

FREQUENTLY ASKED QUESTIONS RELATIVE TO MEDICAID CONCERNING PT/OT/ SPEECH THERAPY SERVICES

1. When the physician writes a new prescription for services though the current prescription is still valid regarding time constraints, do I need to adhere to the new prescription or start once the time is up on the old one?

You should begin following the new prescription. Once a physician writes a prescription, it becomes the authorization for the services rendered in the future from that time. A physician can write a prescription with a future date to begin new or updated services. It is recommended to get the scripts dated in accordance with dates on the service plan (maximum length of a prescription is a year). A physician will not backdate a script, plus Medicaid doesn't approve of this.

2. Can the physician write one prescription for the evaluation and treatment? Do I need an additional prescription written for make-up session(s)?

The physician needs to write separate prescriptions for each service rendered. The evaluation can be written on a prescription pad or a DMS-640 form. The prescriptions for treatment and make-up sessions need to be completed on DMS-640 forms. A script for a make-up session is not necessary if the service is given during that same week. Ex. A session missed on Monday can be made up on Friday. A session missed on Thursday cannot be made up the next week without a script from the PCP.

3. With regard to supervision of unlicensed therapy students, do I have to be present in order to be in compliance with what is considered supervision?

Yes. Therapies carried out by unlicensed students 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. To qualify as providing the service, the licensed therapist must be present and engaged in student oversight during the entirety of any encounter that will be billed to Medicaid as occupational, physical or speech therapy.

4. What is the process of appealing a denial by Medicaid? What are common reasons for the denials?

If you receive an Explanation of Recoupment, then a letter explaining the process will accompany the denial. If it is a Professional Review Organization (PRO) denial, then address the appeal to Arkansas Foundation for Medical Care (AFMC) in writing within 30 days of receiving

the denial. If the denial is a Utilization Review Denial, submit a written request for appeal within 30 days of receiving the denial letter from Medicaid. Upon receipt of the appeal, the Medical Director will review the case and notify the provider in writing regarding the outcome. The provider can request an appeal of the action before the appropriate peer review committee's next meeting, if he/she feels that his/her claim has been overlooked or a mistake has been made. Common reasons for denial are: technical errors by the providers making claims, sloppiness of notes, not signing notes or forgetting to list credentials, not providing accurate information, lack of documentation with regard to medical necessity.

5. Do I need to get a prescription from the PCP after the initial evaluation? What about for the yearly evaluation? What about the three-year evaluation?

A prescription is needed prior to any evaluation or re-evaluation. A yearly evaluation is no longer necessary, as long as an update and yearly review have been completed by the therapist. The three-year evaluation is still required. If you do a yearly evaluation to establish progress with that student (not billing Medicaid), then a prescription is not necessary.

6. Regarding retrospective reviews, what kinds of documentation in treatment notes is expected?

It is necessary to provide a written record of specific activities (tests, etc.) that are done with the child, even if the child wasn't able to complete an activity, not just a focus on mastery components. Click [here](#) for an overview of the retrospective review process.

7. Is there a difference between a prescription and referral? Do therapists need to continue getting referrals every six months, if the prescription is valid for a year?

Yes there is a difference. A referral is usually used for doing an evaluation and does not state "treat the child". The prescription is to prescribe therapy or treatment for a specific child. Medicaid is now allowing schools to use one referral for the entire school year. Medicaid requests that the prescription be very specific, including the exact year that the service is to be provided. If the PCP does not get the prescription signed until after the beginning of the school year, then Medicaid will retroactively reimburse for schools only (if on the prescription the PCP notes on the other information line ..."for the school year of").

8. Are the requirements for evaluation different for early childhood than that from school aged children/students?

No. Medicaid allows the public schools providing therapy to school age children in school (kindergarten through 12th grade) to evaluate every three years. With regard to the early childhood population, Medicaid recently changed their annual evaluation requirements to now allow evaluations to last for three years.

9. What specifically needs to be included in my progress notes for therapy?

Therapists have the option to format their progress notes in any way they wish. The content needs to include a specific description of the therapy being provided, activities that elicit the desired responses and some form of measurement. Actual time in/out that the therapy was provided, date of service, and full name of therapist with credentials also need to be included. It is helpful, but not necessary, to include the units. Click [here](#) for documentation examples.

10. Is a + or – response needed for every documented progress note?

No. A + or – response is a valid way of monitoring the student's progress, but it should be emphasized that reviewers look for trials such as 2/5. If a + and – system is used, it should be accompanied with a legend to decipher what it means.

11. Does Psychological Testing need to be completed every three (3) years?

No. For Medicaid reviews, as long as the IQ testing was done on or after the students 10th birthday, then it will be accepted (as of 1/1/05). This test will be valid until the student turns 21 years of age. For students under the age of 10 receiving therapy, IQ testing is no longer required.

12. Is there a specific list of tests that Medicaid recommends for providers when evaluating students?

Medicaid has compiled a list of tests that have been approved and recommended for use by qualified providers. For speech, new tests are approved regularly, thus further clarification other than the list may be required. Click [here](#) to view the tests.

13. How should I document in progress notes when I have a child that is nonverbal and cannot take a test or complete a specified task (a child with autism, for example)?

If a child cannot complete a norm-referenced, standardized, age appropriate test, all that is asked is that you attempt to give the test or just document that in no way can the child complete the testing and why the child cannot. Then provide a detailed narrative of how the delays are affecting the child's ability to function in life, what areas you wish to target, and what you want to work on for the next six months to a year. The child will need to be evaluated more frequently with no formal testing. Every three (3) months write about how the therapy is going with that child.

14. Is the annual update seen differently than the review? Does re-evaluation need to have a post- test completed? Can we complete a post - test annually?

An annual update/review is viewed as meaning the same thing. Public schools are allowed to do a full battery of testing every three years with an annual review or update on the in-between years. For schools, no additional testing is required the next year, but most therapists do some kind of test the next year to be able to say that the child still qualifies for therapy. Medicaid wishes that the therapists get an additional evaluation referral from the PCP in order to do any additional testing.

15. Must a child be categorized as “severe” to qualify for services? If a post-test is completed and the child is not considered “severe”, but “moderate”, can we still bill for that child?

As long as the child scores a standard score of at least a –1.5 standard deviation below the mean in two areas or a –2.00 standard deviations below in one area, then the child would be qualified for therapy.

16. I have specific questions related to billing, who do I need to contact?

You would first consult with the Provider Assistance Center at EDS. The phone number is 1 (800) 457- 4454. Depending on the nature of your question, they may refer you to your Arkansas Medicaid Provider Representative. The state is divided into seven districts with one Provider Representative for each district. The Provider Assistance Center can give you the Provider Representative for your area.

17. Who can I contact with questions about guidelines for occupational, physical therapy, and speech language pathology?

You can contact Arkansas Foundation for Medical Care (AFMC) at 479 649-8501. Click [here](#) to visit the AFMC website homepage.

18. If a child is transitioning from preschool to kindergarten can I use their last evaluation (while still in preschool) to determine eligibility for the next two years?

Yes. Medicaid has recently changed their testing regulations for services related to the early childhood population. They now allow/accept evaluations for three years, like the school age population.

19. After an evaluation has been performed, can I still be reimbursed for the evaluation from Medicaid if the student doesn't meet the criteria for medical necessity?

Yes, as long as the PCP prescribed the evaluation.

20. When the PCP wrote a prescription for therapy services, he put the wrong date. What needs to be done to correct this?

One of two things can be done. The best practice would be to get the PCP to write a new prescription on a new form. If this isn't feasible, the PCP will need to put a single line through his mistake, initial it, and then add the correct date. If there have been several alterations to the prescription form, AFMC might not approve it. This can raise several questions related to who is making the changes.

21. Our SLP therapist was "grand-fathered" in to the licensure system. She is working under the supervision of another licensed SLP (with her CCC's); can we still bill Medicaid when she doesn't have a Medicaid provider number?

Yes. The school can use their provider number for billing for SLP services. This is only true for SLP services due to current regulations.

22. With regard to signatures on therapy notes, do I need to include my credentials and full name?

Be sure to sign each therapy note with professional credentials. With regard to specific signatures on therapy notes, you should use the same signature that was given on your contract with Provider Enrollment at Medicaid. If your name or signature has changed since enrolling, call or submit a letter to DMS reflecting an example of the signature you intend to use on any Medicaid business.

23. What are the necessary requirements when completing a full evaluation?

The requirements can be found on the Medicaid website under section II of the OT/PT/SLP manual.

- 1 Date of evaluation.
2. Child's name and date of birth.
3. Diagnosis applicable to the specific therapy.

4. Background information including pertinent medical history and gestational age.
5. Standardized test results, including all subtest scores, if applicable. Test results, if applicable, should be adjusted for prematurely if the child is one year old or less and this should be noted in the evaluation.
6. Objective information describing the child's gross/fine motor/speech language abilities/deficits, i.e.: range of motion measurements, manual muscle testing, muscle tone, speech delays, articulation deficits, or a narrative description of the child's functional mobility skills/language skills.
7. The child should be tested in their native language, if not, an explanation must be provided in the evaluation.
8. Assessment of the results of the evaluation including recommendations for frequency and intensity of treatment.
9. The providing therapist's full name and credentials of the therapist performing the evaluation.

24. I've seen the examples of denied therapy notes in the past, do any examples of accepted notes or recommended notes by AFMC exist?

Yes. AFMC has posted several examples of progress notes that satisfy the documentation requirements for reviews. Please click [here](#) for those examples.

25. Regarding supervision of an assistant, the Medicaid manual states that the supervising therapist must observe a therapy session with the child and review the treatment plan and progress notes at a minimum of every 30 days. How long of a therapy session is necessary for this supervision of the assistant per 30 days?

The Official Notice states, "the supervising therapist must observe a therapy session." If the child is to be seen for 60 minutes per weeks twice a week, then that would be two 30 minute therapy sessions. That would mean that the supervising therapist would be observing one complete 30-minute therapy session sometime during the 30-day period. It would depend on what the PCP ordered, 45 minutes per week three times a week or 60 minutes per week three times a week, etc. The length of one session for the child would be what Medicaid expected the supervising therapist to observe. The observation requirements are for one session per month per child.

26. Can the PCP prescribe services in May for the next school year? An example of this would be: in May of 2004, the doctor completes the form noting services for 2004-05 school year.

Medicaid requires that the schools get their one referral a year and a prescription for the school year as well. The prescription is good for 12 months. I understand that the schools do much of their testing for qualifying for therapy at the end of the previous school year. As long as the child met Medicaid eligibility criteria, the PCP signed the prescription for 12 months late enough in May to cover all dates the next year, then yes they could go and get their prescriptions that early. The problem would be is if they got them the first few weeks of May and then the next school year goes past to the end of May or early June, the prescription would have expired. There is an advantage to waiting. If the PCP lists under "other information" on the DMS-640 form that this prescription is for the 2003-2004 school year, it doesn't matter when he/or she signs it, as long as it gets signed sometime during that school year.

27. With regard to referrals, my school rarely bills for evals because of the time lines they have for educational requirements (they have 60 days to have the eval completed, have a difficult time getting the PCP to sign off for one before that time period is up). Does the eval prescription have to be in place before the eval can be completed?

Yes, if the school is going to bill Medicaid for their evaluation time, Medicaid asks that they get the evaluation referral first, then evaluate, then obtain the treatment prescription.

28. I have a student who is approaching the time for a three-year re-evaluation. May I use the results from a post-test completed six months ago as part of the re-evaluation?

It is always advisable for the provider to do a complete three-year comprehensive evaluation if therapy is going to be continued for the next school year. Test results from six months ago compared to new testing might be totally different since months have elapsed. The student might not meet Medicaid's guidelines any longer.

29. I have heard that Medicaid is developing and implementing a new DMS-640 for prescription/evaluation/referrals for the therapies. Is this true? How can I get a copy of one? Does it effect my prescriptions that are already in place?

Effective November 1, 2004, the revised form DMS-640 will need to be used for services starting on or after that date. Existing prescriptions/referrals will be valid until the service date has expired, then you would begin to use the newest version of the DMS-640. You can access a revised DMS-640 at the Medicaid website (go to the Provider section, then Official Notices) at www.medicaid.state.ar.us or at the Special Education website under the Medicaid section at <http://arksped.k12.ar.us>.

30. With regard to OT/PT/SLP, is there a list available noting the interventions and reimbursement rates for the different therapies?

Occupational Therapy:

- Evaluation - \$41.20 (30 min. unit)
- Group Therapy by assistant - \$3.96 (15 min unit)
- Individual Therapy - \$18.13 (15 min unit)
- Group Therapy - \$4.95 (15 min unit)
- Individual Therapy by assistant - \$14.50 (15 min unit)

Physical Therapy:

- Evaluation - \$41.20 (30 min. unit)
- Individual Therapy - \$18.13 (15 min. unit)
- Group Therapy - \$4.95 (15 min. unit)
- Individual Therapy by assistant - \$14.50 (15 min. unit)
- Group Therapy by assistant - \$3.96 (15 min. unit)

Speech-Language Pathology:

- Evaluation - \$41.20 (30 min. unit)
- Individual Therapy - \$18.13 (15 min. unit)
- Group Session - \$4.95 (15 min. unit)
- Individual Therapy by assistant - \$14.50 (15 min. unit)
- Group Therapy by assistant - \$3.95 (15 min. unit)
- Eval, Augmentative Comm. Device - \$148.96
- EPSDT periodic hearing screen - \$10.93
- EPSDT inter-periodic hearing screen - \$10.93

******* FOR FURTHER FAQs PERTAINING TO OT/PT/SLP, CLICK [HERE](#). *******