

## ***Claiming the Most Medicaid Dollars in the Schools*** ***Quick Fact Sheet***

### ***OT/PT/SLP Quick Facts:***

#### **Prescription and Referral**

- Medicaid requires form DMS-640 to be used for all prescriptions for therapy services. If form DMS-640 was used for the initial referral for evaluation, a separate DMS-640 form is required for prescription. After the initial referral and initial prescription, subsequent referrals and prescriptions for continued therapy may be made at the same time using the same DMS –640.
- Medicaid requires schools to get one referral and one prescription for the school year for treatment. An evaluation requires a separate referral. The prescription can be valid for up to 12 months. In order to be valid for this time period, the PCP will need to write for the “school year of .....”.
- Extended school year services can also be covered if the IEP recognizes the need and the prescription includes that period of time.

#### **Medical Necessity:**

- To be considered medically necessary, the following condition must be met:
  - 1) The services must be considered under accepted standards of practice to be a specific and effective treatment for the patient’s condition;
  - 2) The services must be of such a level of complexity, or the student’s condition must be such that the services required can be safely and effectively performed only by or under the supervision of a qualified speech and language pathologist;
  - 3) There must be reasonable expectation that therapy will result in meaningful improvement or reasonable expectation that therapy will prevent a worsening of the condition.
- A diagnosis alone is not sufficient documentation to support the medical necessity of therapy. The student’s diagnosis must clearly establish and support that the prescribed therapy is medically necessary.
- Assessment for therapy includes a comprehensive evaluation of the student’s physical and/or speech language deficits and functional limitation, treatment planned and goals to address each identified problem. With regard to testing for OT/PT, if the student scores a standard score of at least a –1.5 standard deviation below the mean in one subtest area then the student would qualify for billable therapy services. For SLP services to qualify, the student must score at least a-1.5 standard deviation in two areas or a –2.00 standard deviations below in one area.

#### **Treatment/Progress Notes:**

- All treatment/progress notes must include dates and times for each service billed. A full signature and credentials of the providing therapist must be included on each daily progress note entry.
- In addition, Medicaid requires that each treatment/progress note entry must contain a description of specific therapy services provided daily, the activities rendered during each therapy session and a form of measurement.

#### **Supervision:**

- All assistants, students, and other therapy staff not qualified in the state must be supervised by qualified therapists. For speech therapists in the public schools who do not have their CCC's, they must be supervised by a qualified speech therapist. The supervision includes oversight of treatment with signatures and credentials on all notes and evaluations. The supervising therapist must

document approval of progress made and any recommended change in the treatment plan.

**Benefit Limits:**

- Evaluations for OT/PT/and SLP services are limited to 4 units (30 minute units) per state fiscal year. Individual and group therapy services are limited to a maximum of four 15 minute units of therapy per day. Group therapy must be provided in a group size of no more than 4 students per group.

**Billing Quick Facts:**

- In order to bill Medicaid for student related services, these services must be listed in an Individualized Education Program (IEP). SBMH services are the only services that can be billed to Medicaid without requiring an IEP.
- In cases where Medicaid eligible students have third party insurance coverage, a denial from these companies is necessary before you can bill Medicaid for related services. In some cases, third party insurance companies will not issue a denial letter, but a letter noting their lack of coverage for school related services. This will suffice as a denial letter for the purposes of billing Medicaid. There must be an annual attempt to secure reimbursement from third party insurance companies prior to billing Medicaid.
- Many times parents will not allow schools to access their third party insurance for school related issues. When this occurs, schools cannot access Medicaid because third party liability requirements cannot be met. *\*\*\*It is important to note that some parents automatically mark “no” when asked about third party billing, when in fact that they may not have third party insurance. The school district representative should inquire if the parent has third party insurance, and then offer an explanation of why the district would be pursuing Medicaid funds for related services.*
- School services for 504 students should not be billed to Medicaid; it is the schools responsibility to provide the services for these students.

**Medicaid Application Quick Facts:**

- Medicaid requires a separate application for each service provided.
- Arkansas school districts are able to offer Occupational Therapy (OT), Physical Therapy (PT), Speech/Language Pathology (SLP), School-Based Mental Health (SBMH), Private Duty Nursing (PDN), Targeted Case Management (TCM), and Personal Care (PC). Primary to your district’s submission of an application to Medicaid, ADE certification is often necessary.
- Blank Medicaid applications can be accessed at the Arkansas Medicaid Website (<http://www.medicaid.state.ar.us>) or at the Special Education Website (<http://arksped.k12.ar.us>).

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