

## **DMS 640 Validation and EOB/PA request process Questions & Answers**

### **1. How are submissions serialized, tracked, and notifications of approvals/denials posted?**

All DMS 640 Validations and Prior Authorizations will be assigned a review identification number. You will receive the number when the electronic submission is complete for reference, but the review will not be eligible for billing until the review has been completed and approved. An Approval letter will be issued the following business day. Status and review decisions are available to view in ReviewPoint. Billing information must have 48 hours for processing to allow a claim to be submitted.

If you are registered and your email has been validated, a letter will be issued by email. If you are not registered to receive letters by email, a letter will be issued by postal mail. Note: If you receive your correspondence by mail and have undergone any changes in your address, please verify your mailing address. You can send an email to [Therapy.Review@afmc.org](mailto:Therapy.Review@afmc.org) and we will verify the address we have on file for you.

### **2. What if we bill and it fails after we get approval?**

First, make sure the 48-hour window for claims processing has been met. If you are still unable to bill, contact AFMC and we will investigate if an error has occurred. We will make the correction and notify you when you are able to re-bill the claim. If the claim is rejected because an incorrect procedure code was requested by the provider, this will need to be submitted in writing for us to make the change in the claim. We will also re-issue an approval. This approval will retro back to the original start date of the service plan.

### **3. Can we simply call to get the error fixed, or do we have to resubmit the DMS again and wait another 10 days?**

An incomplete DMS 640 Validation cannot be entered into the claims processing system. A new request will need to be submitted.

### **4. One by one DMS-640 uploads, correct?**

For the most accurate claims processing, we require an individual request for each child and each discipline.

### **5. Treatment script only needed (script that shows the actual prescribed minutes), correct? Does the Referral box need to be checked on the DMS-640 as well?**

We only require a DMS 640 form for treatment.

- 6. Some DMS's have more than one discipline with over 90 minutes written on them - can we just submit the single script with 1 to 3 disciplines, or do we have to submit a separate PDF for EACH discipline for the same beneficiary? This would also save time and reduce uploads.**

For the most accurate claims processing, we require an individual request for each child and each discipline.

- 7. Exactly what time, either Saturday July 1st or Monday July 3rd can we start to upload our scripts for validation? 8:00 AM? 12:01 AM?**

ReviewPoint will be available for DMS 640 Validation and PA submission on July 1, 2017 at 12:01 am.

- 8. What documentation will be required for adults who receive therapy in DDTCS centers?**

A valid standard prescription and evaluation.

- 9. What guidelines will be used for Prior Authorization reviews?**

The Arkansas Medicaid Provider Manual, Section II. Guidelines to determine medical necessity are the same as required for Retrospective Therapy review. The requirements for medical necessity as outlined by Arkansas Medicaid have not changed due to the PA process.

- 10. Who will review DMS 640 Validations and Prior Authorization requests for Therapy services?**

The DMS Validation is not a review for medical necessity. This is a process to enter the service plan in the system to allow billing for greater than 90 minutes per week.

Prior authorization requests will be reviewed by a Licensed Therapist of the same discipline and a Board Certified Pediatrician contracted by AFMC.

- 11. Have the new rules for the therapy thresholds and the prior authorization number requirement for any therapy billed over 90 minutes per week per discipline been tested in the current MMIS system?**

Yes, we have been working closely with DXC processing test files.

- 12. When are physicians going to be trained/educated on the therapy threshold changes and the extended services/prior authorization process? It is important that they understand that the extended services/prior authorization process will delay the start of the full recommendation for therapy treatment and as such, completing the DMS prescription for therapy treatment in a timely manner will be even more critical.**

AFMC Beneficiary Relations department will issue a Physician targeted E-blast to address the upcoming changes in Therapy billing requirements.

- 13. When are therapy providers going to be trained on the specifics of the extended services/prior authorization system and documentation requirements/expectations – has AFMC developed a standard tool/flow chart that they will use when reviewing the requests to insure consistency throughout all reviews?**

AFMC has developed tools for Providers to use to submit DMS-640 validations and EOB/PA requests. We will issue these in an E-blast to providers this week and they will also be available at afmc.org

- 14. Will AFMC utilize the “Reviewer Guide for Physical and Occupational Therapy Documentation” and the “Reviewer Guide for Speech Therapy Documentation” (developed by the Workgroup based on the WHOICF) for use in the review process of the extended benefits/prior authorization requests for therapy recommendations above 90 minutes per week per discipline?**

AFMC will continue to use the Arkansas Medicaid Manual guidelines for EOB/PA review, the same guidelines used currently for Retrospective Therapy Review.

- 15. Will the Therapy Advisory Group that has worked with Medicaid and AFMC over the last 10 + years begin meeting at least monthly (may be with DDS and AFMC now) to work through logistics, questions and system glitches as we begin the implementation of these changes?**

We will work with DMS to determine the frequency of meetings with the TAC moving forward.

- 16. When submitting a request for extended services/prior authorization, our understanding is that it is the DMS prescription for treatment script that will need to be submitted with the therapy evaluation and any other relevant documentation and not the DMS prescription for referral – is this correct?**

Only the completed DMS 640 prescription information is required.

- 17. If an extended services/prior authorization request is not reviewed and either approved or denied by AFMC within the 72 hour turnaround time from date of receipt of the request by AFMC, and it is ultimately denied once it is reviewed, will the therapy recommended above the 90 minutes per week be approved and prior authorized from the end of the 72 hour turnaround time to the time the request was denied?**

Yes, the request would retro back to the requested start date of services.

- 18. DMS 640 Prescription for Therapy Treatment (For therapy above 90 minutes per week that expire after 6/30/2017 – Grandfathering of existing therapy treatment above 90 minutes per week per discipline through expiration of existing DMS 640 prescription for therapy treatment)**

**Will providers be able to begin submitting the DMS 640 prescriptions for therapy treatment on 7/1/2017? If yes, what time? If no, when and what time?**

Yes, 12:01 am.

- 19. When will providers receive step-by-step instructions on the submission process?**

AFMC has developed instructional tools that are available on afmc.org.

- 20. Will providers be able to submit the DMS 640 prescriptions for therapy treatment in a batch (or in one pdf file) or will they have to enter each one individually into Review Point?**

**If a DMS 640 prescription for therapy treatment has more than one therapy listed, will the provider be able to submit just one DMS 640 prescription for therapy treatment for the beneficiary that will cover all therapy listed or will the provider have to submit the same DMS 640 2 or 3 times (once for each therapy listed)?**

For the most accurate claims processing, we require individual requests for each child and each discipline.

- 21. Will providers receive an electronic notification that a prior authorization number has been assigned to the DMS 640 prescription for therapy treatment or that the DMS 640 prescription for therapy treatment has been denied prior authorization? If denied, will the notification include why the DMS 640 was denied – missing information, not legible, etc.?**

When a request is completed on the provider portal, a reference identification number is assigned to the review. Upon approval of the service plan, this number will be used for billing. This authorization number will require 48 hours for the claim to be processed.

- 22. Does AFMC still anticipate having all of the DMS 640 prescriptions for therapy treatment processed within 10 business days of receipt?**

We are allowing for additional staffing to process the anticipated volume of provider requests.

- 23. Is the DMS 640 prescription for therapy treatment services the only document that needs to be submitted for therapy recommendations above 90 minutes per week that expire after 6/30/2017, the 6 month referral DMS 640 does not need to be sent in also, correct?**

Only the completed DMS 640 prescription information is required.

- 24. For adults who receive therapy in a DDTCS center the DMS 640 is not required and as such, many of the centers receive the prescription for therapy treatment services from the adult's physician on the physician's regular prescription form. We just want to make sure DDS and AFMC are aware of this difference in the prescription document for adults (21 years and older) versus children (under 21).**

Yes. Additionally, we outlined the requirements in our instructional tools to make providers aware also.

- 25. Can you please review the calculation of units with us for putting into ReviewPoint? Start date (7.1.17) through the end of the prescription?**

Yes. All DMS-640 Validations will have a start date of 7/1/17. EOB/PA requests will have a start date as determined by the prescription. Please request the total number of units for the service plan.

*Unit Calculation Example:*

*The child is prescribed 120 minutes per week for Physical Therapy.*

*One therapy unit is equal to 15 minutes. 120 minutes divided by 15= 8 units per week.*

*The child's length of treatment time is for 6 months which= 24 weeks.*

*8 units per week x 24 weeks = 192 units total.*

*The provider would request: 97110 for 192 units.*

**26. Calculation of units if utilizing both a therapist and an assistant?**

Yes. Please request the number of units for each Therapy code.

**27. How would an authorization be set up? Would the PA be utilized when billing for all of the units? If so, many clinics that utilize EMR systems are concerned and will not be able to separate the 90 minutes from the minutes that required an authorization.**

An Authorization number will include the total number of units for all minutes per week in the service plan.

**We will have four documents available on our website to assist in the submission process:**

**ReviewPoint instructions for entering and submitting requests**

**ReviewPoint instructions for uploading a document**

**AFMC DMS-640 Validation Process Tool**

**AFMC EOB/PA requirements**