Arkansas Department of Human Services

Division of Developmental Disabilities Services

Director's Office

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To: Families, Beneficiaries, and Providers
From: Melissa Stone, Director MSS
Subject: Changes to Therapy beginning July 1, 2017
Date: June 15, 2017

The Division of Developmental Disabilities Services (DDS) sent out a previous correspondence on May 26, 2017, outlining the validation process of current DMS-640s beginning July 1, 2017. As stated in that previous correspondence, in the fall of 2016, DDS proposed changes in the Medicaid Provider Manuals and Medicaid State Plan for Occupational, Physical, and Speech Therapy, for clients with developmental disabilities or delays. The changes established the amount of therapy services that can be billed per week without an extension of benefits/prior authorization. Currently, therapy providers can bill up to four (4) units, or 60 minutes of each discipline per day and there is no prior authorization for these services. Beginning on July 1, 2017, therapists will not be able to bill more than 90 minutes (6 units) per week of therapy in each discipline without an extension of benefits/prior authorization. The changes to the weekly therapy amounts go into effect on July 1, 2017. There were no changes made to the medical necessity definition.

As previously stated in the May 26, 2017, correspondence, we have worked with representatives from ArkSHA, AROTA, and ArPTA and with AFMC, our contracted Quality Improvement Organization (QIO) like-vendor, to come up with a plan for implementing the 90 minute per week, per discipline established therapy amounts in July of this year. The plan is as follows:

For any therapy discipline with a prescription that is 90 minutes or less per week (regardless of the prescription date): You can continue to bill through the MMIS system without taking any additional steps, just as were prior to July 1, 2017.

For any therapy discipline with a prescription that was valid before July 1, 2017, and is in excess of 90 minutes per week: We have worked with AFMC to develop a "validation process." Providers will submit a beneficiary's existing DMS-640 (completed, dated, and signed) to AFMC via the electronic portal, beginning July 1, 2017. The DMS-640 is the only document that providers must submit for validation. AFMC will do a quick validation review, just making sure that the DMS-640 is complete and dated prior to July 1, 2017, and then will enter an authorization for that beneficiary in MMIS until the expiration of the prescription. This is NOT a medical necessity review. AFMC will raise the units in MMIS to comply with the DMS-640 for each beneficiary.

Based on our current volume projections, AFMC estimates they can perform this validation review within 10 business days, assuming the DMS-640s are submitted timely and

complete. You can also submit these requests via mail or facsimile, but that will delay the process.

We continue to receive questions regarding what should be billed during the validation process. DDS suggests that providers wait and bill the total amount once the DMS-640 is validated due to the fact that AFMC will have gone into MMIS and raised the units appropriately to do so.

We also continue to receive questions regarding if a provider should continue to provide therapy to beneficiaries above 90 minutes in one or more discipline during the validation process. As stated above and in the May 26, 2017, correspondence, AFMC will simply be looking to ensure that the beneficiary's existing DMS-640 is completed (dated and signed).

Lastly, DDS has received questions from providers who bill Medicaid for occupational therapy, speech therapy, or physical therapy for rehabilitative services purposes (relating to an injury or surgery) that is not in any way related to a developmental disability or delay. At this time, because the same codes are utilized for occupational, speech, and physical therapy regardless of whether prescribed for habilitative (for developmental disabilities or delays) or rehabilitative (for an injury or surgery) purposes, all Providers who bill the applicable codes should follow the validation process outlined above. I have attached a list of the affected codes.

However, please note that those billing MMIS for rehabilitative therapy are excluded from the medical necessity review outlined below. Therapy that rehabilitative in nature will only go through the DMS-640 validation process each time a new prescription is made and will continue to be subject to retrospective review by AFMC as they have done in the past.

For any prescription that is written on July 1, 2017 or later that is in excess of 90 minutes per week: You will need to get prior approval for an extension of benefits by submitting the request to AFMC along with all supporting documentation (the evaluation, diagnosis, etc.). AFMC will review this request in accordance with the same standards used to conduct retrospective reviews of therapy, set forth in the Occupational Therapy, Physical Therapy and Speech Therapy Manuals, along with the current practice standards for that discipline. AFMC has committed to completing these reviews within three (3) business days and will use credentialed clinicians of the same discipline in their review process.

I would like emphasize that no changes were made to the medical necessity definition or standard of review outlined in the Medicaid Physical Therapy, Occupational Therapy, and Speech Therapy Manual. Specifically, AFMC's clinicians will review extension of benefit/prior authorization requests in accordance with the criteria in the Manual. This includes, but is not limited to verifying:

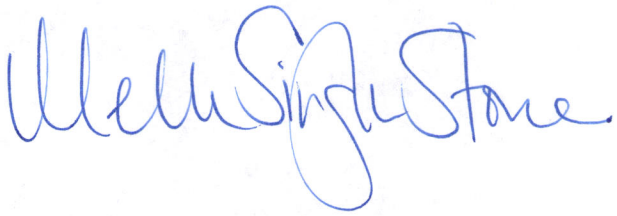
- the prescription;

- that a comprehensive, age appropriate evaluation was conducted using an approved standardized testing instrument listed in the manual;
- that the therapy is conducted due to a valid diagnosis;
- that the therapy administered effectively treats the beneficiary's condition;
- that there is a reasonable expectation that therapy will result in meaning improvement or that the therapy will prevent a worsening of the condition;
- that the frequency, intensity and duration of therapy is realistic for the age of the child.

We encourage all Providers to register for access to AFMC's electronic portal. The portal registration link and a registration instructional video can be accessed at: http://afmc.org/reviewpoint/

Once you complete the Provider Portal Registration form, you will be instructed to verify/validate your email address. Upon completion of these two steps, you will receive a "Welcome" email from AFMC providing you with your user name and the link to set your password. The internal validation process may take from one to two weeks. For assistance, contact the ReviewPoint helpdesk at: (479) 573-7777.

Again, DDS appreciates your patience as we work through changes to improve our system. We will be holding a Roundtable in July to receive immediate feedback on the validation process and the extension of benefit/prior authorization process from representatives of ArkSHA, AROTA, and ArPTA. DDS wants to work with Providers to ensure services are not disrupted and that the process is as simple as possible. Thank you again!



216.100 Extended Therapy Services 7-1-17

Arkansas Medicaid applies the following therapy benefits to all therapy services in this program:

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

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

C. All requests for extended therapy services must comply with Sections 216.300 through 216.315.

262.100 Occupational, Physical, Speech Therapy Procedure Codes 7-1-17

The following occupational, physical and speech-language pathology procedure codes are payable for therapy services indicated. Refer to Section IV - Glossary - for definitions of "group" and "individual" as they relate to therapy sessions.

A. OCCUPATIONAL THERAPY

Procedure Code	Required Modifiers	Description
97003	—	Evaluation for Occupational Therapy (30-minute unit; maximum of 4 units per state fiscal year, July 1 through June 30)