

Therapy Workgroup Open Meeting - Minutes
Blue Flame Room
May 3, 2007

Members Present:

Marilyn Strickland with Medicaid, Rosemary Edgin with utilization review, Jarrod McClain with AFMC, Cheri Stevenson with ArkSHA, Cheryl Freeman with utilization review, Judy Eddington with DDS, Debbie Ashworth with ARPTA, Angela Traweek with AROTA, Ruth Castleberry representing DDTCS providers, Debra Garrison representing public schools in Proxy for Tony Boaz, Kim Jones with ArkSHA, and Shellie Weir with ArkSHA.

Marilyn Strickland: Opened meeting at 10:10

Good News – Medicaid had put in executive recommendation to increase therapy rate and it was approved. Marilyn stated that she wants to put together a workgroup that includes reps from each therapy association to develop a methodology to utilize new rate. The new methodology will go to Feds for approval, then to Finance and Administration then to Governors office for final approval. There will be public postings and opportunities for public hearings throughout the process. The proposed changes must be published in the newspaper. Effective date can be locked in at July 1 even though decision for process will take longer. Billing under new rate will be retroactive.

Marilyn reported that she and Roy Jeffus want to look at Pay Per Performance (PPP) – and protocols for such. Also working on EPSDT to ensure these are done timely and adequately. AFMC is working on an incentive payment for therapists by using PPP. Therapists will receive a bonus incentive for doing a good job.

Marilyn reported that the minutes have been approved for March.

Jarrold McClain reported the following:

- Marylyn has talked with AFMC about holding public school letters of pending decisions until August 19, 20. Then they will have 30 days to respond to decisions pending at that point
- Extension of benefits (EOB) – defined by Jarrod. He stated that if you need more evaluation or Rx time, then therapists can request EOB. Handouts were provided that detailed the EOB process. There's a phone number where you can talk to a person who will look up information or answer questions for you. Must have MC (RA) denial prior to requesting EOB
- Old tests on Medicaid accepted list was discussed. Not all tests that are used by therapists are listed on test list. Those that are not must have documentation to support the test that was used.
- Jarrod encouraged group to work together with him as most things can be worked out related to decisions pending or claim denials.
- Newly accepted tests were provided at the meeting via a handout – Protocols that cannot be found are the responsibility of the therapist.
- BOT-II and REEL III will be accepted as of March 1, 2007. BOMP is still on the list and accepted. BOMP and BOT-II are two separate tests with different protocols and criteria. Don't intermix those tests.
- Encourage group to continue to use the status review program on the therapy web page to inquire about status of reviews

Beth Stamp was unable to attend so Marilyn spoke in her place regarding the following:

Co – Rx – still discussed – no absolute decision related to that as of yet.

Ruth Castleberry

Clinical observation – those are part of evaluations and need to be included in evaluation reports. Also attempt to evaluate/observe in natural environment.

Debra Garrison:

Outpatient/School based therapy

Schools do not have a monopoly on therapy. Outpatient has its regulations. Therapy in school revolves around the education of the child. Medicaid will not allow providers to bill for duplicate services. Providers need to coordinate services to ensure same service is not duplicated on same day.

Same provider of service can do services on same day as long as they don't exceed 4 units per day per child per code.

Question raised re: If two providers are providing an evaluation per fiscal year, then it will go over the limit of 4 eval units. Jarrod answered stating this is where EOB comes in to play.

Debbie added that therapists can also collaborate evaluation efforts by doing an evaluation addendum.

Judy Eddington:

- REEL 3 has been added as standardized test, which is good for 0-3 population. Update for EI – DDS is working on a better PA process and they will have a rate increase for therapy to match what MC comes up with.

Question re: Informed clinical opinion vs. clinical observation

Judy answered: about the same. Ruth said “clinical opinion” is recommendations which support your “clinical observation”, so both clinical opinion and clinical observation need to be present in evaluations.

Cheri-

Continue to work on IQ standards for kids less than 10 years old. IDEA was re-authorized November 2005 which takes IQ out as a requirement to determine ST eligibility. Group is struggling with how to deal with “language” – that it is not just “expressive and receptive”. Cheri@accessschools.org – Cheri offered to assist with denials related to pragmatics, English, grammar, etc. She also recommended communicating with Jarrod.

Jarrod responded: collectively he can take data that is collected to shed more light on the situation. Cheri reiterated that the associations need to be involved collectively (in numbers) to provide the data necessary to justify changes to current MC standards. Shelly added that a barrier is making all the areas of language justify eligibility and to make the tools necessary to communicate effectively to regulatory agencies.

Sheila – reported on NPI

2-3 weeks ago – a letter went out to providers who have not submitted NPI to Medicaid yet. Letters will go out again this week. Reporting NPI can be done via the Medicaid website, or providers can send it via mail in writing. Providers can call Sheila for technical assistance. Marilyn says come May 21, NPI will be turned on, but Arkansas will accept Medicaid ID # or NPI, then come October 15 – only NPI will be accepted. There will be a link in the letters telling providers how to look up other providers NPI numbers related to referring physicians, etc. letters will be marked on website. RA messages will come out as well.

Any problems accessing others NPI can be directed to Cheryl Freeman.

Question: Do you have a Medicaid # prior to NPI?

Answer: No, you can apply for NPI – will still need to “enroll” in Medicaid if they haven’t already.

Question: School District employee- One NPI or more?

Answer: How do you want to do your reporting: How is accounting done? Can have multiple numbers – use taxonomy codes to link to Medicaid. Debra advised school districts to get one NPI number for their district.

Sheila stressed that when you report it, you can print it for your records – will need that for electronic billings.

Question: How can we get on mailing list for therapy open meetings?

Answer: The open meetings are announced via ARPTA, AROTA, ARSHA, and AFMC websites. DDS sends notice out to DDTCS and EI providers.

Debra says school districts ending in 42 must list performing provider – so therapists will have to have NPI number’s too.

Question: Do PCP’s need to put NPI number next to signature at the bottom of the page? Is AFMC going to deny if NPI number is not on there?

Answer: per Jarrod – no

Answer: Peggy Starling says that MD’s have been instructed to “share” their NPI number (per Medicaid requirements). Report any MD’s who won’t cooperate to Peggy Starling

Question: Will there be another meeting re: billing, NPI?

Answer: Per Sheila, there are workshops in June/July for paper claims and NPI. People are welcome to attend. Flyers will come out. Watch for them. Watch RA messages for updates.

Peggy Starling – AFMC.org – to register for meeting

3 required meetings coming up for MD's. These meetings will cover incentives for MD's if we want an idea of how that's done. MD's are encouraged not to give referrals unless they have done EPSDT.

Judge Vicki Wyatt – Office of Appeals

(handout) – details Paul Fisher's info to contact with questions, concerns, or problems. Paul is new and he will take your info and question and call you back as he will need to research answer.

Reconsiderations need to go to AFMC = not office of appeals.

When reconsiderations are denied, you may request an appeal – must write a letter stating why you are appealing the decision and send the AFMC denial letter along with it.

Appeals and Hearing Process:

Vicki stressed how important documentation is on the "front end".

When requesting an appeal, provide detailed information as to why the appeal is being requested and provide documentation that shows how the denial came to be.

Rich says with appeal, remedies are very limited. Appeals are purely a document review – all documents must be submitted at initial and reconsideration reviews. No new documents are allowed in most circumstances. There are some special circumstances that will warrant extra documentation.

Question: regarding deadlines not being met secondary to MD's failing to complete 640 correctly

Answer: Take that issue to Jarrod as soon as you know there's a problem that will delay meeting the deadline.

Don't wait – call immediately, Jarrod can document what complication the provider is having and hold the review for a "few days". He can't "stop" the review process. There are avenues – just communicate with Jarrod to work them out.

Vicki stated that the example letter handed out from AFMC re: EOB does not have reconsiderations and address listed on it – Jarrod clarified that the "sample letter" handed out did not have the correct information, but that the official letter that goes to providers is correct.

Appeals and Hearing Process:

Once you receive denial from AFMC you have the right to appeal through OCC. Put request in writing with supporting documentation. Then you will receive a scheduling letter as to when your case will be heard. At that time, you need to have your documentation ready and be prepared to present your case. You will present first at a hearing to state why you believe the case should be appealed and your documentation to support that.

- then you will be cross examined
- then you can make closing remarks
- then decision is made based on information presented at hearing. Cannot add to hearing after it is over.

Per Rich Rosen – recommend you bring your records with you – can request a copy of what the attorney and judge has so you will have the same pages.

Rich says a lot of issues he sees are whether or not a test is approved by MMY. If using a test not approved on APA list, then therapists are encouraged to go to AFMC or the therapy workgroup.

OCC is there to litigate the case – it is not a round table discussion.

Question: What percentage of cases have been overturned?

Answer: AFMS has changed their mind on a case when being discussed by attorneys prior to hearing – once case goes to hearing – all have been upheld to date.

Vicki stated "guidelines must be followed by Medicaid and state regulatory agencies or Medicaid funding may be taken away from the state".

Normal time frames for hearing is approximately 90 days from date of request for hearing.

Per Rich: Must prove where AFMC is wrong thru policy and fact.

Hearings are done via phone unless a face to face is requested.

Question: What about supporting documentation that comes after the dates of service? Reconsiderations, etc.
Answer: Can request a judiciary review in your county of residence. Circuit court judge will only review what was recorded at appeal hearing. So no new documentation can be presented.

Meeting adjourned at 12:00 noon.