routine general medical examination at a health care facility
(View ICD codes.)	Other medical examination for administrative purposes
(View ICD codes.)	Health examination of defined subpopulations
(View ICD codes.)	Examination for normal comparison or control in clinical research
(View ICD codes.)	Unspecified general medical examination
(View ICD codes.)	Other specified examination

242.300 Place of Service and Type of Service Codes 10-13-03

Not applicable to this program.

242.400 Billing Instructions - Paper Only 11-1-17

Medicaid does not supply providers with Uniform Billing claim forms. Numerous venders sell CMS-1450 (UB-04 forms.) **View a sample CMS-1450 (UB-04) claim form.**

Complete Arkansas Medicaid program claims in accordance with the National Uniform Billing Committee UB-04 data element specifications and Arkansas Medicaid's billing instructions, requirements and regulations.

The National Uniform Billing Committee (NUBC) is a voluntary committee whose work is coordinated by the American Hospital Association (AHA) and NUBC is the official source of information regarding form CMS-1450 (the UB-04 claim form). **View or print NUBC contact information.**

The committee develops, maintains, and distributes to its subscribers the Official UB-04 Data Specifications Manual (UB-04 Manual) and periodic updates. The NUBC is also a vendor of CMS-1450 (UB-04) claim forms.

Following are Arkansas Medicaid's instructions for completing, in conjunction with the UB-04 Manual, a CMS-1450 (UB-04) claim form.

Please forward the original of the completed form to the Claims Department. **View or print the Claims Department contact information.** One copy of the claim form should be retained for your records.

NOTE: A provider furnishing services without verifying beneficiary eligibility for each date of service does so at the risk of not being reimbursed for the services. The provider is strongly encouraged to print the eligibility verification and retain it until payment is received.

242.410 Completion of CMS-1450 (UB-04) Claim Form 12-15-14

Field #	Field name	Description
1.	(blank)	*Inpatient and Outpatient:* Enter the provider's name, (physical address – service location) city, state, zip code, and telephone number.
2.	(blank)	The address that the provider submitting the bill intends payment to be sent if different from FL 01. (Use this address for provider's return address for returned mail).
3a.	PAT CNTL #	*Inpatient and Outpatient:* The provider may use this optional field for accounting purposes. It appears on the RA beside the letters "MRN." Up to 16 alphanumeric characters are accepted.
3b.	MED REC #	*Inpatient and Outpatient:* Required. Enter up to 15 alphanumeric characters.
4.	TYPE OF BILL	*Inpatient and Outpatient:* See the UB-04 manual. Four-digit code with a leading zero that indicates the type of bill.
5.	FED TAX NO	The number assigned to the provider by the Federal government for tax reporting purposes. Also known as tax identification number (TIN) or employer identification number (EIN).
6.	STATEMENT COVERS PERIOD	Enter the covered beginning and ending service dates. Format: MMDDYY. *Inpatient:* Enter the dates of the first and last covered days in the FROM and THROUGH fields. The FROM and THROUGH dates cannot span the State's fiscal year end (June 30) or the provider's fiscal year end. To file correctly for covered inpatient days that span a fiscal year end: 1. Submit one interim claim (a first claim or a continuing claim, as applicable) on which the THROUGH date is the last day of the fiscal year that ended during the stay. On a first claim or a continuing claim, the patient status code in field 17 must indicate that the beneficiary is still a patient on the indicated

Field #	Field name	Description
		THROUGH date. 2. Submit a second interim claim (a continuing claim or a last claim, as applicable) on which the FROM date is the first day of the new fiscal year. When the discharge date is the first day of the provider's fiscal year or the state's fiscal year, only one (bill type: admission through discharge) claim is necessary, because Medicaid does not reimburse a hospital for a discharge day unless the discharge day is also the first covered day of the inpatient stay. When an inpatient is discharged on the same date he or she is admitted, the day is covered when the TYPE OF BILL code indicates that the claim is for admission through discharge, the STAT (patient status) code indicates discharge or transfer, and the FROM and THROUGH dates are identical. *Outpatient:* To bill on a single claim for outpatient services occurring on multiple dates, enter the beginning and ending service dates in the FROM and THROUGH fields of this field. The dates in this field must fall within the same fiscal year – the state's fiscal year and the hospital's fiscal year. When billing for multiple dates of service on a single claim, a date of service is required in field 45 for each HCPCS code in field 44 and/or each revenue code in field 42.
7.	(blank)	Reserved for assignment by the NUBC.
8a.	PATIENT NAME	*Inpatient and Outpatient:* Enter the patient's last name and first name. Middle initial Is optional.
8b.	(blank)	Not required.
9.	PATIENT ADDRESS	*Inpatient and Outpatient:* Enter the patient's full mailing address. Optional.
10.	BIRTH DATE	*Inpatient and Outpatient:* Enter the patient's date of birth. Format: MMDDYYYY.
11.	SEX	*Inpatient and Outpatient:* Enter M for male, F for female, or U for unknown.
12.	ADMISSION DATE	*Inpatient:* Enter the inpatient admission date. Format: MMDDYY. *Outpatient:* Not required.
13.	ADMISSION HR	*Inpatient and Outpatient:* Enter the national code that corresponds to the hour during which the patient was admitted for inpatient care.
14.	ADMISSION TYPE	*Inpatient:* Enter the code from the UB-04 Manual that indicates the priority of this inpatient admission. *Outpatient:* Not required.

Field #	Field name	Description
15.	ADMISSION SRC	*Inpatient and Outpatient:* Admission source.
16.	DHR	*Inpatient:* See the UB-04 Manual. Required. Enter the hour the patient was discharged from inpatient care.
17.	STAT	*Inpatient:* Enter the national code indicating the patient's status on the Statement Covers Period THROUGH date (field 6). *Outpatient:* Not applicable.
18.-28.	CONDITION CODES	*Inpatient and Outpatient:* Required when applicable. See the UB-04 Manual for requirements and for the codes used to identify conditions or events relating to this bill.
29.	ACDT STATE	Not required.
30.	(blank)	Unassigned data field.
31.-34.	OCCURRENCE CODES AND DATES	*Inpatient and Outpatient:* Required when applicable. See the UB-04 Manual.
35.-36.	OCCURRENCE SPAN CODES AND DATES	*Inpatient:* Enter the dates of the first and last days approved, per the facility's PSRO/UR plan, in the FROM and THROUGH fields. See the UB-04 Manual. Format: MMDDYY. *Outpatient:* See the UB-04 Manual.
37.	Not used	Reserved for assignment by the NUBC.
38.	Responsible Party Name and Address	See the UB-04 Manual.
39.	VALUE CODES	*Outpatient:* Not required. *Inpatient:*
a.	CODE	Enter 80.
	AMOUNT	Enter number of covered days. Enter number of days (units billed) to the left of the vertical dotted line and enter two zeros (00) to the right of the vertical dotted line.
b.	CODE	Enter 81.
	AMOUNT	Enter number of non-covered days. Enter number of days (units billed) to the left of the vertical dotted line and enter two zeros (00) to the right of the vertical dotted line.
40.	VALUE CODES	Not required.
41.	VALUE CODES	Not required.
42.	REV CD	*Inpatient and Outpatient:* See the UB-04 Manual.
43.	DESCRIPTION	See the UB-04 Manual.
44.	HCPCS/RATE/HIPPS CODE	See the UB-04 Manual.

Field #	Field name	Description
45.	SERV DATE	*Inpatient:* Not applicable. *Outpatient:* See the UB-04 Manual. Format: MMDDYY.
46.	SERV UNITS	Comply with the UB-04 Manual's instructions when applicable to Medicaid.
47.	TOTAL CHARGES	Comply with the UB-04 Manual's instructions when applicable to Medicaid.
48.	NON-COVERED CHARGES	See the UB-04 Manual, line item "Total" under "Reporting."
49.	Not used	Reserved for assignment by the NUBC.
50.	PAYER NAME	Line A is required. See the UB-04 for additional regulations.
51.	HEALTH PLAN ID	Report the HIPAA National Plan Identifier; otherwise report the legacy/proprietary number.
52.	REL INFO	Required when applicable. See the UB-04 Manual.
53.	ASG BEN	Required. See "Notes" at field 53 in the UB-04 Manual.
54.	PRIOR PAYMENTS	*Inpatient and Outpatient:* Required when applicable. Enter the total of payments previously received on this claim. Do not include amounts previously paid by Medicaid. * D**o not** include in this total the automatically deducted Medicaid or ARKids First-B co-payments. See the UB-04 Manual.
55.	EST AMOUNT DUE	Situational. See the UB-04 Manual.
56.	NPI	Enter NPI of billing provider or enter the Medicaid ID.
57.	OTHER PRV ID	Not required.
58. A, B, C	INSURED'S NAME	*Inpatient and Outpatient:* Comply with the UB-04 Manual's instructions when applicable to Medicaid.
59. A, B, C	P REL	*Inpatient and Outpatient:* Comply with the UB-04 Manual's instructions when applicable to Medicaid.
60. A, B, C	INSURED'S UNIQUE ID	*Inpatient and Outpatient:* Enter the patient's Medicaid identification number on first line of field.
61. A, B, C	GROUP NAME	*Inpatient and Outpatient:* Using the plan name if the patient is insured by another payer or other payers, follow instructions for field 60.
62. A, B, C	INSURANCE GROUP NO	*Inpatient and Outpatient:* When applicable, follow instructions for fields 60 and 61.
63. A, B, C	TREATMENT AUTHORIZATION CODES	*Inpatient:* Enter any applicable prior authorization, benefit extension, or MUMP certification control number in field 63A. *Outpatient:* Enter any applicable prior authorization or benefit extension number in field 63A.
64. A, B, C	DOCUMENT CONTROL NUMBER	Field used internally by Arkansas Medicaid. No provider input.

Field #	Field name	Description
65. A, B, C	EMPLOYER NAME	*Inpatient and Outpatient:* When applicable, based upon fields 51 through 62, enter the name(s) of the individuals and entities that provide health care coverage for the patient (or may be liable).
66.	DX	Diagnosis Version Qualifier. See the UB-04 Manual. Qualifier Code “9” designating ICD-9-CM diagnosis required on claims. Qualifier Code “0” designating ICD-10-CM diagnosis required on claims. Comply with the UB-04 Manual’s instructions on claims processing requirements.
67. A-H	(blank)	*Inpatient and Outpatient:* Enter the ICD-9-CM or ICD-10-CM diagnosis codes corresponding to additional conditions that coexist at the time of admission, or develop subsequently, and that have an effect on the treatment received or the length of stay. Fields are available for up to 8 codes.
68.	Not used	Reserved for assignment by the NUBC.
69.	ADMIT DX	Required for inpatient. See the UB-04 Manual.
70.	PATIENT REASON DX	See the UB-04 Manual.
71.	PPS CODE	Not required.
72	ECI	See the UB-04 Manual. Required when applicable (for example, TPL and torts).
73.	Not used	Reserved for assignment by the NUBC.
74.	PRINCIPAL PROCEDURE	*Inpatient:* Required on inpatient claims when a procedure was performed. On all interim claims, enter the codes for all procedures during the hospital stay. *Outpatient:* Not applicable.
	CODE	Principal procedure code.
	DATE	Format: MMDDYY.
74a-74e	OTHER PROCEDURE	*Inpatient:* Required on inpatient claims when a procedure was performed. On all interim claims, enter the codes for all procedures during the hospital stay. *Outpatient:* Not applicable.
	CODE	Other procedure code(s).
	DATE	Format: MMDDYY.
75.	Not used	Reserved for assignment by the NUBC.
76.	ATTENDING NPI	Enter NPI of the primary attending physician or enter the Medicaid ID.
	QUAL	Not required.
	LAST	Enter the last name of the primary attending physician.
	FIRST	Enter the first name of the primary attending physician.

Field #	Field name	Description
77.	OPERATING NPI	NPI not required.
	QUAL	Not applicable.
	LAST	Not applicable.
	FIRST	Not applicable.
78.	OTHER NPI	Enter NPI of the primary care physician or enter the Medicaid ID.
	QUAL	Not required.
	LAST	Enter the last name of the primary care physician.
	FIRST	Enter the first name of the primary care physician.
79.	OTHER NPI/QUAL/LAST/FIRS	Not used.
80.	REMARKS	For provider's use.
81.	Not used	Reserved for assignment by the NUBC.

242.500 Billing for Inpatient Hospital Services When a Beneficiary Turns Age 21 10-22-10

A. The benefit limit for acute care/general and rehabilitative hospital inpatient services is 24 paid inpatient days per state fiscal year (July 1 through June 30) for Medicaid beneficiaries aged 21 and older.

B. When a beneficiary turns 21 during an inpatient stay, the dates of service on or after his/her 21st birthday must be billed separately.

C. Refer to Section 213.010 for Inpatient Hospital Benefit Limits for Medicaid beneficiaries aged 21 and older.