

MEDICAID - AFMC ISSUES
SUMMARY OF MEDICAID WORK GROUP MEETING
September 23, 2004

1. **TIMELY RESPONSE FROM AFMC-** Several therapists in the work group expressed concern over the length of time that it takes AMFC to send out the initial denial letter for each review. It was felt that the whole review process needs to be expedited. Some therapists had just received denials for the January review, which would have covered dates of service from September 2003-December 2003. Mrs. Strickland initially felt that therapists should have a "tickler file". She felt that the therapist should call AFMC on a regular basis in regards to the audits that are "unresolved" that are in this file. One of the PTs on the committee stated that she had 21 reviews for the January review, 27 each for the April and July periods that there has been no communication on. It was explained to the Medicaid members of the committee that therapists assume there is nothing wrong with the review if they do not hear anything. Otherwise, there would be 75 charts in this "tickler file" for this therapist. Therapists are requesting that a letter be sent to the provider, after a file has been reviewed and has been approved. Medicaid agreed to meet with AFMC regarding this.

2. **ISSUES WITH ARKANSAS CHILDREN'S HOSPITAL-** ACH did an internal audit concerning the referral/script turn around time. They report their average lag time is 11 days. There is only one person handling all the referrals at ACH. Her name is Angie Massey. Her fax number is 501)364-7591 or phone 501)364-1276.

3. **REPEAT AUDITS-** Clarification on this- No child will be looked at twice in the same fiscal year. Medicaid's fiscal year runs from July 1st-June 30th. If you do receive repeat audits, you need to call Jarrod McClain @ 479)649-8501.

4. **PEER REVIEW AND THERAPY RECOUPMENT-** Most of the denials that were being appealed and going to peer review were due to issues over make up sessions and test usage. Medicaid has made the decision not to uphold these denials. They report that no denials will be based on tests used until the test list has been APA'ed. A letter also will be going out to provider's, for educational purposes, regarding make-up sessions. From the present time forward, all make-up sessions will require a script. Previous denials based on this issue have been overturned. Also refer to your RA for instructions for rebilling of services that AFMC denied and recoupment occurred on, due to billing errors. Medicaid reports with all these thrown out, that there are very few denials left to go before the peer review. Medicaid is also in the process of doing an updated section for the Medicaid manual to clarify the peer review process.

5. **SUPERVISION OF ASSISTANTS-** Mrs. Strickland had not had time to review each disciplines recommended guidelines obtained from their respective state boards at the time of this meeting. She states that she will review this and have an answer prior to the open meeting in October. Work group members will be e-mailed her decision as soon as one has been made.

6. **TESTS-** Will be APA'ed. This takes approximately 90 days. Therefore, a complete and final list will not be available until at least January 2005. The qualifying scores will be included for each test.

7. **IQ TESTING/LANGUAGE SCORES-** You speech people should be thrilled, as of January 1st, 2005, IQ scores compared to language scores will no longer be required for children under age 10. It was stated that IQ and language are intertwined and children with language delays are going to test lower on IQ testing, whether there is a true cognitive deficit or not. Be aware that if it starts to look

like this new guideline is being misused (as determined by AFMC review) to provide speech services to children who do not dually need the services, then this new standard may be revamped or even rescinded. A flow chart of how this will be implemented for the age 10-21 population should be on the speech web site in the near future.

8. EARLY INTERVENTION- EI and Medicaid have agreed to streamline their qualification guidelines. To qualify for EI or Medicaid, two tests must be given. One test must be standardized and one test criteria referenced. If the two tests do not support each other, a third test must be given. This test may be standardized or criterion based. For 0-3, a 25% delay or two standard deviations below the mean will be accepted. Also, informed clinical opinion will be a consideration. The wording for this must go through endorsement channels and legal approvals of the ICC, DDS and then Medicaid. Therefore, this will be months before it is finalized.

9. MAINTENANCE GUIDELINES-This is finalized. Please review summary report from July 22nd work group meeting on the PT website, item #8.

10. DMS-640 FORM- The 640 form will be changed to include a box under each therapy discipline that the physician may check if he does not agree with the provision of services. A provider on the work group brought to the attention of the group that this could open up a whole can of worms. If EI is able to use the fact that a physician has checked the box “therapy not medically necessary” as a Medicaid denial (to enable them to access other funding sources) , even though Medicaid was never billed, then providers should be able to take a parent’s refusal to allow private insurance to be billed as a insurance denial (even though insurance was never billed) to then bill Medicaid. Medicaid is going to consult with their attorney that specializes in third party billing regarding this matter.

11. OPEN MEETING- OCTOBER 28TH, 2004- The meeting is to be held at 400 E. Capitol in Little Rock at the Blue Flame Room. It is in the same building as the Office of Child Support Enforcement. No food or drink will be permitted inside the auditorium. Providers should park in the lots directly north of the building on 4th street or at the overflow lot at 3rd and Rock. There is a sign that says “pay before you park” however, guests to this building do not have to pay. Meeting is 10:00-12:00.

12. REFERRALS-We are still working on trying to convince Medicaid to do away with some of these referrals and scripts required for each child. Therapists explained that you can have a current script and current referral but if you need to reeval a child for some reason, you have to get another referral. In the therapist’s opinion, we have three pieces of paper that all cover the same time period. If nothing else, we would like to see at least the evaluation script be good for 1 year, no matter how many times you eval the child. Medicaid wants specific examples of how one child may be covered by multiple referrals and scripts. Please, mark out the child’s name and any identifying information and fax examples of this to Debbie or Beth, for us to present at the next work group meeting.

Next work group meeting is December 2nd. Please contact Beth Stamp at Office: (501)941-5630, Fax: (501)843-2270 or e-mail at bstamp@alliedtherapy.com or Debbie Ashworth at Cell: (479)651-3389, Fax: (479)474-4044 or e-mail: dashworthpa@msn.com with any suggestions or comments you would like us to address at the next work group.