

SECTION II - OCCUPATIONAL THERAPY, PHYSICAL THERAPY, AND SPEECH-LANGUAGE PATHOLOGY SERVICES

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200.000 OCCUPATIONAL THERAPY, PHYSICAL THERAPY, AND SPEECH-LANGUAGE PATHOLOGY GENERAL INFORMATION

201.000 Arkansas Medicaid Participation Requirements 1-1-22

201.100 Individual Service Provider Participation Requirements 1-1-22

Individual providers of occupational therapy, physical therapy, and speech-language pathology services must meet the following requirements to be eligible to participate in the Arkansas Medicaid Program:

- A. Complete the Provider Participation and enrollment requirements contained within Section 140.000 of this manual; and
- B. Meet the participation requirements of the applicable service discipline in Section 202.000 of this manual.

201.200 Group Service Provider Participation Requirements 1-1-22

- A. Group providers of occupational therapy, physical therapy, and speech-language pathology 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; and
 2. Each individual therapist, therapy assistant, speech-language pathologist, and speech language pathologist assistant providing services on behalf of the group must meet the participation requirements for the applicable service discipline in Section 202.000 and also be enrolled in the Arkansas Medicaid Program.
- B. Group providers of occupational therapy, physical therapy, and speech-language pathology services are “pay to” providers only. The service must be performed and billed

by a Medicaid-enrolled and licensed therapist, speech-language pathologist, therapy assistant, or speech-language pathology assistant within the group.

201.300 **School District, Education Service Cooperative, and Early Intervention Day Treatment Provider Participation Requirements** **1-1-22**

- A. School districts and education service cooperatives must be certified by the Arkansas Department of Education in order to participate in the Arkansas Medicaid Program.
- B. Early Intervention Day Treatment (EIDT) providers must have an EIDT license issued by the Arkansas Department of Human Services, Division of Provider Services and Quality Assurance (DPSQA) in order to participate in the Arkansas Medicaid Program.
- C. A school district, education service cooperative, or EIDT program may elect to employ or contract with the therapists, speech-language pathologists, therapy assistants, and speech-language pathology assistants that perform those services on its behalf.
 1. If a school district, education service cooperative, or EIDT program contracts with a therapist, speech-language pathologist, therapy assistant, or speech-language pathology assistant to perform services on its behalf, then the practitioner must meet the participation requirements for the applicable service discipline in Section 202.000 and be enrolled in the Arkansas Medicaid Program.
 2. If a school district, education service cooperative, or EIDT program employs a therapist, speech-language pathologist, therapy assistant, or speech-language pathology assistant to perform services on its behalf, the practitioner has the option of either enrolling with the Arkansas Medicaid Program or requesting a Practitioner Identification Number. [View or print form DMS-7708.](#)
- D. The individual practitioner who performs a service must be identified on the claim as the performing provider when the school district, education service cooperative, or EIDT program bills for that service.

201.400 **Service Providers in Arkansas and Bordering States** **1-1-22**

Providers of occupational therapy, physical therapy, and speech-language pathology 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 Section 201.100 and Section 201.200, as applicable.

201.500 **Service Providers in States Not Bordering Arkansas** **1-1-22**

Providers of occupational therapy, physical therapy, and speech-language pathology 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 client. A separate single case agreement must be entered into for each Arkansas Medicaid eligible client. 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 \(Application Packet\).](#)

202.000 **Occupational Therapy, Physical Therapy, and Speech-Language Pathology Service Provider Participation Requirements**

202.100 **Occupational Therapy**

- 202.110 Occupational Therapist Participation Requirements 1-1-22**
- A. An occupational therapist must be either:
 - 1. Certified by the National Board for Certification in Occupational Therapy; or
 - 2. A graduate of a program in occupational therapy, who is accredited by the Commission on Accreditation of Allied Health Education Programs and actively acquiring the supplemental clinical experience required to be certified by the National Board for Certification in Occupational Therapy.
 - B. An occupational therapist must be licensed to practice as an occupational therapist in the therapist's state of residence.
- 202.120 Occupational Therapy Assistant Participation Requirements 1-1-22**
- A. An occupational therapy assistant must have an associate (or more advanced) degree in occupational therapy from a program approved by the National Board for Certification in Occupational Therapy.
 - B. An occupational therapy assistant must be licensed to practice as an occupational therapy assistant in the therapist's state of residence.
 - C. An occupational therapy assistant must be under the supervision of a licensed occupational therapist enrolled in the Arkansas Medicaid Program. See Supervision requirements in Section 203.000.
- 202.200 Physical Therapy**
- 202.210 Physical Therapist Participation Requirements 1-1-22**
- A. A physical therapist must be a graduate of a physical therapy program accredited by both the Commission on Accreditation of Allied Health Education Programs and the American Physical Therapy Association.
 - B. A physical therapist must be licensed to practice as a physical therapist in the therapist's state of residence.
- 202.220 Physical Therapy Assistant Participation Requirements 1-1-22**
- A. A physical therapy assistant must have an associate (or more advanced) degree in physical therapy from a program approved by the American Physical Therapy Association.
 - B. A physical therapy assistant must be licensed to practice as a physical therapy assistant in his or her state of residence.
 - C. The physical therapy assistant must be under the supervision of a licensed physical therapist enrolled in the Arkansas Medicaid Program. See Supervision requirements in Section 203.000.
- 202.300 Speech-Language Pathology**
- 202.310 Speech-Language Pathologist Participation Requirements 1-1-22**
- A. A speech-language pathologist must have completed or received one (1) of the following:

1. A certificate of clinical competence from the American Speech-Language-Hearing Association;
 2. The educational and work experience requirements necessary to qualify for a certificate of clinical competence from the American Speech-Language-Hearing Association (ASHA); or
 3. The educational requirements and be actively acquiring the supervised work experience requirements to qualify for a certificate of clinical competence from ASHA.
- B. A speech-language pathologist must be licensed to practice as a speech-language pathologist in the pathologist's state of residence.

202.320 **Speech-Language Pathology Assistant Participation Requirements** **1-1-22**

- A. A speech-language pathology assistant must have a bachelor's (or more advanced) degree in speech-language pathology.
- B. A speech-language pathology assistant must be licensed to practice as a speech-language pathology assistant in the pathologist's state of residence.
- C. A speech-language pathology assistant must be under the supervision of a qualified speech-language pathologist enrolled in the Arkansas Medicaid Program. See Supervision requirements in Section 203.000.

202.330 **Speech-Language Pathology Licensure Exemptions Under Arkansas Code §17-100-104** **1-1-22**

Arkansas Code §17-97-104, allows the following individuals to perform speech-language pathology services without state licensure:

- A. An individual performing speech-language pathology services solely within the confines or under the jurisdiction of a public school system if the individual holds a valid and current certificate as a speech therapist or speech-language pathologist issued by the Arkansas Department of Education.
- B. An individual performing speech-language pathology services solely within the confines of their duties as an employee of the State of Arkansas, provided that the person was an employee of the State of Arkansas on January 1, 1993.
- C. An individual performing speech-language pathology services solely within the confines of their duties as an employee of any entity licensed or certified as a Developmental Disability Services community provider by the Division of Provider Services and Quality Assurance Services if the individual:
 1. Holds a minimum of a bachelor's degree in speech-language pathology;
 2. Is supervised by a licensed speech-language pathologist; and
 3. Complies with Arkansas regulations as a Speech-Language Pathology Support Personnel.

202.400 **Services by an Unlicensed Student** **1-1-22**

Occupational therapy, physical therapy, and speech-language pathology 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, such that the licensed provider is considered to be providing the service.

203.000 **Supervision** **1-1-22**

- A. A therapist or speech-language pathologist is responsible for the quality of work performed by each therapy assistant or speech-language pathology assistant under the therapist's supervision.
 - 1. A supervising therapist or speech-language pathologist 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 therapist or speech-language pathologist must conduct an in-person observation of each therapy assistant or speech-language pathology assistant that they supervise throughout a service session at least once every thirty (30) calendar days.
 - 3. A therapist or speech-language pathologist must review the treatment plan and progress notes of each therapy assistant or speech-language pathology assistant that they supervise at least once every thirty (30) calendar days.
- B. A therapist or speech-language pathologist must review and approve all written documentation completed by a therapy assistant or speech-language pathology assistant under their supervision prior to the filing of claims for the service provided.
 - 1. Each page of progress note entries must be signed by the supervising therapist or speech-language pathologist with their full signature, credentials, and date of review.
 - 2. The supervising therapist or speech-language pathologist must document approval of progress made and any recommended changes in the treatment plan.
 - 3. All supervision activities must be documented and available for review in the client's service record.
- C. A therapist or speech-language pathologist may not supervise more than five (5) therapy assistants or speech-language pathology assistants at any given time.

204.000 **Documentation Requirements** **1-1-22**

204.100 **Documentation Requirements for all Medicaid Providers** **1-1-22**

See Section 140.000 for the documentation that is required for all Arkansas Medicaid Program providers.

204.200 **Occupational Therapy, Physical Therapy, and Speech-Language Pathology Documentation Requirements** **1-1-22**

- A. Occupational therapy, physical therapy, and speech-language pathology providers are required to maintain the following documentation in each client's service record:
 - 1. A written referral for occupational therapy, physical therapy, or speech-language pathology services signed and dated within the past twelve (12) months by the client's primary care or attending physician or certified nurse practitioner.
 - 2. A written prescription for occupational, physical therapy, or speech-language pathology services signed and dated by the client's primary care or attending physician or certified nurse practitioner within the past twelve (12) months (unless the prescription specifies a shorter period).
 - 3. A treatment plan for the prescribed occupational therapy, physical therapy, or speech-language pathology services developed and signed by a provider licensed in the prescribed discipline(s) or the prescribing physician or certified nurse practitioner. See Section 214.110(C).
 - 4. Where applicable, an Individualized Family Service Plan established pursuant to Part C of the Individuals with Disabilities Education Act.

5. Where applicable, the Individual Treatment Plan developed by the Early Childhood Developmental Specialist assigned to the client by the Early Intervention Day Treatment program.
 6. Where applicable, the Individual Educational Plan (IEP) established pursuant to Part B of the Individuals with Disabilities Education Act.
 - a. The entire volume of the IEP is not required.
 - b. The following are the only required pages of the IEP:
 - i. First page;
 - ii. Present Level of Academic Achievement and Functional Performance page(s);
 - iii. Goals and Objectives page(s) (pertinent to the service requested);
 - iv. Services Summary/Schedule of Services page(s); and
 - v. Signature page.
 7. Service delivery documentation, which must include for each individual session:
 - a. Client's name;
 - b. The date and beginning and ending time of service session;
 - c. A description of specific services provided and the activities rendered during each session;
 - d. The full name, credentials, and signature of the rendering therapist, therapist assistant, speech-language pathologist or speech-language pathologist assistant are provided for each session; and
 - e. Weekly or more frequent progress notes signed or initialed by the therapist or speech-language pathologist overseeing the services, describing the client's status with respect to his or her goals and objectives.
 8. All evaluation reports, progress notes, and any related correspondence.
 9. Discharge notes and summary, if applicable.
- B. Any individual provider of occupational therapy, physical therapy, or speech-language pathology services must maintain:
1. Verification of their required qualifications. Refer to Section 202.000 of this manual; and
 2. Any written contract between the individual provider and the group provider, school district, education service cooperative, and EIDT program on behalf of which they provide services.
- C. Any group provider, school district, education service cooperative, and EIDT program must maintain appropriate employment, certification, and licensure records for all individuals employed or contracted by the group to provide occupational therapy, physical therapy, or speech-language pathology services. If an individual practitioner provides services to a group provider, school district, education service cooperative, and EIDT program pursuant to a contract, then a copy of the contractual agreement must be maintained.

205.000 Electronic Signatures**1-1-22**

The Arkansas Medicaid program will accept electronic signatures in compliance with Arkansas Code § 25-31-103 et seq.

206.000 Required Referral to First Connections pursuant to Part C of Individuals with Disabilities Education Act ("IDEA")**1-1-22**

First Connections is the program in Arkansas that administers, monitors, and carries out all Part C of IDEA activities and responsibilities for the state. Each occupational therapy, physical therapy, and speech-language pathology service provider must, within two (2) working days of first contact, refer to the First Connections program any infant or toddler from birth to thirty-six (36) months of age for whom there is a diagnosis or suspicion of a developmental delay or disability. The referral must be made to the DDS First Connections Central Intake Unit. [View or print referral form.](#) Each provider is responsible for documenting that a proper and timely referral to First Connections has been made.

207.000 **Required Referral to Local Education Agency (“LEA”) pursuant to Part B of IDEA** **1-1-22**

- A. Each occupational therapy, physical therapy, and speech-language pathology service provider must, within two (2) working days of first contact, refer to the Local Education Agency (LEA) any child three (3) years of age or older that has not entered kindergarten for whom there is a diagnosis or suspicion of a developmental delay or disability.
- B. Each occupational therapy, physical therapy, and speech-language pathology service provider must refer any child under three (3) years of age that they are currently serving to the LEA at least ninety (90) days prior to the child’s third birthday. If the child begins services less than ninety (90) days prior to their third birthday, the referral should be made in accordance with the late referral requirements of the IDEA.
- C. Referrals must be made to the LEA where the child resides.
- D. Each service provider is responsible for maintaining documentation evidencing that a proper and timely referral to has been made.

210.000 **PROGRAM COVERAGE**

211.000 **Introduction** **1-1-22**

The Arkansas Medicaid Program will reimburse enrolled providers for medically necessary covered services when such services are provided pursuant to a plan of care to Medicaid-eligible individuals under twenty-one (21) years of age in the Child Health Services (EPSDT) Program. Medicaid reimbursement is conditional upon compliance with this manual, manual update transmittals, and official program correspondence.

- A. Occupational therapy, physical therapy, and speech-language pathology services for individuals twenty-one (21) years of age and older are not covered services under this manual.
- B. Refer to one (1) of the following Medicaid program manuals for the coverage and requirements related to occupational therapy, physical therapy, and speech-language pathology services for individuals twenty-one (21) years of age and older:
 1. Hospital/Critical Access Hospital (CAH)/End-Stage Renal Disease (ESRD);
 2. Home Health;
 3. Hospice;
 4. Adult Developmental Day Treatment; and
 5. Physician/Independent Lab/CRNA/Radiation Therapy Center.

212.000 **Client Eligibility Requirements** **1-1-22**

212.100 Child Health Services (EPSDT) Participation 1-1-22

A client must be under twenty-one (21) years of age and participating in the EPSDT program to be eligible to receive occupational therapy, physical therapy, or speech-language pathology services through the Arkansas Medicaid Program.

212.200 Referral to Evaluate 1-1-22

- A. Occupational therapy, physical therapy, and speech-language pathology services require a written referral signed by the client's primary care or attending physician or certified nurse practitioner, as appropriate.
1. The original referral is to be maintained by the physician or certified nurse practitioner.
 2. A copy of the referral must be maintained in the client's service record.
- B. A referral for occupational therapy, physical therapy, and speech-language pathology services must be renewed at least once every twelve (12) months; however, when a school district is providing the occupational therapy, physical therapy, or speech-language pathology services in accordance with a client's Individualized Education Program (IEP), a referral is required at the beginning of each school year.

212.300 Treatment Prescription 1-1-22

- A. Occupational therapy, physical therapy, and speech-language pathology services require a written prescription signed by the client's primary care or attending physician or certified nurse practitioner, as appropriate.
1. The original prescription is to be maintained by the physician or certified nurse practitioner.
 2. A copy of the prescription must be maintained in the client's service record.
- B. A prescription for occupational therapy, physical therapy, or speech-language pathology services is valid for the shorter of the length of time specified on the prescription or one (1) year.
- C. The prescription for occupational therapy, physical therapy, and speech-language pathology services must be on a form DMS-640 – "Occupational, Physical and Speech Therapy for Medicaid Eligible Beneficiaries Under Age 21 Prescription/Referral". [View or print form DMS-640.](#)
- D. The prescription must demonstrate the medical necessity for the occupational therapy, physical therapy, or speech-language pathology services.
1. The client's diagnosis must clearly establish and support the prescribed occupational therapy, physical therapy, or speech-language pathology services.
 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 client's dates of service.
 3. The following diagnosis codes are not specific enough to identify the medical necessity for occupational therapy, physical therapy, or speech-language pathology services and may not be used. [\(View ICD codes.\)](#)

212.400 Comprehensive Assessment 1-1-22

- A. Occupational therapy, physical therapy, and speech-language pathology services must be medically necessary as demonstrated by the results of a comprehensive assessment in the area of deficit.
1. A diagnosis alone is not sufficient documentation to demonstrate medical necessity.
 2. The comprehensive assessment must indicate each the following:
 - a. The provision of occupational therapy, physical therapy, or speech-language pathology services would be an effective treatment for the client's condition under accepted standards of practice;
 - b. The prescribed occupational therapy, physical therapy, or speech-language pathology services are of a level of complexity or the client's condition is such that the services can be only be safely and effectively performed by or under the supervision of a licensed occupational therapist, physical therapist, or speech-language pathologist, as appropriate; and
 - c. There is a reasonable expectation that the occupational therapy, physical therapy, or speech-language pathology services will result in meaningful improvement or prevent a worsening of the client's condition.
 3. The frequency, intensity, and duration of the prescribed occupational therapy, physical therapy, and speech-language pathology services must be medically necessary based on the results of the comprehensive assessment and realistic for the age of the client.
- B. Each comprehensive assessment specific to the suspected area(s) of deficit must include the following:
1. The client's name and date of birth;
 2. The diagnosis specific to the service and suspected area(s) of deficit;
 3. Background information on the client including pertinent medical history;
 4. The gestational age, if the client is less than twelve (12) months of age;
 - a. To calculate a client's gestational age, subtract the number of weeks born before forty (40) weeks of gestation from the chronological age of the client.
 - b. For example, a client who is thirty-two (32) weeks of age and who was born in the twenty-eighth week of gestation would have a gestational age of twenty (20) weeks according to the following equation: 32 weeks - (40 weeks - 28 weeks) = 20 weeks.
 5. One (1) or more standardized evaluations of the client specific to the suspected area(s) of deficit, including all relevant scores, quotients, and indexes, if applicable.
 - a. See Sections 212.500 and 212.510 for requirements relating to occupational therapy and physical therapy standardized evaluations.
 - b. See Sections 212.500 and 212.520 for requirements relating to speech-language pathology standardized evaluations.
 - c. If administration of a standardized evaluation instrument is inappropriate or unavailable, then an in-depth, detailed narrative functional profile of the client's abilities and deficits may be used as a substitute for a standardized evaluation if it specifically includes the following:
 - i. The reason a standardized evaluation is inappropriate for or cannot be used with the client;
 - ii. The client'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 that occupational therapy, physical therapy, or speech-language pathology services are medically necessary for the client.
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 occupational therapy, physical therapy, or speech-language pathology services.
 7. A description of functional strengths and limitations of the client, a suggested treatment plan, and goals to address each identified problem.
 8. The signature and credentials of the qualified practitioner that performed the standardized evaluation.
- C. All aspects of a comprehensive assessment for occupational therapy, physical therapy, or speech-language pathology services, including the administration of the standardized evaluation, must be communicated and conducted in the client's primary or preferred language.
- D. Supplemental screeners, evaluations, tools, assessments, clinical observation, and clinical analysis procedures used as part of the comprehensive assessment to support the qualifying standardized evaluation(s) results do not have to conform to the requirements of Section 212.510 and Section 212.520; however, these supplemental measures cannot be used to replace the use of a qualifying standardized evaluation except as provided in Section 212.400(B)(5)(c).

212.410 Occupational and Physical Therapy Comprehensive Assessments 1-1-22

In addition to those requirements in Section 212.400(B), each comprehensive assessment used to establish medical necessity for occupational therapy and physical therapy services must include objective information describing the client'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 client's functional mobility skills.

212.420 Speech-Language Pathology Comprehensive Assessments 1-1-22

- A. In addition to those requirements in Section 212.400(B), each comprehensive assessment used to establish medical necessity for speech-language pathology services must include:
1. An oral-peripheral speech mechanism examination, which must include a description of the structure and function of the orofacial structures; and
 2. An assessment of hearing, articulation, voice, and fluency skills. For a suspected voice, fluency, or speech production disorder, there must also be a formal screening of language skills performed using an instrument such as the Fluharty-2, KLST-2, CELF-4 Screen or TTFC.
- B. Depending on the type of communication disorder suspected, the following are required to be included as part of a comprehensive assessment used to establish medical necessity:
1. Language Disorder: a comprehensive measure of language must be included for initial eligibility purposes. Use of one-word vocabulary tests alone will not be accepted;
 2. Speech Production Disorder: a comprehensive measure with all errors specific to the type of speech production disorder reported (for example, positions, processes, and motor patterns);
 3. Voice Disorder: a medical evaluation to determine the presence or absence of a physical etiology is required as part of the comprehensive assessment; and

4. Oral Motor, Swallowing, or Feeding Disorder: if swallowing problems or signs of aspiration are noted, then a referral for a videofluoroscopic swallow study must be made and documented as part of the comprehensive assessment.

212.500 Standardized Evaluation

1-1-22

- A. Except as provided in Section 212.400(B)(5)(c), one (1) or more standardized evaluations are a required component of the comprehensive assessment used to establish a client's eligibility to receive occupational therapy, physical therapy, and speech-language pathology services.
 1. Beneficiaries receiving occupational therapy, physical therapy, or speech-language pathology services outside of public schools must receive an annual standardized evaluation(s) to demonstrate continued eligibility.
 2. Beneficiaries receiving occupational therapy, physical therapy, or speech-language pathology services as a part of an Individual Program Plan (IPP) or an Individual Education Plan (IEP) through public schools must receive a standardized evaluation(s) every three (3) years to demonstrate continued eligibility; however, an annual update of the client's progress is required.
- B. Section 212.510(B), Section 212.510(C), and Section 212.520(B) link to the list of the standardized evaluation instruments and clinical analysis procedures that are accepted by the Arkansas Medicaid Program for the purpose of establishing eligibility to receive occupational therapy, physical therapy, and speech-language pathology services, respectively.
- C. The lists of standardized evaluation instruments and clinical analysis procedures accepted by the Arkansas Medicaid Program for establishing eligibility for occupational therapy, physical therapy, and speech-language pathology services is not all-inclusive.
- D. When using a standardized evaluation instrument that is not on the Arkansas Medicaid approved list, a justification must be included in the evaluation report explaining why the chosen instrument is valid, reliable, and appropriate for purposes of establishing eligibility for services.
- E. Any standardized evaluation used to establish eligibility for occupational therapy, physical therapy, and speech-language pathology services must conform to the following standards:
 1. The evaluation must be norm-referenced and specific to the service provided;
 2. The evaluation must be age appropriate for the client;
 3. All evaluation subtests, components, and scores must be reported;
 - a. Evaluation results must be reported as standard scores, Z scores, T scores, or percentiles; age-equivalent and percentage of delay scores cannot be used to determine eligibility; and
 - b. Evaluation results should be adjusted for prematurity if the client is under one (1) year old, and the adjustment should be noted in the evaluation report.
 4. The evaluation must be performed by a qualified evaluator that has the credentials and training recommended by the evaluation instrument.

212.510 Occupational and Physical Therapy Standardized Evaluations

1-1-22

- A. The medical necessity of occupational therapy and physical therapy services is established by a score on a standardized evaluation performed within the past twelve (12) months that indicates a composite or subtest area score of at least one point five (1.5) standard deviations below the mean.

- B. [View or print the list of standardized evaluation instruments](#) accepted by Arkansas Medicaid Program to establish eligibility for Occupational therapy services.
- C. [View or print the list of standardized evaluation instruments](#) accepted by Arkansas Medicaid Program to establish eligibility for Physical therapy services.

212.520 Speech-Language Pathology Standardized Evaluations

1-1-22

- A. The standardized evaluation(s) and required scoring to establish medical necessity for speech-language pathology services varies depending on the suspected communication disorder.
 - 1. Language Disorder: impaired comprehension or use of spoken language, written, or other symbol systems. A language disorder may involve one (1) or any combination of the following components: phonology, morphology, syntax, semantics, prosody, and pragmatics.
 - a. Children birth to three (3) years of age: a score on a standardized evaluation performed within the past twelve (12) months that indicates a composite or quotient score of at least one point five (1.5) standard deviations below the mean, along with corroborating data from a second criterion referenced evaluation.
 - b. Children three (3) to twenty-one (21) years of age: a score on two (2) standardized evaluations performed within the past twelve (12) months that both result in a composite or quotient score of at least one point five (1.5) standard deviations below the mean.
 - c. If both evaluations do not agree or do not indicate a composite or quotient score on a of at least one point five (1.5) standard deviations below the mean, then a third evaluation may be used to demonstrate medical necessity; however, for a client from three (3) to twenty-one (21) years of age, the third evaluation must be a norm-referenced, standardized evaluation that results in a composite or quotient score on a of at least one point five (1.5) standard deviations below the mean.
 - 2. Speech Production (Articulation, Phonological, and Apraxia): a score on two (2) standardized evaluations performed within the past twelve (12) months that both result in standard scores of at least one point five (1.5) standard deviations below the mean. If only one (1) evaluation results in a standard score of at least one point five (1.5) standard deviations below the mean, then corroborating data from clinical analysis procedures can be used as a substitute for a second evaluation.
 - 3. Voice Disorder: a detailed functional profile of voice parameters that indicate a moderate or severe voice deficit or disorder.
 - 4. Fluency: a standardized evaluation and at least one (1) supplemental tool to address affective components each performed within the last twelve (12) months. The results of the standardized evaluation and supplemental tool must establish one of the following:
 - a. The client is within three (3) years of stuttering onset and exhibits significant risk factors for persistent developmental stuttering;
 - b. The client has a persistent stutter and a score on a standardized evaluation within one (1.0) standard deviation from the mean or greater during functional speaking tasks; or
 - c. A score on a standardized evaluation that indicates either:
 - i. A standard score within one (1.0) standard deviation from the mean or greater; or
 - ii. An index score of at one point five (1.5) standard deviations below the mean when comparing beneficiaries who stutter to individuals who do not

stutter.

5. Oral Motor, Swallowing, or Feeding Disorder: an in-depth functional profile of oral motor structures and function using a comprehensive checklist or profile protocol that indicates a moderate or severe oral motor, swallowing, or feeding deficit or disorder.

- B. [View or print the list of standardized evaluation instruments](#) and clinical analysis procedures accepted by Arkansas Medicaid Program to establish eligibility for Speech-language Pathology services.

213.000 Exclusions 1-1-22

An individual who has been admitted as an inpatient to a hospital or is residing in a nursing care facility is not eligible for occupational therapy, physical therapy, or speech-language pathology services under this manual.

214.000 Covered Services 1-1-22

The Arkansas Medicaid Program will only reimburse for the covered services listed in Sections 214.100 through 214.600 delivered in a manner in compliance with this manual, manual update transmittals, and official program correspondence.

214.100 Occupational Therapy, Physical Therapy, and Speech-Language Pathology Evaluation and Treatment Planning Services 1-1-22

- A. A provider may be reimbursed for medically necessary occupational therapy, physical therapy, and speech-language pathology evaluation and treatment planning services. Occupational therapy, physical therapy, and speech-language pathology evaluation and treatment planning services are a component of the process of determining a client's eligibility for occupational therapy, physical therapy, and speech-language pathology services and developing an eligible client's treatment plan.
- B. Medical necessity for occupational therapy, physical therapy, and speech-language pathology evaluation and treatment planning services is demonstrated by a referral from the client's physician or certified nurse practitioner that demonstrates the medical necessity of occupational therapy, physical therapy, and speech-language pathology evaluation and treatment planning 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 prescribing physician or certified nurse practitioner. The treatment plan must include goals that are functional, measurable, and specific for each individual client.
- D. Medically necessary occupational therapy, physical therapy, and speech-language pathology evaluation and treatment planning services are reimbursed on a per unit basis based on complexity. The billable unit includes time spent administering and scoring a standardized evaluation, clinical observation, administering supplemental test and tools, writing an evaluation report and comprehensive assessment along with time spent developing the treatment plan. View or print the billable occupational therapy, physical therapy, and speech-language pathology evaluation and treatment planning complexity codes and descriptions.

214.200 Speech Generating Device Evaluation Services 1-1-22

- A. A provider may be reimbursed for medically necessary evaluations for Speech Generating Devices (SGDs) upon receiving prior authorization. See Section 231.000.
- B. An SGD evaluation must be performed by a multi-disciplinary team that, at a minimum, meets the following parameters:

1. The team must be led by a speech-language pathologist licensed by the Arkansas Board of Examiners for Speech-Language Pathology and Audiology who has a Certification of Clinical Competence from the American Speech-Language and Hearing Association;
 2. The team must include an occupational therapist licensed by the Arkansas State Medical Board;
 3. The team must include a physical therapist if it is determined there is a need for assistance in the evaluation as it relates to the positioning and seating in utilizing specific SGC equipment;
 4. The speech-language pathologist, occupational therapist, and physical therapist must have documented and verifiable training and experience in the use and evaluation of SGD equipment, including without limitation knowledge concerning the SGD equipment's use and working capabilities, mounting and training requirements, warranties, and maintenance;
 5. The team may include any other practitioners or individuals determined necessary to perform a complete evaluation, including without limitation educators, parents, behavior analysts, and vocational rehabilitation counselors, as appropriate; and
 6. Team members must disclose any financial relationship they have with SGD device manufacturers and must certify that their recommendations are based on a comprehensive evaluation and preferred practice patterns and are not due to any financial or personal incentive.
- C. The multi-disciplinary team must evaluate at least three (3) SGD systems from different manufacturers and product lines using an interdisciplinary approach incorporating the goals, objectives, skills, and knowledge of various disciplines.
1. The recommended SGD is prior authorized for purchase only after the client has completed a minimum of a four-week trial period that includes extensive experience with the requested system.
 - a. Data must be collected during the trial period and document that the client can successfully use the recommended SGD device.
 - b. If the client cannot demonstrate successful use of the recommended SGD device, subsequent trial periods with different devices shall occur until a device is identified that the client can successfully use. Information about the trial period must be documented in the evaluation report.
 2. A trial period is not required when replacing an existing SGD unless the client's needs have changed, the current SGD device is no longer available, or another device or method of access is being considered as more appropriate.
- D. After the team has completed the evaluation, the evaluation report must be submitted to the selected prosthetics provider. The evaluation report must include the following:
1. The medical necessity for the SGD and pertinent background information;
 2. Information about the client's current speech-language and communication abilities over the last year;
 3. Limitations of the client's current communication abilities, a list of the systems and devices the client currently uses, and the client's current communication needs;
 4. Information on the client's sensory functioning, including vision and hearing, as related to the SGD;
 5. Information regarding the client's postural and motor abilities. The report must include optimal access/selection technique needed for independent use of SGD;
 6. A description of the functional placement of the SGD (such as mounting devices, carrying cases, and straps);

7. An indication of the client's ability to use various graphic and auditory symbol forms;
 8. Information on vocabulary storage and rate enhancement techniques considered and the justification for those deemed most appropriate;
 9. A summary of the client's required device features and delineate features of devices presented;
 10. A specific recommendation for an SGD system, including a description of the SGD system, all components and accessories, and justification of why the recommended SGD system is more appropriate than the others;
 11. Information about the trial period documenting that the client could successfully use the recommended device, including at a minimum:
 - a. Length of trial;
 - b. Frequency of use of SGD;
 - c. Environments, activities, and communication partners involved;
 - d. Access method(s) used;
 - e. Portability of the SGD;
 - f. Symbolic language system and rate enhancement used;
 - g. Number of symbols and layout of overlay used;
 - h. Sample of language expressed;
 - i. Client's level of independence (prompting strategies) using the SGD and expressing various language functions; and
 - j. A summary of baseline and end of trial data.
 12. An initial treatment plan for implementing use of the device, which must identify:
 - a. Who will be responsible for delivering and programming the SGD;
 - b. Who will develop initial goals and objectives for functional use of SGD; and
 - c. Who will train the client's team members and communication partners in the proper use, programming, care, and maintenance of the SGD.
 13. The signature of the speech-language pathologist and all other professionals directly involved in the evaluation on both the evaluation report and a non-conflict disclosure stating that they do not have financial relationship or other affiliation with a SGD manufacturer.
- E. Medically necessary evaluations for SGDs are covered once every three (3) years. The billable unit includes time spent meeting with the multi-disciplinary team, administering any supplemental instruments, tests and tools, and writing an evaluation report. [View or print the billable augmented communication device evaluation codes and descriptions.](#)

214.300**Occupational Therapy Services**

1-1-22

- A. An enrolled provider may be reimbursed for medically necessary occupational therapy services. Occupational therapy services must be medically necessary in accordance with Section 212.400.
- B. A group occupational therapy provider may contract with or employ its occupational therapy practitioners. The group provider must identify the individual occupational therapist or occupational therapy assistant as the performing provider on the claim when the group occupational therapy provider bills the Arkansas Medicaid Program for the occupational therapy service. The individual occupational therapist or occupational therapy assistant performing the occupational therapy must be enrolled with the Arkansas Medicaid Program and the criteria for group providers of occupational therapy services would apply. See Section 202.000.

- C. All occupational therapy services furnished by an occupational therapy provider must be provided according to a treatment plan developed by a licensed occupational therapist. All occupational therapy services must be provided, documented, and billed in accordance with this manual.
- D. Medically necessary occupational therapy services are reimbursed on a per unit basis and are covered up to six (6) units per week without authorization. See Section 216.000 regarding requests for an extension of benefits to be reimbursed for in excess of six (6) units of occupational therapy services per week. Refer to Section 214.600 regarding occupational therapy services via telecommunication. [View or print the billable occupational therapy codes and descriptions.](#)

214.400**Physical Therapy Services**

1-1-22

- A. An enrolled provider may be reimbursed for medically necessary physical therapy services. Physical therapy services must be medically necessary in accordance with Section 212.400.
- B. A group physical therapy provider may contract with or employ its physical therapy practitioners. The group provider must identify the individual physical therapist or physical therapy assistant as the performing provider on the claim when the group physical therapy provider bills the Arkansas Medicaid Program for the physical therapy service. The individual physical therapist or physical therapy assistant performing the physical therapy must be enrolled with the Arkansas Medicaid Program and the criteria for group providers of physical therapy services would apply. See Section 202.000.
- C. All physical therapy services furnished by a physical therapy provider must be provided according to a treatment plan developed by a licensed physical therapist. All physical therapy services must be provided, documented, and billed in accordance with this manual.
- D. Medically necessary physical therapy services are reimbursed on a per unit basis and are covered up to six (6) units per week without authorization. See Section 216.000 regarding requests for an extension of benefits to be reimbursed for in excess of six (6) units of physical therapy services per week. Refer to Section 214.600 regarding physical therapy services via telecommunication. [View or print the billable physical therapy codes and descriptions.](#)

214.500**Speech-Language Pathology Services**

1-1-22

- A. An enrolled provider may be reimbursed for medically necessary speech-language pathology services. Speech-language pathology services must be medically necessary in accordance with Section 212.400.
- B. A group speech-language pathology provider may contract with or employ its speech-language pathology practitioners. The group provider must identify the individual speech-language pathologist or speech-language pathology assistant as the performing provider on the claim when the group speech-language pathology provider bills the Arkansas Medicaid Program for the speech-language pathology service. The individual speech-language pathologist or speech-language pathology assistant performing the speech-language pathology service must be enrolled with the Arkansas Medicaid Program and the criteria for group providers of speech-language pathology services would apply. See Section 202.000.
- C. All speech-language pathology services furnished by a speech-language pathology provider must be provided according to a treatment plan developed by a licensed speech-language pathologist. All speech-language pathology services must be provided, documented, and billed in accordance with this manual.

- D. Medically necessary speech-language pathology services are reimbursed on a per unit basis and are covered up to six (6) units per week without authorization. See Section 216.100 regarding requests for an extension of benefits to be reimbursed for in excess of six (6) units of speech-language pathology services per week. Refer to Section 214.600 regarding speech-language pathology services via telecommunication. [View or print the billable speech-language pathology codes and descriptions.](#)

214.600 Telemedicine Services

1-1-22

- A. An enrolled provider may be reimbursed for medically necessary occupational therapy, physical therapy, and speech-language pathology services delivered through telemedicine.
1. Occupational therapy, physical therapy, and speech-language pathology evaluation and treatment planning services may not be conducted through telemedicine and must be performed through traditional in-person methods.
 2. Parental or guardian consent is required prior to telemedicine service delivery.
 3. The plan of care and client service record must include the following:
 - a. A detailed assessment of the client that determines they are an appropriate candidate for service delivery by telemedicine based on the client's age and functioning level;
 - b. A detailed explanation of all on-site assistance or participation procedures the therapist or speech-language pathologist is implementing to 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 client.
 - c. A plan and estimated timeline for returning service delivery to in-person if a client is not progressing towards goals and outcomes through telemedicine service delivery.
 4. All telemedicine services must be delivered in accordance with the Arkansas Telemedicine Act Ark. Code Ann. § 17-80-401 to -407.
- B. The service provider is responsible for ensuring service delivery through telemedicine is equivalent to in-person, face-to-face service delivery.
1. The service provider is responsible for ensuring the calibration of all clinical instruments and the proper functioning of all telecommunications equipment.
 2. All services delivered through telemedicine must be delivered in a synchronous manner, meaning through real-time interaction between the practitioner and client via a telecommunication link.
 3. A store and forward telecommunication method of service delivery where either the client or practitioner records and stores data in advance for the other party to review at a later time is prohibited, although correspondence, faxes, emails, and other non-real time interactions may supplement synchronous telemedicine service delivery.
- C. Services delivered through telemedicine are reimbursed in the same manner and subject to the same benefit limits as in-person, face-to-face service delivery. [View or print the billable telecommunication codes and descriptions.](#)

216.000 Benefit Limits**216.100 Extension of Benefits for Occupation Therapy, Physical Therapy, and Speech-language Pathology Services**

1-1-22

An enrolled provider must receive authorization to be reimbursed for more than six (6) units of medically necessary occupation therapy, physical therapy, or speech-language pathology services in a week.

216.300 **Process for Requesting Extended Therapy Services** **7-1-22**

- A. Requests for extended therapy services for beneficiaries under **twenty-one (21) years of age** and adults receiving services in an Adult Developmental Day Treatment (ADDT) must be sent to Arkansas Medicaid's Quality Improvement Vendor (QIO). [View or print the QIO contact information](#). 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 because a benefit is exceeded.
 2. The request must be received by the QIO 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 with the request a copy of the Medical Assistance Remittance and Status Report reflecting the claim's benefits-exceeded denial. Do not send a claim.
 4. The QIO will not accept requests sent via electronic facsimile (FAX) or e-mail.
- 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, including 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 should be attached.

216.305 **Request for Extension of Benefits Documentation Requirements** **1-1-22**

A request for extension of benefits must include clinical documentation demonstrating the medical necessity of the request, and at a minimum include:

- A. The physician or certified nurse practitioner referral and prescription for the amount of service requested;
- B. The comprehensive assessment, diagnosis, clinical records, progress reports, and other information necessary to demonstrate the medical necessity of the request for extension of benefits by the performing provider; and
- C. Be signed by the performing provider

216.310 **Review Process for Request for Extension of Benefits** **1-1-22**

- A. Requests for extension of benefits are initially screened for completeness and researched to determine the client'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 the medical necessity of the request, the request is referred to a physician for review.
 - a. If the reviewing physician determines the documentation demonstrates the medical necessity of the request, then an approval letter is mailed to the requesting provider the following business day.
 - b. If the reviewing physician determines the documentation does not demonstrate the medical necessity of the request, then a denial letter that includes the physician's rationale for denial of the request is mailed to the provider and the client 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 218.000.

217.000**Retrospective Review****1-1-22**

- A. A retrospective review will be performed on billed occupational therapy, physical therapy, and speech-language pathology services. Retrospective Review is a dual review process:
 1. A medical necessity review that determines whether the amount, duration, and frequency of services provided were medically necessary; and
 2. A utilization review that determines whether billed services were prescribed and delivered as billed.
- B. The Quality Improvement Organization (QIO) under contract with the Arkansas Medicaid Program will perform retrospective reviews by reviewing client service records.
 1. The QIO will review a percentage random sample of all in-person occupational therapy, physical therapy, and speech-language pathology services billed and paid that were either: (1) ninety (90) minutes or less per week; or (2) were provided pursuant to a rehabilitation diagnosis (related to an injury, illness, or surgical procedure).
 2. The QIO will review all billed and paid occupational therapy, physical therapy, and speech-language pathology services delivered via telecommunication, as described in Section 214.600.
 3. The QIO will review all billed and paid occupational therapy, physical therapy, and speech-language pathology services which were less than six (6) months from the previous evaluation date when the provider is utilizing a complexity code rather than a timed procedure code.
- C. The QIO will mail a letter to each billing provider requesting copies of the service records for those billed services subject to retrospective review along with instructions for returning the service records.
 1. The provider must deliver the requested service records and other documentation to the QIO within thirty (30) calendar days of the date of the request.
 2. If the requested services records and information is not received within the thirty (30) calendar day timeframe, a retrospective review denial is issued.
 3. The QIO may grant reasonable extensions of time as deemed appropriate in its sole discretion.

217.100**Medical Necessity Review****1-1-22**

- A. Each submission is initially reviewed for completeness. If the service record submission is determined to be incomplete, a request for additional information will be sent to the provider.

- B. If it is determined that a complete service record request was submitted, a qualified clinician will review the documentation in more detail to determine whether it meets Medicaid eligibility criteria for medical necessity. The medical necessity review includes:
 - 1. Verifying the treatment prescription was submitted on a form DMS-640;
 - 2. Verifying the prescription contains the client's name, Medicaid ID number, a valid diagnosis that establishes that the prescribed service is medically necessary, the quantity and duration of the prescribed service, and is signed and dated by the primary care or attending physician or certified nurse practitioner;
 - a. A DMS-640 with a stamped signature or with no signature date will be considered invalid; and
 - b. Changes made to the prescription that alter the type and quantity of services prescribed are invalid unless changes are initialed and dated by the physician or certified nurse practitioner.
- C. If the qualified clinician determines the services were not medically necessary or the prescription is invalid, the service record is referred to an appropriately licensed reviewer.
- D. If the licensed reviewer determines the services were not medically necessary or the prescription is invalid, the service record is referred to the Associate Medical Director (AMD) for the QIO for review.
- E. The AMD will review the service record and make a final decision as to whether the services were medically necessary.
 - 1. If the services are denied due to lack of medical necessity, the service provider, the client, and the prescribing physician or certified nurse practitioner are notified in writing of the denial.
 - 2. Each denial letter contains the rationale for the denial that is case specific and information on how to request an administrative reconsideration.

217.200**Utilization Review**

1-1-22

- A. The utilization review compares the paid claims data to the daily treatment and weekly progress notes in the service record to verify that:
 - 1. The proper procedure code and modifier, if required, were billed; and
 - 2. All service delivery documentation required by Section 202.400(A)(7) is included and supports the billed services.
- B. If the qualified clinician reviewer determines a service record does not support the billed services, the unsupported billed services are referred to an appropriately licensed reviewer.
- C. If the licensed reviewer determines a submitted service record does not support the billed services, the unsupported billed services are referred to the Associate Medical Director (AMD) for review.
- D. The AMD will review the service record and make a final decision as to whether the service record supports the billed services.
 - 1. If services are denied as part of utilization review, the service provider is notified in writing of the denial.
 - 2. Each denial letter contains the rationale for the denial that is case specific and information on how to request an administrative reconsideration.

218.000**Administrative Reconsideration**

1-1-22

- A. A provider may submit additional information for administrative reconsideration of a denial of a request for extension of benefits pursuant to Section 216.000, or a denial of billed services on retrospective review pursuant to Section 217.000, within thirty-five (35) calendar days of the date shown on the denial letter. [View or print the QIO administrative reconsideration submission instructions.](#)
1. Each request for administrative reconsideration must include a copy of the denial letter and additional information substantially different from the service record and information initially submitted. Re-submitting the exact same information that was included with initial submission that was denied will result in the denial being upheld.
 2. Only one (1) reconsideration is allowed per denial.
- B. All documentation submitted with the request for administrative reconsideration is reviewed by an appropriately licensed clinician.
1. If the reviewing clinician determines the denial is inappropriate, then an approval letter granting the reconsideration is mailed to the requesting provider.
 2. If the reviewing clinician determines they cannot grant the reconsideration request for any reason, the request for administrative reconsideration is forwarded to a physician reviewer. The physician reviewer on administrative reconsideration must be different from the physician reviewer that issued that original denial.
- C. The physician reviewer will make a final decision to grant the reconsideration request or uphold the denial. A written notification of the outcome of the reconsideration request is mailed to the service provider and will include a case specific rationale for granting the reconsideration request or upholding the denial.
- D. Any denial that is upheld on administrative reconsideration remains eligible for appeal as provided in Section 190.003.

220.000 Recoupments

220.100 Recoupment Process 1-1-22

The Division of Medical Services, Utilization Review section will recoup payment from a provider for all claims that the contracted Quality Improvement Organization denies through Retrospective Review. The provider will be sent an Explanation of Recoupment Notice that will include the claim date of service, Medicaid client name and ID number, service provided, amount paid by Medicaid, amount to be recouped, and the reason the claim has been denied.

230.000 PRIOR AUTHORIZATION

231.000 Prior Authorization Request for a Speech Generating Device (SGD) Evaluation 1-1-22

- A. Prior authorization from the Division of Medical Services, Utilization Review Section is required for a provider to be reimbursed for conducting an Speech Generating Device (SGD) evaluation. [View or print SGD Prior Authorization request submission instructions.](#)
- B. Each prior authorization request must include:
1. A referral from the client's physician or certified nurse practitioner that documents the physical and intellectual functioning level of the client and the medical reason the client requires an SGD evaluation;

2. If the client is currently receiving speech-language pathology services, documentation from the speech-language pathologist of the cognitive level of the client and the prerequisite communication skills requiring an SGD evaluation of the client; and
 3. A completed Form DMS-679 Request for Prior Authorization and Prescription. [View or print Form DMS-679 and instructions.](#)
- C. If a prior authorization request is approved, then a prior authorization control number will be entered in item 10 of the Form DMS-679 and returned to the provider. If a prior authorization request is denied, a denial letter with the reason for denial will be mailed to the requesting provider and the Medicaid client.

231.100 Administrative Reconsideration of Prior Authorization Denial 1-1-22

Administrative reconsideration of a denial of a prior authorization request in Section 231.000 may be requested within thirty (30) calendar days of the denial date. Requests must be made in writing and must include additional documentation to substantiate the medical necessity of the SGD evaluation. [View or print administrative reconsideration submission instructions.](#) Any denial that is upheld on administrative reconsideration remains eligible for appeal as provided in Section 190.003.

250.000 REIMBURSEMENT

251.000 Method of Reimbursement 1-1-22

- A. Occupational therapy, physical therapy, and speech-language pathology 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, physical therapy, and speech-language pathology services is four (4) clients.

251.010 Fee Schedules 1-1-22

- A. The Arkansas Medicaid program provides fee schedules on the Arkansas Medicaid website. [View or print the occupational, physical, and speech-language pathology 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 procedure [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.