SECTION II – REHABILITATIVE OCCUPATIONAL THERAPY AND PHYSICAL THERAPY SERVICES

CONTENTS

200.000 REHABILITATIVE OCCUPATIONAL THERAPY AND PHYSICAL THERAPY SERVICES GENERAL INFORMATION

200.100 Arkansas Medicaid Participation Requirements 7-1-26

Providers of Occupational Therapy and Physical Therapy rehabilitative services for beneficiaries twenty-one (21) years of age or older must meet the provider participation and enrollment requirements contained within Section 140.000 of this manual. Providers must also meet the participation requirements of the applicable service discipline in Section 201.000 of this manual. Reimbursement is conditional upon compliance with this manual, manual update transmittals, and official program correspondence.

A. Beneficiaries younger than twenty-one (21) years of age who require rehabilitative therapy services are covered under the **Occupational Therapy, Physical Therapy and Speech-Language Pathology program manual**.

B. Beneficiaries twenty-one (21) years of age or older who require rehabilitative physical therapy in the home setting are covered under the **Home Health program manual**.

C. Beneficiaries twenty-one (21) years of age or older who require rehabilitative physical or occupational therapy while under Hospice care are described in the Hospice manual and covered in the **Home Health program manual**.

200.200 Individual Service Provider Participation Requirements 7-1-26

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

A. Complete the provider participation and enrollment requirements contained within Section 140.000 of this manual to enroll as a Medicaid provider; and

B. Meet the credentialling, experience, training, and other qualification requirements of their applicable service discipline contained within Section 201.000 of this manual.

C. Occupational Therapists enrolling as individuals or group providers are categorized as limited risk providers. For providers in the “limited” risk category, DHS must:

1. Verify that the provider meets any applicable federal regulations or state requirements for their provider type prior to making an enrollment determination.
2. Conduct license verifications, including state licensure verifications in states other than where the provider is enrolling, in accordance with 42 CFR 455.412; and
3. Conduct database checks on a pre- and post-enrollment basis to ensure that providers initially meet and continue to meet the enrollment criteria for their provider type, in accordance with 42 CFR 455.436.

D. Physical Therapists enrolling as individual or group providers are categorized as moderate risk providers. For providers in the “moderate” risk category, DHS must:

1. Perform the “limited” screening requirements described in Paragraph C above; and
2. Conduct on-site visits in accordance with 42 CFR 455.432.

200.300 Group Service Provider Participation Requirements 7-1-26

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

1. Complete the provider participation and enrollment requirements contained within Section 140.000 of this manual to enroll as a Medicaid provider; and
2. Each individual physical therapist, physical therapist assistant, occupational therapist, and occupational therapy assistant who provides services on behalf of the

group must complete the individual provider participation and enrollment requirements for their applicable service discipline contained within Sections 201.100 and 202.000 of this manual.

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

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

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

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

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

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

201.100 Occupational Therapy Provider Participation Requirements 7-1-26

201.200 Occupational Therapist Participation Requirements 7-1-26

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

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

B. Hold compact privileges from the Arkansas State Medical Board to practice occupational therapy in the State of Arkansas; or

C. If enrolling to perform occupational therapy services for an Arkansas Medicaid beneficiary outside the State of Arkansas, hold either:

1. A current license to practice as an occupational therapist in the state where services are being performed; or
2. Compact privileges to practice occupational therapy from the licensing board in the state where services are being performed.

201.300 Occupational Therapy Assistant Participation Requirements 7-1-26

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

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

B. Hold compact privileges from the Arkansas State Medical Board to practice occupational therapy as an occupational therapy assistant in the State of Arkansas; or

C. If enrolling to perform occupational therapy assistant services for an Arkansas Medicaid beneficiary outside the State of Arkansas, hold either:

1. A current license to practice as an occupational therapy assistant in the state where services are being performed; or
2. Compact privileges to practice as an occupational therapy assistant from the licensing board in the state where services are being performed.

201.400 Physical Therapy Provider Participation Requirements 7-1-26

201.500 Physical Therapist Participation Requirements 7-1-26

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

A. Be licensed by the Arkansas State Board of Physical Therapy to practice physical therapy in the State of Arkansas;

B. Hold compact privileges from the Arkansas State Board of Physical Therapy to practice physical therapy in the State of Arkansas; or

C. If enrolling to perform physical therapy services for an Arkansas Medicaid beneficiary outside the State of Arkansas, hold either:

1. A current license to practice as a physical therapist in the state where services are being performed; or
2. Compact privileges to practice physical therapy from the licensing board in the state where services are being performed.

201.600 Physical Therapist Assistant Participation Requirements 7-1-26

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

A. Be licensed by the Arkansas State Board of Physical Therapy to practice physical therapy as a physical therapist assistant in the State of Arkansas;

B. Hold compact privileges from the Arkansas State Board of Physical Therapy to practice physical therapy as a physical therapist assistant in the State of Arkansas; or

C. If enrolling to perform physical therapist assistant services for an Arkansas Medicaid beneficiary outside the State of Arkansas, hold either:

1. A current license to practice as a physical therapist assistant in the state where services are being performed; or
2. Compact privileges to practice as a physical therapist assistant from the licensing board in the state where services are being performed.

201.700 Services by an Unlicensed Student 7-1-26

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

201.800 Supervision 7-1-26

201.900 Physical Therapy 7-1-26

A. A physical therapist is morally, ethically, and legally responsible for the quality of work performed by each physical therapist assistant under the physical therapist's supervision.

1. A supervising therapist must be immediately available to provide assistance and direction throughout the time the service is being performed. Availability by telecommunication is sufficient to meet this requirement.
2. A supervising therapist must be consulted for changes in treatment, plan of care, or the identified goals.
3. A supervising therapist must be consulted for recommendations before prescription of durable medical equipment (DME) or assistive devices.
4. A supervising therapist must provide one (1) billable unit of service and write a progress report every ten (10) visits.

B. A supervising therapist is responsible for ensuring documentation completed by a therapist assistant under their supervision is sufficient to claim reimbursement for each date of service.

C. A physical therapist may not supervise more than five (5) therapist assistants at any given time.

202.000 Occupational Therapy 7-1-26

A. An occupational therapist is morally, ethically, and legally responsible for the quality of work performed by each occupational therapy assistant under the occupational therapist's supervision.

1. A supervising therapist must be immediately available to provide assistance and direction throughout the time the service is being performed. Availability by telecommunication is sufficient to meet this requirement.
2. A supervising therapist must be consulted for changes in treatment, plan of care, or the identified goals.
3. A supervising therapist must be consulted for recommendations before prescription of durable medical equipment (DME) or assistive devices.
4. A supervising therapist must provide one (1) billable unit of service and write a progress report every ten (10) visits.

B. A supervising therapist is responsible for ensuring documentation completed by a therapy assistant under their supervision is sufficient to claim reimbursement for each date of service.

C. An occupational therapist may not supervise more than five (5) occupational therapy assistants at any given time.

202.100 Documentation Requirements 7-1-26

202.200 Documentation Requirements for all Medicaid Providers 7-1-26

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

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

A. Rehabilitative occupational therapy and physical therapy service providers are required to maintain the following documentation in each beneficiary's service record:

1. A written referral, plan of care document, or prescription for rehabilitative occupational therapy or physical therapy treatment services, or both, signed and dated by the beneficiary's primary care provider, attending physician, or certified nurse practitioner within the past three (3) months (unless the prescription specifies a shorter period). (See Section 210.400)
2. The evaluation and treatment prescription may be obtained at the same time and provided on the same prescription signed by the beneficiary's PCP or attending physician or nurse practitioner.
3. A treatment plan for the prescribed occupational therapy or physical therapy rehabilitative services, or both, developed and signed by a provider licensed in the prescribed discipline(s) or the prescribing provider.
4. Rehabilitative occupational therapy or physical therapy services delivery documentation, which must include for each individual session:
    a. The beneficiary's name;
    b. The date and the beginning and ending times of each therapy session;
    c. A description of the specific services provided, and the activities rendered during each therapy session;
    d. The rendering service provider's full name, his or her credentials, and his or her signature for each therapy session; and
    e. The supervising therapist's progress report assessing improvements at least every ten (10) visits (Refer to Section 201.400 of this manual).
5. All other evaluation reports, progress notes, and related correspondence.
6. Discharge notes and summary, if applicable.

B. Providers of occupational therapy and physical therapy rehabilitative services must maintain:

1. Verification of their required qualifications. Refer to Section 201.000 of this manual; and
2. Any written contract between the individual provider and the group provider on behalf of which they provide services.

C. Group providers of occupational therapy and physical therapy rehabilitative services must maintain appropriate employment, certification, and licensure records for individuals employed or contracted by the group to provide occupational therapy or physical therapy services the group's behalf. If an individual practitioner provides services to a group provider pursuant to a contract, a copy of the contractual agreement must be maintained.

202.400 Electronic Signatures 7-1-26

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

210.000 PROGRAM COVERAGE

210.100 Introduction 7-1-26

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

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

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

210.200 Beneficiary Eligibility Requirements 7-1-26

210.300 Referral to Evaluate 7-1-26

A. Rehabilitative therapy evaluation services require a written referral signed by the beneficiary’s primary care provider, attending physician, or certified nurse practitioner, as appropriate.

   1. The original referral must be maintained by the referring provider.
   2. A copy of the referral must be maintained in the beneficiary’s service record by the rehabilitative therapy provider.

B. An evaluation referral and a prescription for rehabilitative therapy treatment may be prescribed simultaneously by the appropriate practitioner listed in (A) above. It is not required for the beneficiary to return to the referring or prescribing practitioner if both evaluation and treatment are medically necessary and ordered by the practitioner.

210.400 Treatment Prescription 7-1-26

A. Rehabilitative therapy services require a written prescription signed by the beneficiary’s primary care or attending physician or certified nurse practitioner.

   1. The original prescription must be maintained by the prescribing provider.
   2. A copy of the prescription must be maintained in the rehabilitative therapy provider’s beneficiary’s service record.

B. A prescription for rehabilitative therapy services is valid for the shorter of:

   1. The length of time specified on the prescription; or
   2. Three (3) months.

C. The prescription must demonstrate the medical necessity of rehabilitative therapy services.

1. The beneficiary's diagnosis must clearly establish and support the prescribed occupational therapy or physical therapy rehabilitative services, or both.
2. The prescription diagnosis codes and nomenclature must comply with the coding conventions and requirements established in the International Classification of Diseases Clinical Modification for the edition certified by the Arkansas Medicaid Program for the beneficiary's dates of service.
3. Some diagnosis codes are not specific enough to identify the medical necessity for occupational therapy and physical therapy rehabilitative services and shall not be used. (**View ICD codes.**)

210.500 Rehabilitative Therapy Services Comprehensive Evaluation 7-1-26

A. Rehabilitative therapy services must be medically necessary as demonstrated by the results of a comprehensive evaluation in the suspected area(s) of deficit.

1. A diagnosis alone is not sufficient documentation to demonstrate medical necessity.
2. The comprehensive evaluation must indicate the following:
   a. The provision of occupational therapy or physical therapy rehabilitative services, or both, will be an effective treatment for the beneficiary's condition under accepted standards of practice;
   b. The prescribed rehabilitative therapy services are of a level of complexity, or the beneficiary's condition is such that the services can only be safely and effectively performed by or under the supervision of a licensed occupational therapist or physical therapist, as appropriate; and
   c. There is a reasonable expectation the rehabilitative therapy services will result in meaningful improvement or prevent a worsening of the beneficiary's condition.
3. The frequency, intensity, and duration of the prescribed rehabilitative therapy services must be medically necessary based on the results of the comprehensive evaluation and realistic for the age and physical condition of the beneficiary.

B. Each comprehensive evaluation must include an evaluation report with the following information. There is not a required order or format in which the evaluation report must be prepared:

1. The beneficiary's name and age or date of birth;
2. The prescribing providers name and credentials;
3. The diagnosis specific to the service(s) and suspected area(s) of deficit;
4. Background information on the beneficiary including pertinent medical history;
5. One (1) or more standardized evaluations of the beneficiary specific to the suspected area(s) of deficit, including all relevant scores, quotients, and indexes, if applicable;
   a. Each comprehensive evaluation used to establish medical necessity for occupational therapy and physical therapy rehabilitative services must include objective information describing the beneficiary's gross and fine motor abilities and deficits, such as range of motion measurements, manual muscle testing, muscle tone, or a narrative description of the beneficiary's functional mobility skills.
   b. If administration of a standardized evaluation instrument is inappropriate or unavailable, an in-depth narrative of the functional profile describing the beneficiary's abilities and deficits may be used as a substitute for a standardized evaluation. The narrative must include the following:
      i. The reason a standardized evaluation is inappropriate, or cannot be used with the beneficiary;

ii. The beneficiary's functional impairment(s), including specific skills and deficits;

iii. A list of supplemental assessments, evaluations, tools, and tests conducted to document deficits and develop the in-depth functional profile; and

iv. The rationale, contributing factors, and specific results of any supplemental assessments, evaluations, tools, tests, clinical observation, and clinical analysis procedures conducted that indicate rehabilitative therapy services are medically necessary for the beneficiary.

6. An interpretation of the results of the standardized evaluation and in-person clinical observations, including recommendations for the frequency, duration, and intensity of the rehabilitative therapy services;

7. A description of the functional strengths and limitations of the beneficiary, a suggested treatment plan, and goals to address each identified problem; and

8. The dated signature and credentials of the qualified practitioner that performed the standardized evaluation.

C. All aspects of a comprehensive evaluation for rehabilitative therapy services, including the administration of the standardized evaluation, must be communicated and conducted in the beneficiary's primary or preferred language.

D. Supplemental screeners, evaluations, tools, assessments, clinical observation, and clinical analysis procedures used as part of the comprehensive evaluation to support the qualifying standardized evaluation may not be used to replace the qualifying standardized evaluation except as provided in Section 210.500(B)(5)(b).

210.600 Non-Covered Services 7-1-26

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

Occupational therapy or physical rehabilitative therapy services provided under this manual and under the Home Health manual which are duplicative in nature are not allowed for the same time period. However, if a beneficiary is receiving only nursing care services under the home health manual, rehabilitative occupational or physical therapy services may be provided to the beneficiary.

210.700 Covered Services 7-1-26

A. Arkansas Medicaid will only reimburse those services listed in Section 210.800 through 211.000 of this manual, as well as corresponding manual update transmittals, and relevant official program correspondence. Covered services are subject to all applicable limits.

B. Covered services are only reimbursable if medically necessary.

C. Please refer to the **Home Health program manual** for patients twenty-one (21) years of age and older who are receiving physical rehabilitative therapy in the home setting.

D. Please refer to the **Home Health program manual** for specific coverage rules for patients twenty-one (21) years of age and older who are receiving physical or occupational rehabilitative therapy while under Hospice care.

210.800 Occupational Therapy and Physical Therapy Rehabilitative Evaluation and Treatment Planning Services 7-1-26

A. A provider may be reimbursed for medically necessary rehabilitative therapy evaluation and treatment planning services. Rehabilitative therapy evaluation and treatment planning services are a component of the process for determining a beneficiary's eligibility for rehabilitative therapy treatment services and developing the treatment plan.

B. Need for rehabilitative therapy services is demonstrated by a referral from the beneficiary's primary care provider or attending physician or nurse practitioner validating the medical necessity of the services.

C. The treatment plan must be developed and signed by an enrolled provider who is licensed in the prescribed service discipline or by the beneficiary's primary care provider or attending physician or nurse practitioner. The treatment plan must include functional, measurable, and specific goals for each individual beneficiary.

D. Medically necessary rehabilitative therapy evaluation and treatment planning services are reimbursed on a per-unit basis according to complexity. The billable unit includes time spent administering and scoring a standardized evaluation, clinical observation, administering supplemental tests and tools, writing a comprehensive evaluation report, along with time spent developing the treatment plan. **View or print billable occupational therapy and physical therapy evaluation and treatment planning complexity codes and descriptions.**

210.900 Rehabilitative Therapy Treatment Services 7-1-26

A. An enrolled provider may be reimbursed for rehabilitative therapy treatment services. Occupational therapy or physical therapy rehabilitative treatment services must be medically necessary in accordance with Section 210.500 of this manual.

B. A group rehabilitative therapy provider may contract with or employ its practitioners. The group provider must identify the individual physical therapist, physical therapist assistant, occupational therapist, or occupational therapy assistant as the performing provider on the claim according to their respective therapy discipline when the group therapy provider bills the Arkansas Medicaid Program for rehabilitative therapy services. The individual physical therapist, physical therapist assistant, occupational therapist, or occupational therapy assistant performing the rehabilitative therapy must be enrolled with the Arkansas Medicaid Program and the criteria for individual providers of therapy services shall apply. See Section 202.000 of this manual.

C. All rehabilitative therapy treatment services furnished by a therapy provider must be provided according to a treatment plan developed by a licensed therapist. All rehabilitative therapy treatment services must be provided, documented, and billed in accordance with this manual.

D. Medically necessary rehabilitative therapy services are covered for up to twelve (12) rehabilitative therapy visits per state fiscal year (SFY). A maximum of two (2) units of therapy evaluation per discipline per SFY is also allowed. See Section 220.000 of this manual regarding how to request an extension of benefits. Refer to Section 211.000 of this manual regarding rehabilitative therapy services via telecommunication.

1. **View or print the billable occupational therapy codes and descriptions.**
2. **View or print the billable physical therapy codes and descriptions.**

211.000 Telemedicine Services 7-1-26

A. An enrolled provider may be reimbursed for medically necessary rehabilitative therapy services delivered through telemedicine.

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

B. The service provider is responsible for ensuring service delivery through telemedicine is equivalent to in-person service delivery.

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

C. Services delivered through telemedicine are reimbursed in the same manner as in-person service delivery. **View or print the billable telecommunication codes and descriptions**.

220.000 BENEFIT LIMITS

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

A. Rehabilitative therapy services are subject to a benefit limit of twelve (12) visits per state fiscal year (SFY).

B. Extension of this benefit is automatic for patients whose primary diagnosis for the service furnished is in the following list:

1. Malignant neoplasm (**View ICD Codes**.)
2. HIV infection and AIDS (**View ICD Codes.**)

3. Renal failure (**View ICD Codes.**)
4. Pregnancy (**View ICD Codes.**)

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

D. Requests for benefit extensions for rehabilitative therapy services for beneficiaries twenty-one (21) years of age or older must comply with Section 220.200.

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

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

B. The request must meet medical necessity requirements for the services provided, and adequate documentation must be submitted to support the request.

1. A request for extended rehabilitative therapy services is considered only after a claim is denied because regular benefits were exceeded.
2. The request must be received within ninety (90) calendar days of the date of the denial for exceeding benefits. The count begins on the next working day after the date of the Remittance and Status Report (RA) on which the benefits-exceeded denial appears.
3. The provider must submit a copy of the Medical Assistance Remittance and Status Report (RA) reflecting the denial for exceeding benefits with the extension request. Do not send a claim.
4. Requests for extension submitted by facsimile (FAX) or email will not be accepted for review.

C. Form DMS-671, “Request for Extension of Benefits for Clinical, Outpatient, Diagnostic Laboratory, and Radiology/Other Services,” must be used when requesting extended rehabilitative therapy services. **View or print Form DMS-671**. Correct completion of all fields on this form is required for consideration of the request. The instructions for completion of this form are located on the back of the form. The provider must sign, include his or her credentials, and date the Form DMS-671. All relevant documentation that supports the medical necessity of the request must be attached to be considered.

220.300 Request for Extension of Benefits Documentation Requirements 7-1-26

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

A. PCP or attending provider referral and prescription for the amount of service requested;

B. Documentation to demonstrate the medical necessity of the request for extension of benefits. Appropriate documentation may include without limitation: comprehensive evaluation(s), diagnosis(es), clinical records, or progress reports; and

C. Signature of the performing provider, including credentials, and date signed.

220.400 Review Process for Request for Extension of Benefits 7-1-26

A. Requests for extension of benefits are initially screened for completeness and researched to determine the beneficiary’s eligibility for Medicaid.

B. All documentation submitted with the request is reviewed by an appropriately licensed clinician.

1. If the reviewing clinician determines the documentation demonstrates the medical necessity of the request, then an approval letter is mailed to the requesting provider the following business day;
2. If the reviewing clinician determines the documentation does not demonstrate medical necessity, the request is referred to a physician for review.
    a. If the reviewing physician determines the documentation demonstrates medical necessity, an approval letter is mailed to the requesting provider the following business day.
    b. If the reviewing physician determines the documentation does not demonstrate medical necessity, then a denial letter that includes the physician's rationale for denial of the request is mailed to the provider and the beneficiary the following business day.
3. A provider may request an administrative reconsideration of any denial of a request for extension of benefits in accordance with Section 220.500 of this manual.

220.500 Administrative Reconsideration and Appeals 7-1-26

A. Medicaid allows only one (1) reconsideration of an adverse decision. Reconsideration requests of denied benefit extensions or prior authorizations must be submitted in accordance with Section 160.000 of Section I of this manual.

B. When the state Medicaid agency or its designee denies a reconsideration request or issues any adverse decision, the beneficiary or provider may appeal and request a fair hearing. A request for a fair hearing must be submitted in accordance with Sections 160.000, 190.000, and 191.000 of Section I of this manual.

230.000 REIMBURSEMENT

230.100 Method of Reimbursement

A. Occupational therapy and physical therapy rehabilitative services use fee schedule reimbursement methodology. Under the fee schedule methodology, reimbursement is made at the lower of the billed charge for the service or maximum allowable reimbursement for the service under the Arkansas Medicaid Program.

1. A full unit of service must be rendered in order to bill a unit of service.
2. Partial units of service may not be rounded up and are not reimbursable.

B. The maximum group size for occupational therapy or physical therapy rehabilitative services is four (4) beneficiaries.

230.200 Fee Schedules 7-1-26

A. The Arkansas Medicaid Program provides fee schedules on the Arkansas Medicaid website. **View or print the occupational therapy and physical therapy services fee schedule**.

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

C. Fee schedules and **therapy category codes** do not guarantee payment, coverage, or the reimbursement amount. Fee schedule and procedure code information may be changed or updated at any time to correct a discrepancy or error.