

March 8, 2002

Dear Pediatric Physical Therapist,

The ArPTA was recently invited to participate in a round table discussion with the Arkansas Department of Human Services Division of Medical Services and AMFC on the post payment review process.

Following this letter is a brief summary of the information obtained at that meeting. If you have further questions concerning these issues please contact the practice committee at 870-932-9567 Ext. 47.

As always, we appreciate the opportunity as an organization to be involved in open discussion with organizations that have such an effect on our practices. We hope to remain involved in this type of dialog with DHS, AMFC, and other organizations in the future as the opportunity arises.

Sincerely,

Todd Burton, PT  
Chairman, ArPTA Practice Committee

### **Medicaid-AFMC Post Payment Review Process**

Representatives from AFMC stated that the post payment review process will continue. They stated this is the most effective way for audits to be performed throughout the state. Field audits will also continue as they have in the past.

#### **Selection of Cases:**

The first claims to be reviewed were from the dates of services from June 11, 2001-September 30, 2001. A certain percentage of children were randomly chosen by the computer. If a child was selected, all therapies that child was receiving during those dates were reviewed. Cases for review are based on the child not the provider. The next cases for review will be coming out soon.

#### **DMS 640:**

**Primary Diagnosis:** This is the diagnosis the child is receiving therapy for. It should NOT necessarily be the reason for the doctor's visit, unless that directly relates to therapy.

**Diagnosis Codes:** Diagnosis codes should reflect the diagnosis of the child. For example: if you are treating a child with cerebral palsy, you should use the code for cerebral palsy, not the code for general gross motor delay.

**Last Physical Exam:** This refers to the last visit the child had with the primary care physician. This is not necessarily the EPSDT.

**Physician Signature and Date:** Stamp signatures will not be accepted

**Prescriptions:** A prescription is good for a maximum of 12 months from the date the physician ordered the service and signed the DMS 640. If a range of dates are written on the DMS 640, it will not be accepted. Referrals are good for 6 months. Prescriptions may be signed by a specialist or the PCP, but referrals must be signed by the PCP. Prescriptions with “eval and treat” WILL NOT BE ACCEPTED.

**Billing and Progress Notes:**

- Progress notes should be legible. If the reviewer is unable to read your note, they will be unable to review your note.
- Progress notes should present a clear description of each therapy session.
- Billing must match the signature on the note. If a PT billing code is used, a PT's signature should be on the note, not a PTA's and vice versa.
- When sending notes in for review, highlight your copies if you have more than one progress note per page. This may keep the reviewer from overlooking a note and asking for that note to be sent a second time.
- If you use symbols on your notes (i.e.+, -,/,etc.) please place a legend on your notes so that the reviewer understands your symbols.
- The reviewing therapists asked that progress notes show progress. If you are not showing progress on a certain day, state why not.

**Make-up Visits:**

Make-up visits can only be made within the week the visit was missed. The only exception will be if the PCP signs a new DMS 640 with a statement of medical necessity for the make-up sessions. A plan for the make-up sessions is also required. For example: if the child has missed 3 one hour visits and can only tolerate an extra 30 minutes per week your plan would be to see the child an extra 30 minute session one time per week for six weeks.

**PCP's Responsibility**

The primary care physicians are also being monitored. If you get a medical necessity denial, the PCP is also tabbed with a denial.

**Evaluations and Testing:**

- Be sure your evaluations are objective and give a clear picture of the child being evaluated.
- Two tests are required with at least one being a norm referenced standardized test.
- The child must qualify in 2 areas. These may be areas on the standardized test, or other areas such as range of motion, manual muscle testing, tone, sensation, etc.
- To qualify on the standardized test, the child must have a score 1.5 standard deviations below the mean. A child can qualify for services in one area on a standardized test by scoring 2.0 standard deviations below the mean.
- Make sure findings in areas not included on a standardized test are objective and it is stated in your assessment that the child has deficits in these areas.

**Time frames for review:**

If you receive a request for review your paperwork must be received by AFMC no later than 30 days from the request. A confirmation letter with control numbers will be sent to you upon receipt of your paperwork by AFMC. If you then receive a denial you will have 30 days to ask for a reconsideration. Medical necessity denials and claims denials will be sent separately. The representative from AFMC stated they will be happy to take your phone calls if you have any questions about whether they have received paperwork or if you have any questions.