

**Therapy Work Group Minutes**  
**January 10<sup>th</sup>, 2007**  
**10:00-12:00**

**Committee Members in Attendance:**

**Marilyn Strickland- Medicaid**

**Cheryl Freeman- Medicaid**

**Jarrold McClain, RN- AFMC**

**Angela Traweek, OT**

**Judy Eddington, SLP**

**Beth Stamp, PT**

**Debbie Ashworth, PT**

**Shelly Wier, SLP (via conference call)**

**Kim Jones, SLP**

**Sherry Stevenson, SLP**

**Ruth Castleberry-Governor's Early Intervention Coordination Council**

**Tony Boaz-Arkansas Department of Education**

**Stephanie Smith-Easter Seals**

**Linda Rogers-Easter Seals**

**Agenda Items Discussed:**

1. DMS-640- Mrs. Strickland spoke with David Wroten with the Arkansas Medical Society about issues that therapists have brought up concerning the completion of the DMS 640. He was not completely opposed to the therapist filling out the DMS 640 but did have concerns, especially with therapists filling in the diagnosis. He stated that he has received no complaints from physicians concerning completing this form. Committee members explained that the problem is not filling the form out but physicians or office staff filling it out incorrectly and the hostility some therapists have had to deal with when asking a physician to correct the form. It was agreed that the physicians have no idea how this affects therapy providers. They are unaware that we are audited quarterly or that money will be recouped from us if their paperwork does not meet the guidelines. It was agreed that prior to pursuing this further that more education of the physicians will be attempted. Instruction in the correct completion of this form will be made a part of the PCP regional meetings. Mrs. Strickland was going to speak to Mr. Wroten about including a correctly completed DMS 640 with the reasons why it has to be completed in this manner in their quarterly newsletter.
2. Mrs. Strickland recently had a meeting with two families of autistic children, who expressed concerns that the present guidelines do not allow for their children to receive the amount of therapy services that they need. After a lengthy discussion by all members, it was felt that the guidelines do allow for adequate therapy time for all diagnosis, not just autism. Presently, the only limit of benefits is one hour of therapy per day by each discipline. The other aspect of this is that the therapist must be able to justify these services, whether it is five times per week or twice per week. Some providers have been under the impression that only 3 hours of therapy is allowable per week per discipline. This was tied to the PA process, however the PA process no longer exists.
3. EOB (Extension of Benefits) for evaluations- Speech providers have stated that they "eat" a large amount of therapy time, due to numerous reasons, and when they have attempted to get an extension of benefits to cover this time it is always denied. Clarification was made that you can only apply for EOB after the provider has received a denial, on the RA. Jarrold McClain compiled a report looking into how many EOB requests were approved. As of October 2006,

reports indicate that 71 procedure codes from 13 providers were received, reviewed and entered into the AFMC review system. Out of the 71 procedure codes reviewed, 36 were approved and 35 denied. EOB requests were denied for the following reasons: \* No documentation of service submitted

- \* No order or referral
- \* EOB form incomplete
- \* One provider indicated that they had to retest because they could not get the tests done by the school. The provider did not submit the record or test report and had no referral on one.
- \* Received too late (90 days past RA request or received reconsideration past 35 days.
- \* Private insurance explanation needed.

All EOB requests are entered into the review system for tracking purposes, regardless of whether it is received too late or even if it is obvious that there is missing information. A review is completed and if denied, an initial letter is mailed to notify the provider of the denial. The patient and provider each receive the denial letter. The initial denial letter indicates that a reconsideration may be requested within thirty-five calendar days of the date of the denial letter. If reconsideration is received within the allowed days and the review is approved, an approval case listing letter is mailed to the provider. If upheld, further correspondence is sent notifying the provider of the denial. Jarrod encouraged all providers to apply for the extension of benefits when needed. Providers who have questions regarding EOB requests may contact the AFMC Medicaid help desk at (479) 573-7784 and speak with Robin Keith.

4. AFMC will be updating their web page to include physical therapy and speech therapy maintenance flow sheet. Presently only OT maintenance flow chart is on the web page.

5. Therapy tests up-date- The BOT-2 has been added to the approved test list. Jarrod McClain recommended that the REEL-3 be added to the approved list. No final recommendation was made for or against this test until further research can be concluded. Sherry Stevenson presented five tests that she would like approved for speech. No action was taken on these tests due to time restraints of the meeting.

6. EDS Billing Week-Clarification was made that the EDS billing week, ends at 12:00 A.M. Friday night. This is important for therapists who see patients on Saturday.

7. Co-treatments-It was recommended by the sub-committee assigned to this item that co-treatments be prior authorized. Debbie Ashworth, PT explained to the committee that the issue here is that there could be a multitude of reasons why therapists feel it is in the best interest of the patient to co-treat. That the decision could not be based on diagnosis or other established criteria. Mrs. Strickland felt this was a good solution but stated that she would have to talk to the Office of Chief Counsel (OCC) to see if prior authorizing this is a possibility. However, Jarrod McClain presented to the committee the federal regs from CMS. Under a section, titled team therapy, it states that therapists working together as a "team" to treat one or more patients cannot each bill separately for the same or different service provided at the same time to the same patient. Mrs. Strickland was going to confer with the OCC regarding this. With this being a federal regulation, it sounds like we will not be able to co-treat as the committee had intended and each discipline would only be able to bill for half the treatment session. For example if a PT and an OT co-treat for 30-minutes, each discipline would only be able to bill for one unit of service, not two. The present guidelines already allow for this, therefore there is a possibility no changes will be made regarding this.

8. Definition of “reasonable progress”-Some committee members and providers have expressed concerns due to the fact they have had services denied due to “lack of reasonable progress.” The committee feels that the maintenance flow charts should help providers decide whether the progress has been reasonable or if the service is indeed maintenance. Committee members who have received these denials and Jarrod McClain will bring examples next workgroup meeting for our review to help determine a better definition.
9. Speech Sub-committee- Consisting of Kim Jones, Sherri Stevenson Judy Eddington and Shelly Weir presented a list of changes they would like see made to the Medicaid guidelines to resolve many issues with qualification. These changes were only minimally discussed due to time restraints with the exception of totally removing IQ from the equation. Further discussion by the workgroup will resume next meeting concerning the following changes:
- \* Allow a score of  $-1.50$  standard deviations or more from the mean in at least one subtest area or composite score to qualify for services. This would bring the speech qualifications in line with physical and occupational therapy.
  - For the birth to three population one norm-referenced and one criterion referenced test will be accepted.
  - For the 3-21 population two norm-referenced test must be reported.
  - All errors must be reported for articulation including positions and types of errors.
  - If phonological testing is submitted a traditional articulation test is not required.
  - Information regarding a child’s functional hearing must be included as part of the evaluation.
  - IQ scores would not be required to compare to language scores to qualify for therapy-for any age. The sub-committee’s argument for this stems on the following; Part B Federal Regs did away with the use of IQ scores compared to language scores in October 2006. Shelly Weir stated that services should be based on need and not how we “think” or “guess” how well a child will do with therapy. It was also stated that if a child qualifies on their standard score, that should be enough.
10. Problems with Appeal Process-Committee members and providers that have contacted committee members expressed concerns that the review process is very black and white. One concern is that statements that are made to the providers in the open meetings are not upheld in the hearings because if it is not in the “policy” or Medicaid manual then it carries no weight in the hearings. Compounding this is that when new guidelines are developed, there is at least a 6-month lag time for them to be put in the manual due to the promulgation process. Mrs. Strickland asked that we e-mail her all the problems we have heard about and she would take them to the OCC.

Committee members are taking turns typing the minutes from the workgroup meetings. Debbie Ashworth agreed to do the minutes from this meeting.  
The next work group meeting is Wednesday, February 7<sup>th</sup>.

Providers please contact your appropriate representatives for any comments, concerns or questions regarding the previously listed or new therapy topics.