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AFMC Extension of Benefits/Prior Authorization

Requirements for Arkansas Medicaid Therapy Services greater than 90 Minutes Per Week (under age 21):

1. DMS-640 for Treatment (referrals are not required for the PA process):
A prescription is considered valid if it contains the following information:

- Child's name
- Medicaid ID number
- Valid diagnosis that clearly establishes and supports that the prescribed therapy is medically necessary
- Minutes and duration of therapy
- A signature and date by the PCP or attending physician.

All therapy prescriptions must be on the current DMS-640 form. Rubber-stamped signatures, those signed by the physician s nurse or a nurse practitioner and those without a signature date are not considered valid. Arkansas Medicaid Manual, Section II, 204.000, A., 2 and 214.200. Changes made to the prescription that alters the type and quantity of services prescribed are invalid unless the changes are initialed and dated by the physician. Arkansas Medicaid Manual, Section II, 214.220.

2. A Comprehensive Evaluation:
To establish medical necessity, a comprehensive assessment in the suspected area of deficit must be performed and include the following:

- Date of the evaluation; Arkansas Medicaid Manual, Section II, (PT/ OT) 214.300, B, 1.
- Childs name and date of birth; Arkansas Medicaid Manual, Section II, (PT/ OT) 214.300, B, 2.
- Diagnosis specific to therapy; Arkansas Medicaid Manual, Section II, (PT/ OT) 214.300, B, 3.
- Background information including pertinent medical history; and, if the child is 12 months of age or younger, gestational age. The child should be tested in the child s dominant language; if not, and explanation must be provided in the evaluation. Arkansas Medicaid Manual, Section II, (PT/ OT) 214.300, B, 4.
- Standardized test results, including all subtest scores, if applicable. Test results must be reported as standard scores, Z scores, T scores or percentiles. Age-equivalent scores and percentage of delay cannot be used to qualify for services. Arkansas Medicaid Manual, Section II, (PT/ OT) 214.300, B, 5.

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- If applicable, test results should be adjusted for prematurity (less than 37 weeks gestation) if the child is 12 months of age of younger, and this should be noted in the evaluation. Arkansas Medicaid Manual, Section II, (PT/ OT) 214.300, B, 6.
- Objective information describing the child s gross/fine motor abilities/deficits, e.g., range of motion measurements, manual muscle testing, muscle tone or a narrative description of the child s functional mobility skills (strengths and weaknesses). Arkansas Medicaid Manual, Section II, (PT/ OT) 214.300, B, 7.
- An interpretation of the results of the evaluation, including recommendations for therapy/minutes per week. Arkansas Medicaid Manual, Section II, (PT/ OT) 214.300, B, 8.
- A description of functional strengths and limitations, a suggested treatment plan and potential goals to address each identified problem. Arkansas Medicaid Manual, Section II, (PT/ OT) 214.300, B, 9.
- Signature and credentials of the therapist performing the evaluation.
- Arkansas Medicaid Manual, Section II, (PT/ OT) 214.300, B, 10.

A comprehensive assessment for Oral Motor/Swallowing/Feeding disorder must include:

- Date of evaluation. Arkansas Medicaid Manual, Section II, 214.400, C, 6, a.
- Child's name and date of birth. Arkansas Medicaid Manual, Section II, 214.400, C, 6, b.
- Diagnosis specific to therapy. Arkansas Medicaid Manual, Section II, 214.400, C, 6, c.
- Background information including pertinent medical history; and, if the child is 12 months of age or younger, gestational age. The child should be tested in the child's dominant language; if not, an explanation must be provided in the evaluation. Arkansas Medicaid Manual, Section II, 214.400, C, 6, d.
- Results from an assessment specific to the suspected type of oral motor/swallowing/feeding disorder, including all relevant scores, quotients and/or indexes, if applicable. Arkansas Medicaid Manual, Section II, 214.400, C, 6, e.
- If swallowing problems and/or signs of aspiration are noted, then include a statement indicating that a referral for a video fluoroscopic swallow study has been made. Arkansas Medicaid Manual, Section II, 214.400, C, 6, f.
- If applicable, test results should be adjusted for prematurity (less than 37 weeks gestation) if the child is 12 months of age or younger, and this should be noted in the evaluation. Arkansas Medicaid Manual, Section II, 214.400, C, 6, g.
- Formal or informal assessment of hearing, language, articulation voice and fluency skills. Arkansas Medicaid Manual, Section II, 214.400, C, 6, h.
- An interpretation of the results of the evaluation, including recommendations for frequency and intensity of treatment. Arkansas Medicaid Manual, Section II, 214.400, C, 6, i.

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- A description of functional strengths and limitations, a suggested treatment plan and potential goals to address each identified problem. Arkansas Medicaid Manual, Section II, 214.400, C, 6, j.
- Signature and credentials of the therapist performing the evaluation. Arkansas Medicaid Manual, Section II, 214.400, C, 6, k.

Valid Treatment ICD 10 Diagnosis code for Therapy Services:
The treatment diagnosis must be a diagnosis that supports the Therapy Service requested. A diagnosis specific to each modality listed on the DMS-640 must be documented. Arkansas Medicaid requires *"a valid diagnosis that clearly establishes and supports that the prescribed therapy is medically necessary"*, Arkansas Medicaid Manual, Section II, 214.220.

The following information is required from a Licensed Therapist. This can be contained in the evaluation, as an addendum to the evaluation, or as a statement letter:

- Documentation that the Therapy administered effectively treats the beneficiary's condition.
- Documentation that there is a reasonable expectation of meaningful improvement or that Therapy Services will prevent worsening of the beneficiaries' current condition.
- Frequency, intensity, and duration of the requested Therapy Services is realistic for the age of the child.
- Therapy procedure codes (CPT), including applicable modifiers, with total number of units requested for each code
- Client Name:
- Medicaid ID number:
- Start date and end date of requested service plan:
- Provider Name:
- Provider Medicaid ID number (NPI will not be accepted)
- Provider current address and email:

Acute Outpatient Rehabilitation Services
Acute Outpatient Rehabilitation Services are defined as a short term, high intensity Treatment Plan. This request requires a prescription for services from the PCP or Treating Physician. This can be a DMS-640 treatment form or a standard prescription form. The other requirements for this request are:
- Valid treatment ICD-10 diagnosis code
- Comprehensive Therapy Evaluation as described above

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Guidelines for Medical Necessity for Therapy Services have not changed due to the new requirement for Prior Authorization request. Current approval criteria is listed in Section II of the Arkansas Medicaid Provider Manual. These are the same requirements used for Therapy Retrospective Review.

- Prior Authorizations for Therapy Services can retro up to 30 days from the date of the request, but cannot be authorized for dates of service prior to the date of the Physician signature on the DMS-640 form.
- Therapy services provided in the Public School setting: The start date can retro up to 90 days from the date of the request for services. Additionally, that same 90-day window is allowed for the date on the Physician signature. Requests submitted after these periods will default to the date of the physician signature and previous dates of service will not be payable under the authorization number issued.

This is not a mandatory form, it is a tool provided by AFMC to assist providers with the Prior Authorization process. This form can be printed, information added, and submitted with the request if the provider chooses.