ArPTA, AROTA and ArkSHA MEETING WITH AFMC AND DDS – 7/27/17

- How do we enter/manage therapist and assistants units on the PA to allow flexibility in delivery of therapy units between those entities? AFMC has been dividing PA units arbitrarily between the therapist and the assistant making it difficult to assure delivery of services prescribed for the child. Is there a way to allow approved units in a PA without assigning them specifically between the therapist and the assistant?

  In the current system, the expected amount of units to be delivered between therapist and assistant will still need to be provided. AFMC has been dividing the PA if it is not indicated instead of kicking out the PA for lack of information and delaying the services. AFMC emphasized that if expected units per therapist and assistant are not provided, then units will be given to the therapist, not the assistant. If a change in the number of units is needed based on schedule changes, therapist/assistant availability, etc. providers can call Miranda at AFMC and she can adjust the units. When the new MMIS system is fully implemented (expected implementation date is summer of 2018) this problem will reportedly be resolved. AFMC reported that most providers have done a wonderful job giving assistants a certain percentage of time so far.

- Why are there changes in the number of units requested? It is our understanding that the initial PA is good for the length of the current DMS 640—several of our PA requests were approved but not for the length of the DMS 640 (like 2 weeks short)

  Providers need to see if the evaluation date lapses prior to the DMS 640. In some cases, units requested are being reduced because the DMS-640 date and the evaluation date do not line up….in other words, both documents don't mesh and most likely the evaluation needs to be updated. If units have been reduced and the reasons stated above do not apply, then providers will need to email Dana at AFMC with 1) Contact name; 2) Contact number; 3) Request IDs

- We still have PA requests not approved and /or we haven't received the approval notice with the PA number despite the fact we submitted them all on July 3rd. That exceeds the 10 day turnaround promised and is keeping us from being current on billing receipts.

  AFMC has less than 100 validations left to complete after completing approximately 14,000 validations.

  If providers are experiencing this problem, they should contact Jarrod McClain at AFMC. Providers are also encouraged to contact their state association representatives to address these issues in future meetings.

- We desperately need a dedicated person or persons to contact regarding problems or questions regarding this process at AFMC. Attempts to call and/or email are frequently met with no response.

  If phone calls and/or email are not responded to, providers should contact Marilyn Little Chief Operating Officer at AFMC.

- What was the final ruling on maximum # of units provided in a day? still 4? or up to 6 based on the "weekly cap".

  There is now a weekly cap of 6 units. This is not a daily cap.

- Could we get clarification on when we are able to submit PA requests for existing clients? I ran into a situation in which I was denied a request for an extension of a "grandfathering pa" because my previous DMS form had yet to expire. I had a new one dated before 7/1/17. We attempted to get DMS forms from physicians before they expire, not after, typically 2-3 weeks in advance depending on the physician's office. They would not accept the new one with the rationale I did not need to get a new DMS until the previous one expired.

  AFMC will accept PA requests for existing clients 30 days prior to the expiration date on the DMS-640.

- Most of the therapy providers in Northwest Arkansas are only billing for contact time when evaluating. We have at least one that is also billing for their write up. We are needing clarification as I inquired about this a number of years ago and was told by Robin Raveendran when he was in charge of Medicaid fraud, that only contact time was billable. If this is so, who should we contact to put out an official ruling so all is fair and equitable? - There are 2 codes that can be used for eval paperwork. I think the first one can be used by any provider/any center. It is 90887. It does not require a PA. It is a $15/unit code, but Medicaid will pay $12 a unit on it, but you can only bill 6 of them per year (that may be per discipline or just per beneficiary- I'm not sure & forgot to ask).There is a treatment plan code that pays a little less...99367, but it does require a PA.

  Providers are encouraged to closely examine the manuals for the program that each beneficiary is receiving services from. If the manual indicates direct contact only for billable units, then providers should not bill for evaluation report writing. There are ongoing efforts to merge and align programs for clarification and consistency but nothing will be changed until other changes go into effect in the manual next summer.

- Do we have clarification on being able to check both referral and treatment box on one DMS 640?

  For the <u>initial evaluation</u>, the DMS-640 must have referral only for the evaluation. Then once the evaluation is completed and if therapy is recommended, a DMS-640 for treatment will be needed. For repeat evaluations, both referral and treatment boxes can be marked on the same DMS-640.

- What do we do with multiple facilities billing for one beneficiary?

  You will need to submit your PA/EOB for your service with a statement telling AFMC that the member is receiving therapy from more than one provider. Minutes per week is based on the beneficiary, so if a provider bills 60 minutes per week and the other provider also bills 60 minutes per week this would go beyond the 90 minute threshold and require a PA. Since a

provider will not be able to determine if they are billing before or after the other provider, both providers will need to submit for a PA. Medicaid encouraged care coordination between facilities. If a provider can obtain the evaluation from the other facility then they should and include it with their request for a PA. This will require providers to request disclosure up front from the parents of their beneficiaries of all the facilities they are receiving services from. Medicaid also noted that they believe in the new MMIS system that this issue will be resolved. AFMC noted that they will be running data to determine how prevalent this problem is and how best to handle it in the meantime. We were instructed by AFMC that this could be as earlier as next week.