

DEPARTMENT OF HUMAN SERVICES, DIVISION OF MEDICAL SERVICES

SUBJECT: Arkansas Medicaid Reimbursement for Physical and Occupational Therapy in Clinic-Based Settings (20 CAR pts. 631, 636, 656)

DESCRIPTION:

Statement of Necessity

This rule implements Act 103 of 2025, which requires Arkansas Medicaid to cover rehabilitative physical therapy in a clinic setting. As stated in the Act, “[r]esearch has found that access to rehabilitative physical therapy in clinic-based settings leads to lower total costs of care over time, decreases the need for surgical interventions, and reduces the need for long-term use of opioids and other pain medications.” DHS conducted additional research into occupational therapy offerings and believes that expanding coverage for rehabilitative occupational and physical therapy in clinic-based settings under the program will result in improved outcomes and potential cost savings for the Arkansas Medicaid Program.

Summary

This rule allows adult Medicaid Beneficiaries, twenty-one (21) years of age and older, to receive rehabilitative occupational and physical therapy in clinic settings. A new provider manual, Rehabilitative Occupational Therapy and Physical Therapy Services, explains coverage and reimbursement rules. Corresponding revisions are needed to the Nurse Practitioner and Physician provider manuals. (Note: The provider manual changes in this rule also will be included in the new Physician Assistant provider manual and Clinical Nurse Specialists provider manual being promulgated separately in the Community Health Worker rule).

Revisions to Rule Post Public Comment and CMS Guidance

CMS advised a SPA is not necessary. SPA is removed from the rule and removed from the Summary above.

In response to the Public Comments, the following updates were made to the Rehabilitative Occupational Therapy and Physical Therapy Services manual:

- Section 200.100: Reference to Hospice Manual added.
- “Physical therapy assistant” changed throughout manual to “physical therapist assistant”.
- Section 201.400: Revised to reflect current state regulations in PT and OT Practice Acts, and the ten-day timeframe was changed to ten visits for progress reports, which must follow Medicare requirements.
- Section 201.700: DMS-640 – Clarified intent and corrected the time element from twelve months to three months based on the scope of work for rehabilitation therapy.
- Section 201.700, 5c: The phrase, “which includes the goal(s) or objective(s) the specific service or activity is designed to address” is removed from the

requirement to describe specific services and activities provided during each therapy session.

- Section 201.700, 5e and 6: Requirements removed and note added clarifying the supervising therapist's progress report assessing improvements at least every 10 visits is a documentation requirement. Requirement 6 modified to specify "other" reports, notes, and correspondence to ensure any misinterpretation regarding duplication of documentation is removed.
- Section 210.500, B1: Requirement is revised to require beneficiary's name, and age or date of birth.
- Section 210.600: Section is rewritten to clarify the intent is beneficiaries who are currently admitted as an inpatient in the hospital or are currently residing in a nursing care facility are not eligible for occupational or physical therapy under the rules and regulations of this manual. A second sentence is added to clarify services provided under this manual and under the Home Health manual that are duplicative in nature are not allowed for the same time period. A third sentence is added to explain what is allowed.
- Section 210.700, D: Clarifying language added to the reference, because specific coverage rules are set forth in the Home Health program manual and are referred to within the Hospice manual. Rather than provide a hyperlink to the Hospice manual which would then provide a hyperlink to the Home Health manual, DMS provided the direct hyperlink to the Home Health manual instead.
- Section 210.900, D: The section has been changed to remove "in combination with outpatient hospital and rehabilitative hospital services". The referenced section number is incorrect and will be changed.
- Section 220.100: To be able to accommodate a 12-visit limit for Adult Rehabilitative Therapy clinic services, the state will instead count the 12 visits against a clinic services benefit limit. The references to outpatient hospital services have been removed.
- Section 220.100, 3: No longer applies and has been removed.
- Section 220.100, E: The referenced section number was incorrect and has been changed.

PUBLIC COMMENT: A public hearing was held on this rule on March 25, 2026. The public comment period expired on April 12, 2026. The agency provided a public comment summary which, due to its length, is attached separately.

The proposed effective date is July 1, 2026.

FINANCIAL IMPACT: The agency indicated that this rule has no financial impact.

LEGAL AUTHORIZATION: The Department of Human Services has the responsibility to administer assigned forms of public assistance and is specifically authorized to maintain an indigent medical care program (Arkansas Medicaid). *See* Ark. Code Ann. §§ 20-76-201(1), 20-77-107(a)(1). The Department has the authority to make rules that are necessary or desirable to carry out its public assistance duties. Ark. Code Ann. § 20-76-201(12). The Department and its divisions also have the authority to

promulgate rules as necessary to conform their programs to federal law and receive federal funding. Ark. Code Ann. § 25-10-129(b).

This rule implements Act 103 of 2025. The Act, sponsored by Senator Mark Johnson, required the Arkansas Medicaid Program to reimburse for physical therapy provided in a clinic-based setting.

Rule number 331 - Arkansas Medicaid Reimbursement for Physical and Occupational Therapy in Clinic-Based Settings

Caroline Bergner, JD, Director, for

Linda I. Rosa-Lugo, EdD, CCC-SLP, 2026 ASHA President, and for

Lauren Rogers, Eds, MS, CCC-SLP 2026 ArkSHA President, on behalf of

The American Speech-Language-Hearing Association

Comment: On behalf of the American Speech-Language-Hearing Association (ASHA) and the Arkansas Speech-Language-Hearing Association (ArkSHA), we write to express support for adding coverage of occupational and physical therapy services for Arkansas Medicaid enrolled adults. However, we are extremely concerned that the proposed rule does not include coverage for speech therapy and cochlear-implant related audiology services.¹

ASHA is the national professional, scientific, and credentialing association for 247,000 members, certificate holders, and affiliates who are audiologists; speech-language pathologists (SLPs); speech, language, and hearing scientists; audiology and speech language pathology assistants; and students. Over 3,200 ASHA members reside in Arkansas.² ArkSHA is a nonprofit professional association representing audiologists, speech-language pathologists, and related professionals across the state.

Audiologists diagnose and treat hearing, balance, tinnitus, and other auditory disorders across the lifespan and provide habilitative and rehabilitative services, such as cochlear implant programming and management.³ SLPs prevent, assess, diagnose, and treat speech, language, cognitive-communication, and swallowing disorders across the lifespan.⁴

ASHA and ArkSHA support expanded access to occupational and physical therapies for Medicaid beneficiaries. We understand that this rule implements Act 103 of 2025, which requires Arkansas Medicaid coverage of clinic-based physical therapy.⁵ The Department has also elected to include occupational therapy for adults as an additional benefit, without legislative mandate. Given that speech therapy is categorized alongside occupational and physical therapy in existing Medicaid policy, its exclusion creates an inconsistency in access to clinically related services.

We respectfully request that the Department include coverage of speech therapy and cochlear implant-related audiology services for adults. The Department has previously expressed interest in expanding access to cochlear implant related services as part of its 2023 Medicaid Sustainability Review, indicating alignment with this approach.^{6,7}

Federal Law Requires Coverage of Medically Necessary Services for People With Disabilities

Federal law requires coverage of audiology and speech-language pathology services for children under the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) benefit, which ensures Medicaid-enrolled children (under age 21) receive all medically necessary services to “correct or ameliorate” a

condition.^{8,9} The EPSDT law ensures that children and adolescents receive appropriate preventative, developmental, dental, mental health, and specialty services—including speech, language, and hearing services. Our country has prioritized mandatory services for Medicaid-enrolled children because research shows that children who receive these services are more likely to be academically successful and maintain employment in adulthood.

However, coverage for adults is optional under federal Medicaid law. As a result, many Medicaid-enrolled adults lose access to medically necessary communication, swallowing, and hearing services upon turning 21. When communication and hearing conditions go untreated, vulnerable adults are left without the communication skills they need for a functional and successful life.

Speech-language pathology services are critical for adults recovering from stroke, neurological conditions, and head and neck cancer. These services address communication impairments and dysphagia (swallowing disorders), which, if untreated can lead to aspiration pneumonia, malnutrition, ongoing impeded speech, and prolonged recovery, including hospital readmissions and extended lengths of stay—outcomes that increase Medicaid expenditures.

Audiology services, including cochlear implant evaluation, programming, and follow-up care, are distinct but complementary to speech-language pathology services and are critical for individuals with significant hearing loss. Speech-language pathology services play a central role in developing auditory comprehension and functional communication following implantation. Adults with cochlear implants—and those who are candidates for implantation—require access to both the technology and the full continuum of audiology and speech-language pathology services necessary to support optimal outcomes.

Without Medicaid coverage and associated services, beneficiaries are denied access to a well-established, high-value intervention that improves communication, employment, and overall quality of life. Moreover, failing to cover both implantation and follow-up care undermines the significant clinical and financial investment in cochlear implantation, limiting device effectiveness and diminishing long-term outcomes.

Adult Coverage of Speech Therapy Saves Money

Medicaid coverage of speech-language pathology services reduces costs by preventing complications and improving functional outcomes.^{10,11} Communication disorders like stuttering have measurable financial consequences, including reduced lifetime earnings due to avoidance of speaking-intensive roles, decreased communication confidence, and occupational self-selection.¹² Evidence shows that speech-language pathology services improve communication effectiveness, self-advocacy, and participation in educational and professional settings. By addressing both speech fluency and the psychosocial components of stuttering, speech-language pathology intervention supports greater workforce engagement, expanded career opportunities, and improved long-term earning potential.

For example, speech-language pathology treatment of dysphagia—a swallowing disorder in children and adults—generates significant cost savings. A patient with dysphagia can cost a facility \$5,000 to \$10,000 more than a patient without this condition. Getting a patient to take food by mouth instead of tube may save more than \$50,000 each year. Systematic swallowing screenings and treatment by SLPs in geriatric

and medically complex populations reduce length of hospital stays, readmission rates, and incidence of aspiration pneumonia—high-cost conditions in Medicaid populations. These improvements translate into substantial cost savings at both institutional and health care system-wide levels.

Speech-language pathology services also play a critical role in maximizing outcomes for adults with hearing loss, including those who receive cochlear implants (CIs). Following implantation, patients often require therapy to develop auditory comprehension and functional communication skills. Without these services, individuals may not fully benefit from the device, limiting improvements in employment, independence, and overall quality of life—outcomes that are directly tied to the economic value of cochlear implantation.

In a time of fiscal constraint for Medicaid programs—particularly in light of changes affecting program financing under the One Big Beautiful Bill Act—coverage of services that reduce avoidable complications and improve functional independence is critical to program sustainability.

Adult Coverage of Cochlear Implants and Related Audiology Services Saves Money

Medicaid coverage of audiology services, including cochlear implant-related care, saves money by improving functional outcomes and generating long-term economic gains. CIs are a high-value, technology-driven intervention for individuals with significant hearing loss. Specifically, CIs:

- Are a definitive treatment, meaning this intervention is the best available to treat a particular disease or condition. They are also typically durable for life in 98% of patients (no further surgery is needed in those cases).
- Improve a patient's median income by \$10,000-\$20,000 annually.¹³
- Produce a net economic gain for Arkansas (rather than a loss): Lifetime net gain to states with implant coverage for this population of patients is estimated at approximately \$400,000 per patient, with the greatest gains realized among younger and mid-life adults.¹⁴
- Improve lifetime productivity, earnings, employability.¹⁵
- Are the most successful neural prostheses to date.¹⁶

However, these outcomes are only realized when patients have consistent access to audiology services—including device programming (mapping), maintenance, and auditory rehabilitation—as well as speech-language pathology services that are essential for translating auditory access into meaningful communication outcomes. Without coverage of these essential follow-up services, the effectiveness of cochlear implants is significantly diminished, and the clinical and economic benefits outlined above are not fully achieved.

Ensuring coverage of both cochlear implants and the associated continuum of care is therefore critical to maximizing patient outcomes and realizing long-term cost savings for the Medicaid program.

In Fall 2023, ASHA and ArkSHA were informed that the Department was considering expanding coverage of CI-related services for adults as part of its Medicaid Sustainability Review. ASHA, ArkSHA, and the American Academy of Audiology sent letters supporting the addition of CI coverage for adults.^{17,18}

Medicare, TRICARE, and the Veterans Health Administration all provide coverage for CIs, meaning the Department would join many other health insurance programs offering this critical benefit.

Although no additional coverage was added at that time, we remain hopeful that the Department will consider expanding coverage to ensure more Medicaid-enrolled adults retain access to services. ASHA strongly supports expanding CI coverage by Arkansas Medicaid to include adults or individuals over age 21 because of the many benefits CIs offer these patients.

Conclusion

ASHA and ArkSHA support the Department's efforts to expand access to therapy services. To ensure consistency in coverage and maximize clinical and economic outcomes, we respectfully recommend including speech therapy and cochlear implant-related audiology services for adults as part of this rulemaking.

Citations:

¹ Arkansas Department of Human Services. (n.d.). *Arkansas Medicaid reimbursement for physical and occupational therapy in clinic-based settings*. <https://humanservices.arkansas.gov/wpcontent/uploads/Arkansas-Medicaid-Reimbursement-for-Physical-and-Occupational-Therapy-in-Clinic-Based-Settings-A.pdf>

² American-Speech-Language-Hearing Association. (2024). *Arkansas* [Quick Facts]. <https://www.asha.org/siteassets/advocacy/state-flyers/arkansas-state-flyer.pdf>

³ American Speech-Language-Hearing Association. (n.d.). *Audiologist roles and responsibilities*. <https://www.asha.org/students/audiologist-roles-and-responsibilities>

⁴ American Speech-Language-Hearing Association. (n.d.). *Speech-language pathologists*. <https://www.asha.org/students/speech-language-pathologists>

⁵ Arkansas General Assembly. (2025). *Act 103 of 2025*. <https://arkleg.state.ar.us/Home/FTPDocument?path=%2FACTS%2F2025R%2FPublic%2FACT103.pdf>

⁶ Arkansas Department of Human Services. (n.d.). *Occupational therapy, physical therapy, and speech language pathology services*. <https://humanservices.arkansas.gov/divisions-shared-services/medicalservices/helpful-information-for-providers/manuals/therapy-prov/>

⁷ Arkansas Department of Human Services. (n.d.). *Medicaid sustainability review*. <https://humanservices.arkansas.gov/divisions-shared-services/medical-services/medicaid-sustainability>

⁸ National Archives and Records Administration. (2026). *Code of Federal Regulations: 42 CFR Part 441, Subpart B, early and periodic screening, diagnosis, and treatment (EPSDT) of individuals under age 21*. <https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-C/part-441/subpart-B>

⁹ Department of Health and Human Services. (2014, June). *EPSDT: A guide for states: Coverage in the Medicaid benefit for children and adolescents*. <https://www.medicaid.gov/medicaid/benefits/downloads/epsdt-coverage-guide.pdf>

¹⁰ Law, J., Rush, R., Anandan, C., Cox, M., Wood, R., & Roulstone, S. (2015). Economic evaluation of speech and language therapist-led intervention. In *Evidence-based intervention for preschool children with primary speech and language impairments: Child Talk—An exploratory mixed-methods study* (pp.141–170). NIHR Journals Library. <https://www.ncbi.nlm.nih.gov/books/NBK311176/>

¹¹ McNamara, D. (2024, May 28). *The monetary value of early cochlear implantation*. University of Miami Miller School of Medicine. <https://news.med.miami.edu/cost-of-hearing-loss-and-cochlear-implants>

¹² Jacobs, M., Gerlach-Houck, H., & Briley, P. (2025). Differential impacts of anticipated success on employment outcomes among adults who stutter. *American Journal of Speech-Language Pathology*. <https://pubmed.ncbi.nlm.nih.gov/39546417/>

¹³ Clinkard, D., Barbic, S., Amoodi, H., Shipp, D., & Lin, V. (2015). The economic and societal benefits of adult cochlear implant implantation: A pilot exploratory study. *Cochlear Implants International*, 16(4), 181–185. <https://doi.org/10.1179/1754762814Y.0000000096>

¹⁴ Neve, O. M., Boerman, J. A., van den Hout, W. B., Briare, J. J., van Benthem, P. P. G., & Frijns, J. H. M. (2021). Cost-benefit analysis of cochlear implants: A societal perspective. *Ear and Hearing*, 42(5), 1338–1350. <https://doi.org/10.1097/AUD.0000000000001021>

¹⁵ *ibid.*

¹⁶ Wilson, B. S., & Dorman, M. F. (2008). Interfacing sensors with the nervous system: Lessons from the development and success of the cochlear implant. *IEEE Sensors Journal*, 8, 31–47. 17 American Speech-Language-Hearing Association. (2023, November 30). *ASHA support letter to Arkansas Medicaid on adult cochlear implant coverage*. <https://www.asha.org/siteassets/advocacy/comments/asha-support-letter-to-arkansas-medicaid-on-adultcochlear-implant-coverage-113023.pdf>

¹⁸ American Academy of Audiology & Arkansas Speech-Language-Hearing Association. (2023, September). *Final AAA AR Medicaid letter*. <https://www.audiology.org/wpcontent/uploads/2023/10/Final-AAA-AR-Medicaid-Letter.pdf>

Response:The Department of Human Services (DHS) appreciates the American Speech-Language-Hearing Association (ASHA) and the Arkansas Speech-Language-Hearing Association (ArkSHA) for their support of the proposed rule implementing **Act 103 of 2025**.

The primary distinction of the new physical and occupational therapy coverage is its focus on the continuation of outpatient services within a clinical or office setting. Conversely, the services proposed in this comment represent an expansion of adult care that extends beyond restorative therapy. Notably, research presented during the legislative process suggests this rule would remain revenue-neutral for Medicaid; the costs of increased outpatient utilization are expected to be offset by a corresponding reduction in acute care expenditures.

Although adult speech-language pathology services are not included within the scope of this specific rule, DHS remains committed to exploring avenues for their inclusion. We will continue to evaluate how to provide sustainable coverage for these essential services while remaining mindful of the Medicaid program’s immediate budgetary considerations.

Holly Hertzberg

Public hearing held remotely 03/25/2026 @ 9:30 AM CST

Comment: Okay, thank you. Um, my name is Holly Hertzberg and I’m the new president of the Arkansas Occupational Therapy Association. And on behalf of the Arkansas Occupational Therapy Association, I’d like to express support for the proposed rules regarding the Arkansas Medicaid reimbursement for Physical and Occupational Therapy clinic-based settings. The Arkansas Occupational Therapy Association is extremely grateful for how accessible and receptive Medical Services Direction Pitman and DHS staff

have been to our organization during past discussions concerning this issue. Thank you again to all those who put in tremendous amount of work on these proposed rules. Thank you all so much.

Response: The Department of Human Services (DHS) values the contributions and expertise provided by the Rehabilitation Network of Arkansas, the Arkansas Physical Therapy Association, and other key stakeholders. This collaborative engagement has been instrumental in our efforts to refine and promulgate a more comprehensive manual for rehabilitative therapy providers.

Bo Renshaw

Public hearing held remotely 03/25/2026 @ 9:30 AM CST

Comment: This is Bo Renshaw, and I'm representing the Rehabilitation Network of Arkansas, representing about 3,000 therapists across the state and also the Arkansas Physical Therapy Association, we would like to echo the comments just made that we're appreciative of the support of the working through the manual edits and the support that we've been able to get there for comment, and we're fully supportive of the current changes.

Response:

The Department of Human Services (DHS) values the contributions and expertise provided by the Rehabilitation Network of Arkansas, the Arkansas Physical Therapy Association, and other key stakeholders. This collaborative engagement has been instrumental in our efforts to refine and promulgate a more comprehensive manual for rehabilitative therapy providers.

Arkansas Physical Therapy Association (APTA)

Rehabilitation Network of Arkansas (Rehabnet of AR)

Stakeholder workgroup: Bo Renshaw, Seth Coulter, Becky Crenshaw, Camie Boggess, Gabe Freyaldenhoven

Comment: Section 200.100; Item (C) should reference Hospice manual.

Response: Item (C) has been revised to include the reference to the Hospice manual.

Comment: The term "physical therapy assistant" should be changed throughout the manual to read, "physical therapist assistant".

Response: The term has been changed throughout the manual to correctly reflect “physical therapist assistant”.

Comment: 201.400; These requirements are in excess of current state regulations as outline in the PT and OT Practice Acts. Please see the attached documents as suggested edits that are in line with the intended edits in the pediatric regs.

Response: Policy was revised to reflect current state regulations in PT and OT Practice Acts, and the ten-day timeframe was changed to ten visits for progress reports, which must follow Medicare requirements.

Comment: 201.700; Is it DHS’s intention to use the DMS-640, etc. If so, it might be worth specifying that here to give clarity to providers what you are looking for on these documents.

Response: Updated to clarify intent and to correct the time element from twelve months to three months based on the scope of work for rehabilitation therapy.

Comment: 201.700, 5c: The nature of adult PT and OT is a much shorter duration than pediatric therapy. Adult therapy works on every goal, every visit as the duration of care is usually only 3-6 weeks. Pediatric therapy may work on one goal for 4-5 weeks, then turn their attention to a different developmental milestone for 4-5 weeks. Adult therapy shows progress toward each goal every couple of visits by updating measurements affiliated with each individual goal. For example, an adult therapy goal might be, “Increased active range of motion for the left knee to 0-120 degrees within 3 weeks to allow the patient to sit down without modification and to ambulate with proper heel strike.” - Every couple of visits, the therapist would document what the patient’s current range of motion is, showing progress along the way and the effectiveness (medical necessity) of treatment.

Response: The phrase, “which includes the goal(s) or objective(s) the specific service or activity is designed to address” is removed from the requirement to describe specific services and activities provided during each therapy session.

Comment: 201.700, 5e and 6; This requirement is duplicative of the daily note. As noted above, when the therapist documents in their daily note the objective measures contained in their goals, then having to document again in a weekly progress note is duplicate work. While we understand and respect the differences between the adult and pediatric regs, this is a requirement that is planned to be removed in the pediatric regs well.

Response: The requirement itself is removed. A note clarifying the supervising therapist’s progress report assessing improvements at least every 10 visits is a documentation requirement. Requirement 6 is modified to specify “other” reports, notes, and correspondence to ensure any misinterpretation regarding duplication of documentation is removed.

Comment: 210.500, B1; Age AND DOB are duplicate work.

Response: Requirement is revised to require beneficiary’s name, and age **or** date of birth.

Comment: 210.600: Many outpatient therapy patients have had recent surgery. Our perception is the intent of this section is to ensure inpatient patients are not billed as outpatient. We are concerned that as written, it could be understood that a patient cannot be seen in outpatient clinics after surgery. **(Second Sentence):** Does it make sense to have a statement about patients actively being seen in home health or a nursing home are not eligible for services as well?

Response: Section is rewritten to clarify the intent is beneficiaries who are currently admitted as an inpatient in the hospital or are currently residing in a nursing care facility are not eligible for occupational or physical therapy under the rules and regulations of this manual. A second sentence is added to clarify services provided under this manual and under the Home Health manual that are duplicative in nature are not allowed for the same time period. A third sentence is added to explain what is allowed.

Comment: Section 210.700, D: Home Health program manual is referenced for specific coverage rules pertaining to beneficiaries while under Hospice care.

Response: Clarifying language is added to the reference, because specific coverage rules are set forth in the Home Health program manual and are referred to within the Hospice manual. Rather than provide a hyperlink to the Hospice manual which would then provide a hyperlink to the Home Health manual, DMS provided the direct hyperlink to the Home Health manual instead.

Comment: Section 210.900, D: Can you provide clarity on what is intended with this provision. Does this include services from an inpatient rehabilitative hospital services in the 12-visit count? Is it accurate to say that rehabilitative hospital services are all inpatient?

As a matter of practicality, how will therapists know how many visits have been used at another facility earlier in the year? Will providers get this from MMIS. Guidance to providers, even it's given outside this manual, will be very helpful to providers after implementation.

Reference to incorrect section?

Response: The section has been changed to remove "in combination with outpatient hospital and rehabilitative hospital services" .

DMS will provide guidance outside this manual through existing provider communication methods and procedures for determining how many visits have been used.

The referenced section number is incorrect and will be changed.

Comment: 220.100: Would like to discuss the logistics of this. Our understanding is that acute care services or rehabilitative hospital services are covered through a separate benefit, while the PT/OT services contemplated here are under the outpatient benefit.

If a patient has an acute hospital admission or rehab hospital admission, how will 'visits' be counted

Response: A patient is not eligible for outpatient hospital services while they are admitted as an inpatient to an acute hospital or rehabilitation hospital. Only outpatient acute hospital and outpatient rehabilitative hospital services are counted. (Currently, there is no prohibition for acute care hospitals or rehabilitative hospitals to enroll and provide outpatient services, if all enrollment criteria are met.)

However, you are correct that outpatient hospital services are covered through a separate benefit that CMS considers to be “institutional” in nature and the state cannot combine an outpatient clinic benefit with an outpatient hospital benefit. To be able to accommodate a 12-visit limit for Adult Rehabilitative Therapy clinic services, the state will instead count the 12 visits against a clinic services benefit limit. The references to outpatient hospital services has been removed.

Comment: 220.100, 3; We would value clarity to help us understand this provision

Response: 220.100, 3, no longer applies and has been removed.

Comment: 220.100, E; Section not in the manual

Response: The referenced section number is incorrect and will be changed.

Comment: 220.200, B, 1; Is the intention for each individual visit that is applied for to get it’s own request? What is the timeframe for return of these requests to the provider? As therapy is usually done 2-3 x’s week, the provider cannot continue services if the outcome of the request is unknown. Could an EOB be requested to allow for a certain number of visits?

Response: The requirement in this manual follows the requirements set forth for extension of benefit services in Medicaid. The provider may submit an extension request for more than one denied service at a time. For instance, if a provider receives denial information on a single remittance advice that three services within a week’s time were denied, the three could be submitted together on one request.



ARKANSAS
DEPARTMENT OF
**HUMAN
SERVICES**

Office of Policy and Rules

P.O. Box 1437, Slot S295, Little Rock, AR 72203-1437

P: 501.320.6383 F: 501.404.4619

March 12, 2026

Mrs. Rebecca Miller-Rice
Administrative Rules Review Section
Arkansas Legislative Council
Bureau of Legislative Research
#1 Capitol, 5th Floor
Little Rock, AR 72201

Dear Mrs. Rebecca Miller-Rice:

Re: Arkansas Medicaid Reimbursement for Physical and Occupational Therapy in Clinic-Based Settings

Please arrange for this rule to be reviewed by the ALC-Administrative Rules Subcommittee. If you have any questions or need additional information, please contact me at 501-320-6383 or by emailing Mac.E.Golden@dhs.arkansas.gov.

Sincerely,

Mac Golden

Mac Golden
Attorney III
Office of Policy and Rules

Attachments

**QUESTIONNAIRE FOR FILING PROPOSED RULES WITH
THE ARKANSAS LEGISLATIVE COUNCIL**

DEPARTMENT _____
 BOARD/COMMISSION _____
 BOARD/COMMISSION DIRECTOR _____
 CONTACT PERSON _____
 ADDRESS _____
 PHONE NO. _____ EMAIL _____
 NAME OF PRESENTER(S) AT SUBCOMMITTEE MEETING _____
 PRESENTER EMAIL(S) _____

INSTRUCTIONS

In order to file a proposed rule for legislative review and approval, please submit this Legislative Questionnaire and Financial Impact Statement, and attach (1) a summary of the rule, describing what the rule does, the rule changes being proposed, and the reason for those changes; (2) both a markup and clean copy of the rule; and (3) all documents required by the Questionnaire.

If the rule is being filed for permanent promulgation, please email these items to the attention of Rebecca Miller-Rice, miller-ricer@blr.arkansas.gov, for submission to the Administrative Rules Subcommittee.

If the rule is being filed for emergency promulgation, please email these items to the attention of Director Marty Garrity, garritym@blr.arkansas.gov, for submission to the Executive Subcommittee.

Please answer each question completely using layman terms.

1. What is the official title of this rule?

2. What is the subject of the proposed rule? _____
3. Is this rule being filed under the emergency provisions of the Arkansas Administrative Procedure Act? Yes No

If yes, please attach the statement required by Ark. Code Ann. § 25-15-204(c)(1).

If yes, will this emergency rule be promulgated under the permanent provisions of the Arkansas Administrative Procedure Act? Yes No

4. Is this rule being filed for permanent promulgation? Yes No

If yes, was this rule previously reviewed and approved under the emergency provisions of the Arkansas Administrative Procedure Act? Yes No

If yes, what was the effective date of the emergency rule? _____

On what date does the emergency rule expire? _____

5. Is this rule required to comply with a *federal* statute, rule, or regulation? Yes No

If yes, please provide the federal statute, rule, and/or regulation citation.

6. Is this rule required to comply with a *state* statute or rule? Yes No

If yes, please provide the state statute and/or rule citation.

7. Are two (2) rules being repealed in accord with Executive Order 23-02? Yes No

If yes, please list the rules being repealed.

If no, please explain.

8. Is this a new rule? Yes No

Does this repeal an existing rule? Yes No

If yes, the proposed repeal should be designated by strikethrough. If it is being replaced with a new rule, please attach both the proposed rule to be repealed and the replacement rule.

Is this an amendment to an existing rule? Yes No

If yes, all changes should be indicated by strikethrough and underline. In addition, please be sure to label the markup copy clearly as the markup.

9. What is the state law that grants the agency its rulemaking authority for the proposed rule, outside of the Arkansas Administrative Procedure Act? Please provide the specific Arkansas Code citation(s), including subsection(s).

10. Is the proposed rule the result of any recent legislation by the Arkansas General Assembly?
Yes No

If yes, please provide the year of the act(s) and act number(s).

11. What is the reason for this proposed rule? Why is it necessary?

12. Please provide the web address by which the proposed rule can be accessed by the public as provided in Ark. Code Ann. § 25-19-108(b)(1).

13. Will a public hearing be held on this proposed rule? Yes No

If yes, please complete the following:

Date: _____

Time: _____

Place: _____

Please be sure to advise Bureau Staff if this information changes for any reason.

14. On what date does the public comment period expire for the permanent promulgation of the rule? Please provide the specific date. _____

15. What is the proposed effective date for this rule? _____

16. Please attach (1) a copy of the notice required under Ark. Code Ann. § 25-15-204(a)(1) and (2) proof of the publication of that notice.

17. Please attach proof of filing the rule with the Secretary of State, as required by Ark. Code Ann. § 25-15-204(e)(1)(A).

18. Please give the names of persons, groups, or organizations that you anticipate will comment on these rules. Please also provide their position (for or against), if known.

19. Is the rule expected to be controversial? Yes No

If yes, please explain.

NOTICE OF RULE MAKING

The Department of Human Services (DHS) announces for a public comment period of thirty (30) calendar days a notice of rulemaking for the following proposed rule under one or more of the following chapters, subchapters, or sections of the Arkansas Code: §§20-76-201, 20-77-107, and 25-10-129. The projected effective date of the rule is July 1, 2026, if approved. There is no fiscal impact.

The Division of Medical Services (DMS) issues a rule to implement Act 103 of 2025. This rule allows adult Medicaid Beneficiaries, twenty-one (21) years of age and older, to receive rehabilitative occupational and physical therapy in clinic settings. Effective for dates of service on or after July 1, 2026, adult rehabilitative occupational and physical therapy services are limited to twelve (12) visits. There is a maximum of two (2) units of therapy evaluations per discipline per State Fiscal Year (July 1 through June 30). Extensions of the benefit limit will be provided if medically necessary. Implementation requires a revision to the Arkansas Medicaid State Plan and issuance of a new provider manual, Rehabilitative Occupational Therapy and Physical Therapy Services, which explains coverage and reimbursement rules. Corresponding revisions are issued for the Nurse Practitioner and Physician provider manuals.

The proposed rule is available for review at the Department of Human Services (DHS) Office of Policy and Rules, 2nd floor Donaghey Plaza South Building, 7th and Main Streets, P. O. Box 1437, Slot S295, Little Rock, Arkansas 72203-1437. You may also access and download the proposed rule at ar.gov/dhs-proposed-rules.

Public comments can be submitted in writing at the above address or at the following email address: ORP@dhs.arkansas.gov. All public comments must be received by DHS no later than April 12, 2026. Please note that public comments submitted in response to this notice are considered public documents. A public comment, including the commenter's name and any personal information contained within the public comment, will be made publicly available and may be seen by various people.

A public hearing will be held online by remote access. Public comments may be submitted at the hearing. The details for attending the online public hearing appear at ar.gov/dhspublichearings.

If you need this material in a different format, such as large print, contact the Office of Policy and Rules at 501-320-6428. The Arkansas Department of Human Services is in compliance with Titles VI and VII of the Civil Rights Act and is operated, managed and delivers services without regard to religion, disability, political affiliation, veteran status, age, race, color or national origin. 4502292178

Elizabeth Pitman, Director
Division of Medical Services

From: [Legal Ads](#)
To: [Lisa Teague](#)
Subject: Re: Full Run Ad (r. 331)
Date: Thursday, March 12, 2026 3:08:55 PM
Attachments: [image001.png](#)

EXTERNAL SENDER: This email originated from outside of the organization. Do not click links or open attachments unless you recognize the sender and know the content is safe.

Scheduled for Sat 3/14, Sun 3/15, and Mon 3/16. Thank you.

Gregg Sterne, Legal Advertising
Arkansas Democrat-Gazette
legalads@arkansasonline.com

From: "Lisa Teague" <Lisa.Teague@dhs.arkansas.gov>
To: "legalads" <legalads@arkansasonline.com>
Cc: "Jack Tiner" <jack.tiner@dhs.arkansas.gov>, "Mac Golden" <Mac.E.Golden@dhs.arkansas.gov>, "Lakeya Gipson" <Lakeya.Gipson@dhs.arkansas.gov>, "Elaine Stafford" <elaine.stafford@dhs.arkansas.gov>
Sent: Wednesday, March 11, 2026 10:02:48 AM
Subject: Full Run Ad (r. 331)

Good morning,

Please run the attached Notice of Public Hearing in the *Arkansas Democrat-Gazette* on the following days:

- Saturday, March 14, 2026
- Sunday, March 15, 2026
- Monday, March 16, 2026

I am aware that the print version will only be provided to all counties on Sundays.

Invoice to: AR Dept of Human Services

P.O. Box 1437

Slot S535

Little Rock, AR 72203

ATTN: Lakeya Gipson

(Lakeya.Gipson@dhs.arkansas.gov)

Or email invoices to: dms.invoices@arkansas.gov

NOTE: Please reply to this email using "REPLY ALL"



Lisa Teague

Rules & Regulations Coordinator

Arkansas Department of Human Services

Office of Policy and Rules

P: 501.396.6428

lisa.teague@dhs.arkansas.gov

humanservices.arkansas.gov

From: [Lisa Teague](#)
To: [Arkansas Register](#)
Cc: [Jack Tiner](#); [Mac Golden](#); [Lakeya Gipson](#); [JAMIE EWING](#)
Subject: DHS/DMS - Proposed Rule - Arkansas Medicaid Reimbursement for Physical and Occupational Therapy in Clinic-Based Settings (Rule 331)
Date: Thursday, March 12, 2026 3:17:00 PM
Attachments: [SOS Initial-Arkansas Medicaid Reimbursement for PT and OT in Clinic-Based Settings.pdf](#)
[image001.png](#)

Good afternoon,

Attached is the proposed rule titled “Arkansas Medicaid Reimbursement for Physical and Occupational Therapy in Clinic-Based Settings”. The public notice will run in the Arkansas Democrat-Gazette March 14, 15, & 16, 2026. The Public comment period end 04/12/26. Please post.

Thank you,



Lisa Teague

Rules & Regulations Coordinator
Arkansas Department of Human Services
Office of Policy and Rules

P: 501.396.6428

lisa.teague@dhs.arkansas.gov

humanservices.arkansas.gov

Privacy Notice: This email may contain confidential information protected by state/federal laws. If you are not the intended recipient, please let the sender know, and delete the message/attachment(s) from your system.

FINANCIAL IMPACT STATEMENT

PLEASE ANSWER ALL QUESTIONS COMPLETELY.

DEPARTMENT _____
BOARD/COMMISSION _____
PERSON COMPLETING THIS STATEMENT _____
TELEPHONE NO. _____ **EMAIL** _____

To comply with Ark. Code Ann. § 25-15-204(e), please complete the Financial Impact Statement and email it with the questionnaire, summary, markup and clean copy of the rule, and other documents. Please attach additional pages, if necessary.

TITLE OF THIS RULE _____

1. Does this proposed, amended, or repealed rule have a financial impact?
Yes No

2. Is the rule based on the best reasonably obtainable scientific, technical, economic, or other evidence and information available concerning the need for, consequences of, and alternatives to the rule?
Yes No

3. In consideration of the alternatives to this rule, was this rule determined by the agency to be the least costly rule considered? Yes No

If no, please explain:

(a) how the additional benefits of the more costly rule justify its additional cost;

(b) the reason for adoption of the more costly rule;

(c) whether the reason for adoption of the more costly rule is based on the interests of public health, safety, or welfare, and if so, how; and

(d) whether the reason for adoption of the more costly rule is within the scope of the agency's statutory authority, and if so, how.

4. If the purpose of this rule is to implement a *federal* rule or regulation, please state the following:
 - (a) What is the cost to implement the federal rule or regulation?

Current Fiscal Year

General Revenue _____
 Federal Funds _____
 Cash Funds _____
 Special Revenue _____
 Other (Identify) _____

Total _____

Next Fiscal Year

General Revenue _____
 Federal Funds _____
 Cash Funds _____
 Special Revenue _____
 Other (Identify) _____

Total _____

(b) What is the additional cost of the state rule?

Current Fiscal Year

General Revenue _____
 Federal Funds _____
 Cash Funds _____
 Special Revenue _____
 Other (Identify) _____

Total _____

Next Fiscal Year

General Revenue _____
 Federal Funds _____
 Cash Funds _____
 Special Revenue _____
 Other (Identify) _____

Total _____

5. What is the total estimated cost by fiscal year to any private individual, private entity, or private business subject to the proposed, amended, or repealed rule? Please identify those subject to the rule, and explain how they are affected.

Current Fiscal Year

\$ _____

Next Fiscal Year

\$ _____

6. What is the total estimated cost by fiscal year to a state, county, or municipal government to implement this rule? Is this the cost of the program or grant? Please explain how the government is affected.

Current Fiscal Year

\$ _____

Next Fiscal Year

\$ _____

7. With respect to the agency's answers to Questions #5 and #6 above, is there a new or increased cost or obligation of at least one hundred thousand dollars (\$100,000) per year to a private individual, private entity, private business, state government, county government, municipal government, or to two (2) or more of those entities combined?

Yes No

If yes, the agency is required by Ark. Code Ann. § 25-15-204(e)(4) to file written findings at the time of filing the financial impact statement. The written findings shall be filed simultaneously with the financial impact statement and shall include, without limitation, the following:

- (1) a statement of the rule's basis and purpose;
- (2) the problem the agency seeks to address with the proposed rule, including a statement of whether a rule is required by statute;
- (3) a description of the factual evidence that:
 - (a) justifies the agency's need for the proposed rule; and
 - (b) describes how the benefits of the rule meet the relevant statutory objectives and justify the rule's costs;
- (4) a list of less costly alternatives to the proposed rule and the reasons why the alternatives do not adequately address the problem to be solved by the proposed rule;
- (5) a list of alternatives to the proposed rule that were suggested as a result of public comment and the reasons why the alternatives do not adequately address the problem to be solved by the proposed rule;
- (6) a statement of whether existing rules have created or contributed to the problem the agency seeks to address with the proposed rule and, if existing rules have created or contributed to the problem, an explanation of why amendment or repeal of the rule creating or contributing to the problem is not a sufficient response; and
- (7) an agency plan for review of the rule no less than every ten (10) years to determine whether, based upon the evidence, there remains a need for the rule including, without limitation, whether:
 - (a) the rule is achieving the statutory objectives;
 - (b) the benefits of the rule continue to justify its costs; and
 - (c) the rule can be amended or repealed to reduce costs while continuing to achieve the statutory objectives.

Arkansas Medicaid Reimbursement for Physical and Occupational Therapy in Clinic-Based Settings

Statement of Necessity

This rule implements Act 103 of 2025, which requires Arkansas Medicaid to cover rehabilitative physical therapy in a clinic setting. As stated in the Act, "... [r]esearch has found that access to rehabilitative physical therapy in clinic-based settings leads to lower total costs of care over time, decreases the need for surgical interventions, and reduces the need for long-term use of opioids and other pain medications." DHS conducted additional research into occupational therapy offerings and believes that expanding coverage for rehabilitative occupational and physical therapy in clinic-based settings under the program will result in improved outcomes and potential cost savings for the Arkansas Medicaid Program.

Summary

This rule allows adult Medicaid Beneficiaries, twenty-one (21) years of age and older, to receive rehabilitative occupational and physical therapy in clinic settings. A new provider manual, *Rehabilitative Occupational Therapy and Physical Therapy Services*, explains coverage and reimbursement rules. Corresponding revisions are needed to the Nurse Practitioner and Physician provider manuals. (Note: The provider manual changes in this rule also will be included in the new Physician Assistant provider manual and Clinical Nurse Specialists provider manual being promulgated separately in the Community Health Worker rule).

Revisions to Rule Post Public Comment and CMS Guidance

1. CMS advised a SPA is not necessary. SPA is removed from the rule and removed from the Summary above.
2. In response to the Public Comments, the following updates were made to the *Rehabilitative Occupational Therapy and Physical Therapy Services* manual:
 - (a) Section 200.100: reference to *Hospice Manual* added.
 - (b) "Physical therapy assistant" changed throughout manual to "physical therapist assistant".
 - (c) Section 201.400: revised to reflect current state regulations in PT and OT Practice Acts, and the ten-day timeframe was changed to ten visits for progress reports, which must follow Medicare requirements.
 - (d) Section 201.700: DMS-640 – clarified intent and corrected the time element from twelve months to three months based on the scope of work for rehabilitation therapy.
 - (e) Section 201.700, 5c: The phrase, "which includes the goal(s) or objective(s) the specific service or activity is designed to address" is removed from the requirement to describe specific services and activities provided during each therapy session.

- (f) Section 201.700, 5e and 6: requirements removed and note added clarifying the supervising therapist's progress report assessing improvements at least every 10 visits is a documentation requirement. Requirement 6 modified to specify "other" reports, notes, and correspondence to ensure any misinterpretation regarding duplication of documentation is removed.
- (g) Section 210.500, B1: Requirement is revised to require beneficiary's name, and age or date of birth.
- (h) Section 210.600: Section is rewritten to clarify the intent is beneficiaries who are currently admitted as an inpatient in the hospital or are currently residing in a nursing care facility are not eligible for occupational or physical therapy under the rules and regulations of this manual. A second sentence is added to clarify services provided under this manual and under the Home Health manual that are duplicative in nature are not allowed for the same time period. A third sentence is added to explain what is allowed.
- (i) Section 210.700, D: Clarifying language added to the reference, because specific coverage rules are set forth in the Home Health program manual and are referred to within the Hospice manual. Rather than provide a hyperlink to the Hospice manual which would then provide a hyperlink to the Home Health manual, DMS provided the direct hyperlink to the Home Health manual instead.
- (j) Section 210.900, D: The section has been changed to remove "in combination with outpatient hospital and rehabilitative hospital services". The referenced section number is incorrect and will be changed.
- (k) Section 220.100: To be able to accommodate a 12-visit limit for Adult Rehabilitative Therapy clinic services, the state will instead count the 12 visits against a clinic services benefit limit. The references to outpatient hospital services have been removed.
- (l) Section 220.100, 3: No longer applies and has been removed.
- (m) Section 220.100, E: The referenced section number was incorrect and has been changed.

TOC not required

214.800 Occupational, Physical, and Speech-Language Therapy 4-1-247-1-
26

- A. Medicaid covers occupational, physical, and speech-language therapy services for eligible beneficiaries under age twenty-one (21) in the Child Health Services (EPSDT) Program by qualified occupational, physical, or speech-language therapy providers. -Therapy services are not covered as nurse practitioner services. -The following is provided for the nurse practitioner's information.
- B. Occupational, Physical, and Speech-Language therapies are covered for beneficiaries in the ARKids First-A and ARKids--B program ~~benefits~~.
- C. Therapy services for individuals age twenty-one (21) and older are ~~only~~ covered when provided ~~through the following Medicaid Programs: Adult Developmental Day Treatment (ADDT), Hospital/Critical Access Hospital (CAH), Rehabilitative Hospital, Home Health, Hospice and Physician. Refer to these Medicaid provider manuals for conditions of coverage and benefit limits as follows:~~
1. Habilitative therapy services provided in an Adult Developmental Day Treatment (ADDT) center; or
 2. Rehabilitative Therapy services when provided in accordance with the **Rehabilitative Occupational Therapy and Physical Therapy Services Manual**.
- D. All habilitative therapy services for beneficiaries under age twenty-one (21) require a referral for evaluation utilizing the form DMS-640 and a separate form DMS-640 for the written prescription from the patient's primary care physician-provider (PCP) or attending ~~physician-provider if the beneficiary is exempt from PCP Managed Care Program requirements~~. -A referral for habilitative therapy services must be renewed every twelve (12) months. -After the initial referral using the form DMS-640 and initial prescription, utilizing a separate form DMS-640, subsequent referrals and prescriptions for continued therapy may be made at the same time using the same DMS-640. -The prescription for treatment is valid for one year unless the prescribing physician specifies a shorter period.
- E. The PCP or attending physician-provider must complete and sign the DMS-640 for beneficiaries under age twenty-one (21) receiving habilitative therapy.
- F. The PCP or attending physician must initiate a referral and prescription for rehabilitative therapy for beneficiaries over age twenty-one (21) using the DMS-640A. -An original signature is required when making a referral or prescribing a therapy service. -An electronic signature is acceptable on either document, provided it is in compliance with Arkansas Code Ann. 25-31-103. -A copy of the prescription-DMS-640A must be maintained in the beneficiary's records maintained by the therapy provider. -The original prescription-DMS-640A is to be maintained by the ~~physician prescribing PCP or attending provider~~. [View or print form DMS-640 \(for beneficiaries under age twenty-one \(21\)\)](#).
- ~~FG.~~ -For range of benefits, see the following procedure codes: [View or print the procedure codes for therapy services](#).
- H. Extended habilitative therapy services may be provided based on medical necessity, for Medicaid beneficiaries under age twenty-one (21).
- I. Rehabilitative Occupational, Therapy and pPhysical, and speech-language therapies Therapy Services are subject to the benefit limit of twelve (12) outpatient hospital therapy visits per state fiscal year (SFY) and two (2) evaluation units per SFY for beneficiaries age twenty-one (21) years of age and over. -Benefit ~~E~~extensions may be provided for rehabilitative therapy services, based on medical necessity, ~~for Medicaid beneficiaries 24~~

years of age and over when provided within a covered program. Extension of the benefit is automatic for patients whose primary diagnosis for the service is one of the following: malignant neoplasm, HIV/AIDS, renal failure, Opioid Use Disorder when the treatment is part of a Medication Assisted Treatment Plan, or pregnancy.

MARKY-UP

TOC not required**214.800 Occupational, Physical, and Speech-Language Therapy 7-1-26**

- A. Medicaid covers occupational, physical, and speech-language therapy services for eligible beneficiaries under age twenty-one (21) in the Child Health Services (EPSDT) Program by qualified occupational, physical, or speech-language therapy providers. Therapy services are not covered as nurse practitioner services. The following is provided for the nurse practitioner's information.
- B. Occupational, Physical, and Speech-Language therapies are covered for beneficiaries in the ARKids First-B program.
- C. Therapy services for individuals age twenty-one (21) and older are covered when provided as follows:
 - 1. Habilitative therapy services provided in an Adult Developmental Day Treatment (ADDT) center; or
 - 2. Rehabilitative Therapy services when provided in accordance with the [Rehabilitative Occupational Therapy and Physical Therapy Services Manual](#).
- D. All habilitative therapy services for beneficiaries under age twenty-one (21) require a referral for evaluation utilizing the form DMS-640 and a separate form DMS-640 for the written prescription from the patient's primary care provider (PCP) or attending provider. A referral for habilitative therapy services must be renewed every twelve (12) months. After the initial referral using the form DMS-640 and initial prescription, utilizing a separate form DMS-640, subsequent referrals and prescriptions for continued therapy may be made at the same time using the same DMS-640. The prescription for treatment is valid for one year unless the prescribing physician specifies a shorter period.
- E. The PCP or attending provider must complete and sign the DMS-640 for beneficiaries under age twenty-one (21) receiving habilitative therapy.
- F. The PCP or attending physician must initiate a referral and prescription for rehabilitative therapy for beneficiaries over age twenty-one (21) using the DMS-640A. An original signature is required when making a referral or prescribing a therapy service. An electronic signature is acceptable on either document, provided it is in compliance with Ark Code Ann. 25-31-103. A copy of the DMS-640A must be maintained in the beneficiary's records maintained by the therapy provider. The original DMS-640A is to be maintained by the prescribing PCP or attending provider. [View or print form DMS-640 \(for beneficiaries under age twenty-one \(21\)\)](#).
- G. For range of benefits, see the following procedure codes: [View or print the procedure codes for therapy services](#).
- H. Extended habilitative therapy services may be provided based on medical necessity, for Medicaid beneficiaries under age twenty-one (21).
- I. Rehabilitative Occupational Therapy and Physical Therapy Services are subject to the benefit limit of twelve (12) outpatient therapy visits per state fiscal year (SFY) and two (2) evaluation units per SFY for beneficiaries twenty-one (21) years of age and over. Benefit extensions may be provided for rehabilitative therapy services, based on medical necessity. Extension of the benefit is automatic for patients whose primary diagnosis for the service is one of the following: malignant neoplasm, HIV/AIDS, renal failure, Opioid Use Disorder when the treatment is part of a Medication Assisted Treatment Plan, or pregnancy.

TOC not required

203.210 Physician's Role in the Occupational, Physical, and Speech-Language Therapy Program

7-1-260

Medicaid covers occupational therapy, physical therapy, and speech-language therapy services when provided to eligible Medicaid beneficiaries under age twenty-one (21) in the Child Health Services (EPSDT) Program by qualified occupational, physical, or speech-language therapy providers. Occupational evaluations and occupational therapy services are payable only to a qualified occupational therapist. Speech-language therapy evaluations may be performed by the physician; however, treatment for speech-language therapy disorders must be referred to a qualified speech-language therapist. Physical therapy evaluations may be performed by the physician and physical therapy sessions may be performed by the qualified physician. Physical therapy treatment may also be referred to a qualified physical therapist.

Occupational therapy, physical therapy, and speech-language therapy pathology services ONLY are covered for beneficiaries in the ARKids First-B Program benefits.

All occupational, physical, and speech-language therapy evaluations and treatment services must be medically necessary and require a referral from the beneficiary's primary care physician provider (PCP) or the attending physician provider if the beneficiary is exempt from PCP Managed Care Program requirements. Therapy treatment services also require a prescription written by the physician-PCP or attending provider who refers the patient to the therapist for specified services. For beneficiaries under age twenty-one (21), form DMS-640 must be used for the initial referral for evaluation and a separate DMS-640 is required for the prescription. View or print form DMS-640. For beneficiaries receiving rehabilitative therapy services, form DMS-640A must be used. An electronic signature is accepted provided it is in compliance with Arkansas Code Ann. § 25-31-103. The physician must maintain the original Therapy and Day Habilitation Services for Medicaid Eligible Beneficiaries Prescription/Referral form DMS-640-DMS-640 or DMS-640A form for each prescription in the beneficiary's medical records. The therapy provider must retain a copy of the DMS-640 or DMS-640A in their established beneficiary medical chart/record. After the initial referral using the form DMS-640 or DMS-640A and initial prescription utilizing a separate form DMS-640 or DMS-640A, subsequent referrals and prescriptions for continued therapy may be made at the same time using the same DMS-640 or DMS-640A.

Therapy services for individuals over age twenty-one (21) age twenty-one (21) and over are only covered when provided through the following Medicaid Programs: Adult Developmental Day Treatment (ADDT) services, Hospital/Critical Access Hospital (CAH), Rehabilitative Hospital, Home Health, Hospice, and Physician. Refer to these Medicaid provider manuals for conditions of coverage and benefit limits, as follows:

- A. Habilitative therapy provided in an Adult Developmental Day Treatment (ADDT) center;
- B. Rehabilitative therapy when provided in accordance with the **Rehabilitative Occupational Therapy, Physical Therapy and Speech-Language Pathology Manual**.

TOC not required

203.210 Physician's Role in the Occupational, Physical, and Speech-Language Therapy Program

7-1-26

Medicaid covers occupational therapy, physical therapy, and speech-language therapy services when provided to eligible Medicaid beneficiaries under age twenty-one (21) in the Child Health Services (EPSDT) Program by qualified occupational, physical, or speech-language therapy providers. Occupational evaluations and occupational therapy services are payable only to a qualified occupational therapist. Speech-language therapy evaluations may be performed by the physician; however, treatment for speech-language therapy disorders must be referred to a qualified speech-language therapist. Physical therapy evaluations may be performed by the physician and physical therapy sessions may be performed by the qualified physician. Physical therapy treatment may also be referred to a qualified physical therapist.

Occupational therapy, physical therapy, and speech-language pathology services are covered for beneficiaries in the ARKids First-B program benefits.

All occupational, physical, and speech-language therapy evaluations and treatment services must be medically necessary and require a referral from the beneficiary's primary care provider (PCP) or the attending provider. Therapy treatment services also require a prescription written by the PCP or attending provider who refers the patient to the therapist for specified services. For beneficiaries under age twenty-one (21), form DMS-640 must be used for the initial referral for evaluation and a separate DMS-640 is required for the prescription. [View or print form DMS-640](#). For beneficiaries receiving rehabilitative therapy services, form DMS-640A must be used. An electronic signature is accepted provided it is in compliance with Ark Code Ann. § 25-31-103. The physician must maintain the original DMS-640 or DMS-640A form for each prescription in the beneficiary's medical records. The therapy provider must retain a copy of the DMS-640 or DMS-640A in their established beneficiary medical chart/record. After the initial referral using the form DMS-640 or DMS-640A and initial prescription utilizing a separate form DMS-640 or DMS-640A, subsequent referrals and prescriptions for continued therapy may be made at the same time using the same DMS-640 or DMS-640A.

Therapy services for individuals age twenty-one (21) and over are covered as follows:

- A. Habilitative therapy provided in an Adult Developmental Day Treatment (ADDT) center;
- B. Rehabilitative therapy when provided in accordance with the [Rehabilitative Occupational Therapy, Physical Therapy and Speech-Language Pathology Manual](#).

SECTION II – REHABILITATIVE OCCUPATIONAL THERAPY AND PHYSICAL THERAPY SERVICES

CONTENTS

200.000	<u>REHABILITATIVE OCCUPATIONAL THERAPY AND PHYSICAL THERAPY SERVICES GENERAL INFORMATION</u>
200.100	<u>Arkansas Medicaid Participation Requirements</u>
200.200	<u>Individual Service Provider Participation Requirements</u>
200.300	<u>Group Service Provider Participation Requirements</u>
200.400	<u>Service Providers in Arkansas and Bordering States</u>
200.500	<u>Service Providers in States Not Bordering Arkansas</u>
201.000	<u>Rehabilitative Occupational Therapy and Physical Therapy Service Provider Participation Requirements</u>
201.100	<u>Occupational Therapy Provider Participation Requirements</u>
201.200	<u>Occupational Therapist Participation Requirements</u>
201.300	<u>Occupational Therapy Assistant Participation Requirements</u>
201.400	<u>Physical Therapy Provider Participation Requirements</u>
201.500	<u>Physical Therapist Participation Requirements</u>
201.600	<u>Physical Therapist Assistant Participation Requirements</u>
201.700	<u>Services by an Unlicensed Student</u>
201.800	<u>Supervision</u>
201.900	<u>Physical Therapy</u>
202.000	<u>Occupational Therapy</u>
202.100	<u>Documentation Requirements</u>
202.200	<u>Documentation Requirements for all Medicaid Providers</u>
202.300	<u>Rehabilitative Occupational Therapy and Physical Therapy Services Documentation Requirements</u>
202.400	<u>Electronic Signatures</u>
210.000	<u>PROGRAM COVERAGE</u>
210.100	<u>Introduction</u>
210.200	<u>Beneficiary Eligibility Requirements</u>
210.300	<u>Referral to Evaluate</u>
210.400	<u>Treatment Prescription</u>
210.500	<u>Rehabilitative Therapy Services Comprehensive Evaluation</u>
210.600	<u>Non-Covered Services</u>
210.700	<u>Covered Services</u>
210.800	<u>Occupational Therapy and Physical Therapy Rehabilitative Evaluation and Treatment Planning Services</u>
210.900	<u>Rehabilitative Therapy Treatment Services</u>
211.000	<u>Telemedicine Services</u>
220.000	<u>BENEFIT LIMITS</u>
220.100	<u>Extension of Benefits for Rehabilitative Therapy Services</u>
220.200	<u>Process for Requesting Extended Rehabilitative Therapy Services</u>
220.300	<u>Request for Extension of Benefits Documentation Requirements</u>
220.400	<u>Review Process for Request for Extension of Benefits</u>
220.500	<u>Administrative Reconsideration and Appeals</u>
230.000	<u>REIMBURSEMENT</u>
230.100	<u>Method of Reimbursement</u>
230.200	<u>Fee Schedules</u>

200.000 REHABILITATIVE OCCUPATIONAL THERAPY AND PHYSICAL THERAPY SERVICES GENERAL INFORMATION

200.100 Arkansas Medicaid Participation Requirements**7-1-26**

Providers of Occupational Therapy and Physical Therapy rehabilitative services for beneficiaries twenty-one (21) years of age or older must meet the provider participation and enrollment requirements contained within Section 140.000 of this manual. Providers must also meet the participation requirements of the applicable service discipline in Section 201.000 of this manual. Reimbursement is conditional upon compliance with this manual, manual update transmittals, and official program correspondence.

- A. Beneficiaries younger than twenty-one (21) years of age who require rehabilitative therapy services are covered under the **Occupational Therapy, Physical Therapy and Speech-Language Pathology program manual**.
- B. Beneficiaries twenty-one (21) years of age or older who require rehabilitative physical therapy in the home setting are covered under the **Home Health program manual**.
- C. Beneficiaries twenty-one (21) years of age or older who require rehabilitative physical or occupational therapy while under Hospice care are described in the Hospice manual and covered in the **Home Health program manual**.

200.200 Individual Service Provider Participation Requirements**7-1-26**

Individual providers of occupational therapy and physical therapy rehabilitative services must meet the following requirements to be eligible to participate in the Medicaid Program:

- A. Complete the provider participation and enrollment requirements contained within Section 140.000 of this manual to enroll as a Medicaid provider; and
- B. Meet the credentialing, experience, training, and other qualification requirements of their applicable service discipline contained within Section 201.000 of this manual.
- C. Occupational Therapists enrolling as individuals or group providers are categorized as limited risk providers. For providers in the "limited" risk category, DHS must:
 - 1. Verify that the provider meets any applicable federal regulations or state requirements for their provider type prior to making an enrollment determination.
 - 2. Conduct license verifications, including state licensure verifications in states other than where the provider is enrolling, in accordance with 42 CFR 455.412; and
 - 3. Conduct database checks on a pre- and post-enrollment basis to ensure that providers initially meet and continue to meet the enrollment criteria for their provider type, in accordance with 42 CFR 455.436.
- D. Physical Therapists enrolling as individual or group providers are categorized as moderate risk providers. For providers in the "moderate" risk category, DHS must:
 - 1. Perform the "limited" screening requirements described in Paragraph C above; and
 - 2. Conduct on-site visits in accordance with 42 CFR 455.432.

200.300 Group Service Provider Participation Requirements**7-1-26**

- A. Group providers of occupational therapy and physical therapy rehabilitative services must meet the following requirements to be eligible to participate in the Arkansas Medicaid Program:
 - 1. Complete the provider participation and enrollment requirements contained within Section 140.000 of this manual to enroll as a Medicaid provider; and
 - 2. Each individual physical therapist, physical therapist assistant, occupational therapist, and occupational therapy assistant who provides services on behalf of the

group must complete the individual provider participation and enrollment requirements for their applicable service discipline contained within Sections 201.100 and 202.000 of this manual.

- B. Group providers must identify the individual licensed practitioner enrolled with Medicaid who performed the service as the rendering provider on their billing claim for each covered service.

200.400 Service Providers in Arkansas and Bordering States **7-1-26**

Providers of occupational therapy and physical therapy rehabilitative services in Arkansas and the six (6) bordering states (Louisiana, Mississippi, Missouri, Oklahoma, Tennessee, and Texas) may enroll as Arkansas Medicaid service providers if they meet the enrollment requirements specified in Sections 201.100, 201.200 and 202.000, as well as the provider enrollment requirements in Section 140.000 of this Manual, as applicable.

200.500 Service Providers in States Not Bordering Arkansas **7-1-26**

Providers of occupational therapy and physical therapy rehabilitative services in states not bordering Arkansas may enter into a single case agreement and enroll as a limited Arkansas Medicaid service provider to a single Arkansas Medicaid-eligible beneficiary. A separate single case agreement must be entered into for each Arkansas Medicaid-eligible beneficiary before the out of state provider may bill for services provided to that beneficiary. A provider will retain their limited-service provider status for one (1) year after the most recent claim's last date of service. **View or print the provider enrollment and contract package (Application Packet).**

201.000 Rehabilitative Occupational Therapy and Physical Therapy Service Provider Participation Requirements **7-1-26**

201.100 Occupational Therapy Provider Participation Requirements **7-1-26**

201.200 Occupational Therapist Participation Requirements **7-1-26**

Individuals must meet one (1) of the following requirements to enroll in Medicaid as an occupational therapist:

- A. Be licensed by the Arkansas State Medical Board to practice occupational therapy in the State of Arkansas;
- B. Hold compact privileges from the Arkansas State Medical Board to practice occupational therapy in the State of Arkansas; or
- C. If enrolling to perform occupational therapy services for an Arkansas Medicaid beneficiary outside the State of Arkansas, hold either:
1. A current license to practice as an occupational therapist in the state where services are being performed; or
 2. Compact privileges to practice occupational therapy from the licensing board in the state where services are being performed.

201.300 Occupational Therapy Assistant Participation Requirements **7-1-26**

Individuals must meet one (1) of the following requirements to enroll in Medicaid as an occupational therapy assistant:

- A. Be licensed by the Arkansas State Medical Board to practice occupational therapy as an occupational therapy assistant in the State of Arkansas;
- B. Hold compact privileges from the Arkansas State Medical Board to practice occupational therapy as an occupational therapy assistant in the State of Arkansas; or
- C. If enrolling to perform occupational therapy assistant services for an Arkansas Medicaid beneficiary outside the State of Arkansas, hold either:
 - 1. A current license to practice as an occupational therapy assistant in the state where services are being performed; or
 - 2. Compact privileges to practice as an occupational therapy assistant from the licensing board in the state where services are being performed.

201.400 Physical Therapy Provider Participation Requirements 7-1-26

201.500 Physical Therapist Participation Requirements 7-1-26

Individuals must meet one (1) of the following requirements to enroll in Medicaid as a physical therapist:

- A. Be licensed by the Arkansas State Board of Physical Therapy to practice physical therapy in the State of Arkansas;
- B. Hold compact privileges from the Arkansas State Board of Physical Therapy to practice physical therapy in the State of Arkansas; or
- C. If enrolling to perform physical therapy services for an Arkansas Medicaid beneficiary outside the State of Arkansas, hold either:
 - 1. A current license to practice as a physical therapist in the state where services are being performed; or
 - 2. Compact privileges to practice physical therapy from the licensing board in the state where services are being performed.

201.600 Physical Therapist Assistant Participation Requirements 7-1-26

Individuals must meet one (1) of the following requirements to enroll in Medicaid as a physical therapist assistant:

- A. Be licensed by the Arkansas State Board of Physical Therapy to practice physical therapy as a physical therapist assistant in the State of Arkansas;
- B. Hold compact privileges from the Arkansas State Board of Physical Therapy to practice physical therapy as a physical therapist assistant in the State of Arkansas; or
- C. If enrolling to perform physical therapist assistant services for an Arkansas Medicaid beneficiary outside the State of Arkansas, hold either:
 - 1. A current license to practice as a physical therapist assistant in the state where services are being performed; or
 - 2. Compact privileges to practice as a physical therapist assistant from the licensing board in the state where services are being performed.

201.700 Services by an Unlicensed Student 7-1-26

Occupational therapy and physical therapy rehabilitative services carried out by an unlicensed student may be covered only when a licensed provider of the service is present and engaged in student oversight during the entirety of the encounter. The licensed provider is considered to be providing the service under this condition.

201.800 **Supervision** **7-1-26**

201.900 **Physical Therapy** **7-1-26**

- A. A physical therapist is morally, ethically, and legally responsible for the quality of work performed by each physical therapist assistant under the physical therapist's supervision.
1. A supervising therapist must be immediately available to provide assistance and direction throughout the time the service is being performed. Availability by telecommunication is sufficient to meet this requirement.
 2. A supervising therapist must be consulted for changes in treatment, plan of care, or the identified goals.
 3. A supervising therapist must be consulted for recommendations before prescription of durable medical equipment (DME) or assistive devices.
 4. A supervising therapist must provide one (1) billable unit of service and write a progress report every ten (10) visits.
- B. A supervising therapist is responsible for ensuring documentation completed by a therapist assistant under their supervision is sufficient to claim reimbursement for each date of service.
- C. A physical therapist may not supervise more than five (5) therapist assistants at any given time.

202.000 **Occupational Therapy** **7-1-26**

- A. An occupational therapist is morally, ethically, and legally responsible for the quality of work performed by each occupational therapy assistant under the occupational therapist's supervision.
1. A supervising therapist must be immediately available to provide assistance and direction throughout the time the service is being performed. Availability by telecommunication is sufficient to meet this requirement.
 2. A supervising therapist must be consulted for changes in treatment, plan of care, or the identified goals.
 3. A supervising therapist must be consulted for recommendations before prescription of durable medical equipment (DME) or assistive devices.
 4. A supervising therapist must provide one (1) billable unit of service and write a progress report every ten (10) visits.
- B. A supervising therapist is responsible for ensuring documentation completed by a therapy assistant under their supervision is sufficient to claim reimbursement for each date of service.
- C. An occupational therapist may not supervise more than five (5) occupational therapy assistants at any given time.

202.100 **Documentation Requirements** **7-1-26**

202.200 Documentation Requirements for all Medicaid Providers 7-1-26

See Section 140.000 of this manual for the documentation that is required for all Medicaid Program providers.

202.300 Rehabilitative Occupational Therapy and Physical Therapy Services Documentation Requirements 7-1-26

A. Rehabilitative occupational therapy and physical therapy service providers are required to maintain the following documentation in each beneficiary's service record:

1. A written referral, plan of care document, or prescription for rehabilitative occupational therapy or physical therapy treatment services, or both, signed and dated by the beneficiary's primary care provider, attending physician, or certified nurse practitioner within the past three (3) months (unless the prescription specifies a shorter period). (See Section 210.400)
2. The evaluation and treatment prescription may be obtained at the same time and provided on the same prescription signed by the beneficiary's PCP or attending physician or nurse practitioner.
3. A treatment plan for the prescribed occupational therapy or physical therapy rehabilitative services, or both, developed and signed by a provider licensed in the prescribed discipline(s) or the prescribing provider.
4. Rehabilitative occupational therapy or physical therapy services delivery documentation, which must include for each individual session:
 - a. The beneficiary's name;
 - b. The date and the beginning and ending times of each therapy session;
 - c. A description of the specific services provided, and the activities rendered during each therapy session;
 - d. The rendering service provider's full name, his or her credentials, and his or her signature for each therapy session; and
 - e. The supervising therapist's progress report assessing improvements at least every ten (10) visits (Refer to Section 201.400 of this manual).
5. All other evaluation reports, progress notes, and related correspondence.
6. Discharge notes and summary, if applicable.

B. Providers of occupational therapy and physical therapy rehabilitative services must maintain:

1. Verification of their required qualifications. Refer to Section 201.000 of this manual; and
2. Any written contract between the individual provider and the group provider on behalf of which they provide services.

C. Group providers of occupational therapy and physical therapy rehabilitative services must maintain appropriate employment, certification, and licensure records for individuals employed or contracted by the group to provide occupational therapy or physical therapy services the group's behalf. If an individual practitioner provides services to a group provider pursuant to a contract, a copy of the contractual agreement must be maintained.

202.400 Electronic Signatures

7-1-26

The Arkansas Medicaid Program will accept electronic signatures in compliance with the Arkansas Electronic Records and Signatures Act found at Arkansas Code § 25-31-103 et seq.

210.000 PROGRAM COVERAGE

210.100 Introduction

7-1-26

The Arkansas Medicaid Program will reimburse enrolled providers for covered occupational therapy and physical therapy rehabilitative services (also referred to as “rehabilitative therapy services”) when such services are provided pursuant to a plan of care to Medicaid-eligible individuals twenty-one (21) years of age and older. Medicaid reimbursement for medically necessary rehabilitative therapy service claims is conditional upon compliance with this manual, manual update transmittals, and official program correspondence.

Rehabilitative therapy services are medically necessary services designed to help beneficiaries regain or improve physical skills lost due to illness or injury. Key elements include intensive therapy with skilled therapist involvement and primary care provider, attending physician, or certified nurse practitioner oversight focused on restoring independence.

Sources for information about other outpatient occupational therapy, physical therapy, and speech-language pathology services available through Medicaid, are listed in Section 201.000 of this manual.

210.200 Beneficiary Eligibility Requirements

7-1-26

210.300 Referral to Evaluate

7-1-26

- A. Rehabilitative therapy evaluation services require a written referral signed by the beneficiary’s primary care provider, attending physician, or certified nurse practitioner, as appropriate.
 - 1. The original referral must be maintained by the referring provider.
 - 2. A copy of the referral must be maintained in the beneficiary’s service record by the rehabilitative therapy provider.
- B. An evaluation referral and a prescription for rehabilitative therapy treatment may be prescribed simultaneously by the appropriate practitioner listed in (A) above. It is not required for the beneficiary to return to the referring or prescribing practitioner if both evaluation and treatment are medically necessary and ordered by the practitioner.

210.400 Treatment Prescription

7-1-26

- A. Rehabilitative therapy services require a written prescription signed by the beneficiary’s primary care or attending physician or certified nurse practitioner.
 - 1. The original prescription must be maintained by the prescribing provider.
 - 2. A copy of the prescription must be maintained in the rehabilitative therapy provider’s beneficiary’s service record.
- B. A prescription for rehabilitative therapy services is valid for the shorter of:
 - 1. The length of time specified on the prescription; or
 - 2. Three (3) months.
- C. The prescription must demonstrate the medical necessity of rehabilitative therapy services.

1. The beneficiary's diagnosis must clearly establish and support the prescribed occupational therapy or physical therapy rehabilitative services, or both.
2. The prescription diagnosis codes and nomenclature must comply with the coding conventions and requirements established in the International Classification of Diseases Clinical Modification for the edition certified by the Arkansas Medicaid Program for the beneficiary's dates of service.
3. Some diagnosis codes are not specific enough to identify the medical necessity for occupational therapy and physical therapy rehabilitative services and shall not be used. (View ICD codes.)

210.500 Rehabilitative Therapy Services Comprehensive Evaluation**7-1-26**

- A. Rehabilitative therapy services must be medically necessary as demonstrated by the results of a comprehensive evaluation in the suspected area(s) of deficit.
1. A diagnosis alone is not sufficient documentation to demonstrate medical necessity.
 2. The comprehensive evaluation must indicate the following:
 - a. The provision of occupational therapy or physical therapy rehabilitative services, or both, will be an effective treatment for the beneficiary's condition under accepted standards of practice;
 - b. The prescribed rehabilitative therapy services are of a level of complexity, or the beneficiary's condition is such that the services can only be safely and effectively performed by or under the supervision of a licensed occupational therapist or physical therapist, as appropriate; and
 - c. There is a reasonable expectation the rehabilitative therapy services will result in meaningful improvement or prevent a worsening of the beneficiary's condition.
 3. The frequency, intensity, and duration of the prescribed rehabilitative therapy services must be medically necessary based on the results of the comprehensive evaluation and realistic for the age and physical condition of the beneficiary.
- B. Each comprehensive evaluation must include an evaluation report with the following information. There is not a required order or format in which the evaluation report must be prepared:
1. The beneficiary's name and age or date of birth;
 2. The prescribing providers name and credentials;
 3. The diagnosis specific to the service(s) and suspected area(s) of deficit;
 4. Background information on the beneficiary including pertinent medical history;
 5. One (1) or more standardized evaluations of the beneficiary specific to the suspected area(s) of deficit, including all relevant scores, quotients, and indexes, if applicable;
 - a. Each comprehensive evaluation used to establish medical necessity for occupational therapy and physical therapy rehabilitative services must include objective information describing the beneficiary's gross and fine motor abilities and deficits, such as range of motion measurements, manual muscle testing, muscle tone, or a narrative description of the beneficiary's functional mobility skills.
 - b. If administration of a standardized evaluation instrument is inappropriate or unavailable, an in-depth narrative of the functional profile describing the beneficiary's abilities and deficits may be used as a substitute for a standardized evaluation. The narrative must include the following:
 - i. The reason a standardized evaluation is inappropriate, or cannot be used with the beneficiary;

- ii. The beneficiary's functional impairment(s), including specific skills and deficits;
 - iii. A list of supplemental assessments, evaluations, tools, and tests conducted to document deficits and develop the in-depth functional profile; and
 - iv. The rationale, contributing factors, and specific results of any supplemental assessments, evaluations, tools, tests, clinical observation, and clinical analysis procedures conducted that indicate rehabilitative therapy services are medically necessary for the beneficiary.
- 6. An interpretation of the results of the standardized evaluation and in-person clinical observations, including recommendations for the frequency, duration, and intensity of the rehabilitative therapy services;
 - 7. A description of the functional strengths and limitations of the beneficiary, a suggested treatment plan, and goals to address each identified problem; and
 - 8. The dated signature and credentials of the qualified practitioner that performed the standardized evaluation.
- C. All aspects of a comprehensive evaluation for rehabilitative therapy services, including the administration of the standardized evaluation, must be communicated and conducted in the beneficiary's primary or preferred language.
 - D. Supplemental screeners, evaluations, tools, assessments, clinical observation, and clinical analysis procedures used as part of the comprehensive evaluation to support the qualifying standardized evaluation may not be used to replace the qualifying standardized evaluation except as provided in Section 210.500(B)(5)(b).

210.600 Non-Covered Services**7-1-26**

A beneficiary who is currently admitted as an inpatient to a hospital or is residing in a nursing care facility is not eligible for occupational therapy or physical rehabilitative therapy services under this manual.

Occupational therapy or physical rehabilitative therapy services provided under this manual and under the Home Health manual which are duplicative in nature are not allowed for the same time period. However, if a beneficiary is receiving only nursing care services under the home health manual, rehabilitative occupational or physical therapy services may be provided to the beneficiary.

210.700 Covered Services**7-1-26**

- A. Arkansas Medicaid will only reimburse those services listed in Section 210.800 through 211.000 of this manual, as well as corresponding manual update transmittals, and relevant official program correspondence. Covered services are subject to all applicable limits.
- B. Covered services are only reimbursable if medically necessary.
- C. Please refer to the **Home Health program manual** for patients twenty-one (21) years of age and older who are receiving physical rehabilitative therapy in the home setting.
- D. Please refer to the **Home Health program manual** for specific coverage rules for patients twenty-one (21) years of age and older who are receiving physical or occupational rehabilitative therapy while under Hospice care.

210.800 Occupational Therapy and Physical Therapy Rehabilitative Evaluation and Treatment Planning Services**7-1-26**

- A. A provider may be reimbursed for medically necessary rehabilitative therapy evaluation and treatment planning services. Rehabilitative therapy evaluation and treatment planning services are a component of the process for determining a beneficiary's eligibility for rehabilitative therapy treatment services and developing the treatment plan.
- B. Need for rehabilitative therapy services is demonstrated by a referral from the beneficiary's primary care provider or attending physician or nurse practitioner validating the medical necessity of the services.
- C. The treatment plan must be developed and signed by an enrolled provider who is licensed in the prescribed service discipline or by the beneficiary's primary care provider or attending physician or nurse practitioner. The treatment plan must include functional, measurable, and specific goals for each individual beneficiary.
- D. Medically necessary rehabilitative therapy evaluation and treatment planning services are reimbursed on a per-unit basis according to complexity. The billable unit includes time spent administering and scoring a standardized evaluation, clinical observation, administering supplemental tests and tools, writing a comprehensive evaluation report, along with time spent developing the treatment plan. **View or print billable occupational therapy and physical therapy evaluation and treatment planning complexity codes and descriptions.**

210.900 Rehabilitative Therapy Treatment Services

7-1-26

- A. An enrolled provider may be reimbursed for rehabilitative therapy treatment services. Occupational therapy or physical therapy rehabilitative treatment services must be medically necessary in accordance with Section 210.500 of this manual.
- B. A group rehabilitative therapy provider may contract with or employ its practitioners. The group provider must identify the individual physical therapist, physical therapist assistant, occupational therapist, or occupational therapy assistant as the performing provider on the claim according to their respective therapy discipline when the group therapy provider bills the Arkansas Medicaid Program for rehabilitative therapy services. The individual physical therapist, physical therapist assistant, occupational therapist, or occupational therapy assistant performing the rehabilitative therapy must be enrolled with the Arkansas Medicaid Program and the criteria for individual providers of therapy services shall apply. See Section 202.000 of this manual.
- C. All rehabilitative therapy treatment services furnished by a therapy provider must be provided according to a treatment plan developed by a licensed therapist. All rehabilitative therapy treatment services must be provided, documented, and billed in accordance with this manual.
- D. Medically necessary rehabilitative therapy services are covered for up to twelve (12) rehabilitative therapy visits per state fiscal year (SFY). A maximum of two (2) units of therapy evaluation per discipline per SFY is also allowed. See Section 220.000 of this manual regarding how to request an extension of benefits. Refer to Section 211.000 of this manual regarding rehabilitative therapy services via telecommunication.
 - 1. **View or print the billable occupational therapy codes and descriptions.**
 - 2. **View or print the billable physical therapy codes and descriptions.**

211.000 Telemedicine Services

7-1-26

- A. An enrolled provider may be reimbursed for medically necessary rehabilitative therapy services delivered through telemedicine.

1. Rehabilitative therapy evaluation and treatment planning services may not be conducted through telemedicine. The evaluation and treatment planning services must be performed using traditional in-person methods.
 2. The plan of care and beneficiary service record for treatment services delivered by telemedicine must include the following:
 - a. A detailed assessment of the beneficiary that determines they are an appropriate candidate for rehabilitative therapy treatment service delivery by telemedicine based on the beneficiary's age and functioning level;
 - b. A detailed explanation of all on-site assistance or participation procedures the therapist is implementing to ensure the effectiveness of service delivery via telemedicine. The detailed explanation must ensure:
 - i. The effectiveness of telemedicine service delivery is equivalent to face-to-face service delivery; and
 - ii. Telemedicine service delivery will address the unique needs of the beneficiary.
 - c. A plan and estimated timeline for returning service delivery to in-person if the beneficiary is not adequately progressing towards goals and outcomes using telemedicine service delivery.
 3. All telemedicine services must be delivered in accordance with the Arkansas Telemedicine Act, found at Ark. Code Ann § 17-80-401 et seq.
- B.** The service provider is responsible for ensuring service delivery through telemedicine is equivalent to in-person service delivery.
1. The service provider is responsible for ensuring the calibration of clinical instruments and the proper functioning of telecommunications equipment.
 2. Rehabilitative therapy services delivered through telemedicine must be delivered in a synchronous manner, meaning through real-time interaction between the practitioner and beneficiary via a telecommunication link.
 3. A store and forward telecommunication method of service delivery where either the beneficiary or practitioner records and stores data in advance for the other party to review at a later time is prohibited as a service delivery mechanism. Correspondence, faxes, emails, and other non-real time interactions may supplement synchronous telemedicine service delivery.
 4. Telemedicine services must be provided using HIPAA compliant technology and in a manner that ensures the beneficiary's privacy is protected as required by HIPAA, HITECH, or other applicable privacy laws.
- C.** Services delivered through telemedicine are reimbursed in the same manner as in-person service delivery. **View or print the billable telecommunication codes and descriptions.**

220.000 **BENEFIT LIMITS**

220.100 **Extension of Benefits for Rehabilitative Therapy Services**

7-1-26

- A. Rehabilitative therapy services are subject to a benefit limit of twelve (12) visits per state fiscal year (SFY).
- B. Extension of this benefit is automatic for patients whose primary diagnosis for the service furnished is in the following list:
 1. Malignant neoplasm (**View ICD Codes.**)
 2. HIV infection and AIDS (**View ICD Codes.**)

3. Renal failure (View ICD Codes.)

4. Pregnancy (View ICD Codes.)

C. For range of benefits, see the following procedure codes: **View or print the procedure codes for therapy services.**

D. Requests for benefit extensions for rehabilitative therapy services for beneficiaries twenty-one (21) years of age or older must comply with Section 220.200.

220.200 Process for Requesting Extended Rehabilitative Therapy Services **7-1-26**

A. Requests for extended rehabilitative therapy services must be submitted to **DHS or its designated vendor** via the provider portal.

B. The request must meet medical necessity requirements for the services provided, and adequate documentation must be submitted to support the request.

1. A request for extended rehabilitative therapy services is considered only after a claim is denied because regular benefits were exceeded.

2. The request must be received within ninety (90) calendar days of the date of the denial for exceeding benefits. The count begins on the next working day after the date of the Remittance and Status Report (RA) on which the benefits-exceeded denial appears.

3. The provider must submit a copy of the Medical Assistance Remittance and Status Report (RA) reflecting the denial for exceeding benefits with the extension request. Do not send a claim.

4. Requests for extension submitted by facsimile (FAX) or email will not be accepted for review.

C. Form DMS-671, "Request for Extension of Benefits for Clinical, Outpatient, Diagnostic Laboratory, and Radiology/Other Services," must be used when requesting extended rehabilitative therapy services. **View or print Form DMS-671.** Correct completion of all fields on this form is required for consideration of the request. The instructions for completion of this form are located on the back of the form. The provider must sign, include his or her credentials, and date the Form DMS-671. All relevant documentation that supports the medical necessity of the request must be attached to be considered.

220.300 Request for Extension of Benefits Documentation Requirements **7-1-26**

A request for extension of benefits must include, at a minimum, the:

A. PCP or attending provider referral and prescription for the amount of service requested;

B. Documentation to demonstrate the medical necessity of the request for extension of benefits. Appropriate documentation may include without limitation: comprehensive evaluation(s), diagnosis(es), clinical records, or progress reports; and

C. Signature of the performing provider, including credentials, and date signed.

220.400 Review Process for Request for Extension of Benefits **7-1-26**

A. Requests for extension of benefits are initially screened for completeness and researched to determine the beneficiary's eligibility for Medicaid.

B. All documentation submitted with the request is reviewed by an appropriately licensed clinician.

1. If the reviewing clinician determines the documentation demonstrates the medical necessity of the request, then an approval letter is mailed to the requesting provider the following business day.
2. If the reviewing clinician determines the documentation does not demonstrate medical necessity, the request is referred to a physician for review.
 - a. If the reviewing physician determines the documentation demonstrates medical necessity, an approval letter is mailed to the requesting provider the following business day.
 - b. If the reviewing physician determines the documentation does not demonstrate medical necessity, then a denial letter that includes the physician's rationale for denial of the request is mailed to the provider and the beneficiary the following business day.
3. A provider may request an administrative reconsideration of any denial of a request for extension of benefits in accordance with Section 220.500 of this manual.

220.500 Administrative Reconsideration and Appeals

7-1-26

- A. Medicaid allows only one (1) reconsideration of an adverse decision. Reconsideration requests of denied benefit extensions or prior authorizations must be submitted in accordance with Section 160.000 of Section I of this manual.
- B. When the state Medicaid agency or its designee denies a reconsideration request or issues any adverse decision, the beneficiary or provider may appeal and request a fair hearing. A request for a fair hearing must be submitted in accordance with Sections 160.000, 190.000, and 191.000 of Section I of this manual.

230.000 REIMBURSEMENT

230.100 Method of Reimbursement

- A. Occupational therapy and physical therapy rehabilitative services use fee schedule reimbursement methodology. Under the fee schedule methodology, reimbursement is made at the lower of the billed charge for the service or maximum allowable reimbursement for the service under the Arkansas Medicaid Program.
 1. A full unit of service must be rendered in order to bill a unit of service.
 2. Partial units of service may not be rounded up and are not reimbursable.
- B. The maximum group size for occupational therapy or physical therapy rehabilitative services is four (4) beneficiaries.

230.200 Fee Schedules

7-1-26

- A. The Arkansas Medicaid Program provides fee schedules on the Arkansas Medicaid website. **View or print the occupational therapy and physical therapy services fee schedule.**
- B. Fee schedules do not address coverage limitations or special instructions applied by the Arkansas Medicaid Program before final payment is determined.
- C. Fee schedules and **therapy category codes** do not guarantee payment, coverage, or the reimbursement amount. Fee schedule and procedure code information may be changed or updated at any time to correct a discrepancy or error.

SECTION II – REHABILITATIVE OCCUPATIONAL THERAPY AND PHYSICAL THERAPY SERVICES

CONTENTS

200.000	REHABILITATIVE OCCUPATIONAL THERAPY AND PHYSICAL THERAPY SERVICES GENERAL INFORMATION
200.100	Arkansas Medicaid Participation Requirements
200.200	Individual Service Provider Participation Requirements
200.300	Group Service Provider Participation Requirements
200.400	Service Providers in Arkansas and Bordering States
200.500	Service Providers in States Not Bordering Arkansas
201.000	Rehabilitative Occupational Therapy and Physical Therapy Service Provider Participation Requirements
201.100	Occupational Therapy Provider Participation Requirements
201.200	Occupational Therapist Participation Requirements
201.300	Occupational Therapy Assistant Participation Requirements
201.400	Physical Therapy Provider Participation Requirements
201.500	Physical Therapist Participation Requirements
201.600	Physical Therapist Assistant Participation Requirements
201.700	Services by an Unlicensed Student
201.800	Supervision
201.900	Physical Therapy
202.000	Occupational Therapy
202.100	Documentation Requirements
202.200	Documentation Requirements for all Medicaid Providers
202.300	Rehabilitative Occupational Therapy and Physical Therapy Services Documentation Requirements
202.400	Electronic Signatures
210.000	PROGRAM COVERAGE
210.100	Introduction
210.200	Beneficiary Eligibility Requirements
210.300	Referral to Evaluate
210.400	Treatment Prescription
210.500	Rehabilitative Therapy Services Comprehensive Evaluation
210.600	Non-Covered Services
210.700	Covered Services
210.800	Occupational Therapy and Physical Therapy Rehabilitative Evaluation and Treatment Planning Services
210.900	Rehabilitative Therapy Treatment Services
211.000	Telemedicine Services
220.000	BENEFIT LIMITS
220.100	Extension of Benefits for Rehabilitative Therapy Services
220.200	Process for Requesting Extended Rehabilitative Therapy Services
220.300	Request for Extension of Benefits Documentation Requirements
220.400	Review Process for Request for Extension of Benefits
220.500	Administrative Reconsideration and Appeals
230.000	REIMBURSEMENT
230.100	Method of Reimbursement
230.200	Fee Schedules

200.000 REHABILITATIVE OCCUPATIONAL THERAPY AND PHYSICAL THERAPY SERVICES GENERAL INFORMATION

200.100 Arkansas Medicaid Participation Requirements

7-1-26

Providers of Occupational Therapy and Physical Therapy rehabilitative services for beneficiaries twenty-one (21) years of age or older must meet the provider participation and enrollment requirements contained within Section 140.000 of this manual. Providers must also meet the participation requirements of the applicable service discipline in Section 201.000 of this manual. Reimbursement is conditional upon compliance with this manual, manual update transmittals, and official program correspondence.

- A. Beneficiaries younger than twenty-one (21) years of age who require rehabilitative therapy services are covered under the [Occupational Therapy, Physical Therapy and Speech-Language Pathology program manual](#).
- B. Beneficiaries twenty-one (21) years of age or older who require rehabilitative physical therapy in the home setting are covered under the [Home Health program manual](#).
- C. Beneficiaries twenty-one (21) years of age or older who require rehabilitative physical or occupational therapy while under Hospice care are described in the Hospice manual and covered in the [Home Health program manual](#).

200.200 Individual Service Provider Participation Requirements

7-1-26

Individual providers of occupational therapy and physical therapy rehabilitative services must meet the following requirements to be eligible to participate in the Medicaid Program:

- A. Complete the provider participation and enrollment requirements contained within Section 140.000 of this manual to enroll as a Medicaid provider; and
- B. Meet the credentialing, experience, training, and other qualification requirements of their applicable service discipline contained within Section 201.000 of this manual.
- C. Occupational Therapists enrolling as individuals or group providers are categorized as limited risk providers. For providers in the "limited" risk category, DHS must:
 1. Verify that the provider meets any applicable federal regulations or state requirements for their provider type prior to making an enrollment determination.
 2. Conduct license verifications, including state licensure verifications in states other than where the provider is enrolling, in accordance with 42 CFR 455.412; and
 3. Conduct database checks on a pre- and post-enrollment basis to ensure that providers initially meet and continue to meet the enrollment criteria for their provider type, in accordance with 42 CFR 455.436.
- D. Physical Therapists enrolling as individual or group providers are categorized as moderate risk providers. For providers in the "moderate" risk category, DHS must:
 1. Perform the "limited" screening requirements described in Paragraph C above; and
 2. Conduct on-site visits in accordance with 42 CFR 455.432.

200.300 Group Service Provider Participation Requirements

7-1-26

- A. Group providers of occupational therapy and physical therapy rehabilitative services must meet the following requirements to be eligible to participate in the Arkansas Medicaid Program:
 1. Complete the provider participation and enrollment requirements contained within Section 140.000 of this manual to enroll as a Medicaid provider; and
 2. Each individual physical therapist, physical therapist assistant, occupational therapist, and occupational therapy assistant who provides services on behalf of the

group must complete the individual provider participation and enrollment requirements for their applicable service discipline contained within Sections 201.100 and 202.000 of this manual.

- B. Group providers must identify the individual licensed practitioner enrolled with Medicaid who performed the service as the rendering provider on their billing claim for each covered service.

200.400 Service Providers in Arkansas and Bordering States 7-1-26

Providers of occupational therapy and physical therapy rehabilitative services in Arkansas and the six (6) bordering states (Louisiana, Mississippi, Missouri, Oklahoma, Tennessee, and Texas) may enroll as Arkansas Medicaid service providers if they meet the enrollment requirements specified in Sections 201.100, 201.200 and 202.000, as well as the provider enrollment requirements in Section 140.000 of this Manual, as applicable.

200.500 Service Providers in States Not Bordering Arkansas 7-1-26

Providers of occupational therapy and physical therapy rehabilitative services in states not bordering Arkansas may enter into a single case agreement and enroll as a limited Arkansas Medicaid service provider to a single Arkansas Medicaid-eligible beneficiary. A separate single case agreement must be entered into for each Arkansas Medicaid-eligible beneficiary before the out of state provider may bill for services provided to that beneficiary. A provider will retain their limited-service provider status for one (1) year after the most recent claim's last date of service. [View or print the provider enrollment and contract package \(Application Packet\).](#)

201.000 Rehabilitative Occupational Therapy and Physical Therapy Service Provider Participation Requirements 7-1-26

201.100 Occupational Therapy Provider Participation Requirements 7-1-26

201.200 Occupational Therapist Participation Requirements 7-1-26

Individuals must meet one (1) of the following requirements to enroll in Medicaid as an occupational therapist:

- A. Be licensed by the Arkansas State Medical Board to practice occupational therapy in the State of Arkansas;
- B. Hold compact privileges from the Arkansas State Medical Board to practice occupational therapy in the State of Arkansas; or
- C. If enrolling to perform occupational therapy services for an Arkansas Medicaid beneficiary outside the State of Arkansas, hold either:
 - 1. A current license to practice as an occupational therapist in the state where services are being performed; or
 - 2. Compact privileges to practice occupational therapy from the licensing board in the state where services are being performed.

201.300 Occupational Therapy Assistant Participation Requirements 7-1-26

Individuals must meet one (1) of the following requirements to enroll in Medicaid as an occupational therapy assistant:

- A. Be licensed by the Arkansas State Medical Board to practice occupational therapy as an occupational therapy assistant in the State of Arkansas;
- B. Hold compact privileges from the Arkansas State Medical Board to practice occupational therapy as an occupational therapy assistant in the State of Arkansas; or
- C. If enrolling to perform occupational therapy assistant services for an Arkansas Medicaid beneficiary outside the State of Arkansas, hold either:
 - 1. A current license to practice as an occupational therapy assistant in the state where services are being performed; or
 - 2. Compact privileges to practice as an occupational therapy assistant from the licensing board in the state where services are being performed.

201.400 Physical Therapy Provider Participation Requirements 7-1-26

201.500 Physical Therapist Participation Requirements 7-1-26

Individuals must meet one (1) of the following requirements to enroll in Medicaid as a physical therapist:

- A. Be licensed by the Arkansas State Board of Physical Therapy to practice physical therapy in the State of Arkansas;
- B. Hold compact privileges from the Arkansas State Board of Physical Therapy to practice physical therapy in the State of Arkansas; or
- C. If enrolling to perform physical therapy services for an Arkansas Medicaid beneficiary outside the State of Arkansas, hold either:
 - 1. A current license to practice as a physical therapist in the state where services are being performed; or
 - 2. Compact privileges to practice physical therapy from the licensing board in the state where services are being performed.

201.600 Physical Therapist Assistant Participation Requirements 7-1-26

Individuals must meet one (1) of the following requirements to enroll in Medicaid as a physical therapist assistant:

- A. Be licensed by the Arkansas State Board of Physical Therapy to practice physical therapy as a physical therapist assistant in the State of Arkansas;
- B. Hold compact privileges from the Arkansas State Board of Physical Therapy to practice physical therapy as a physical therapist assistant in the State of Arkansas; or
- C. If enrolling to perform physical therapist assistant services for an Arkansas Medicaid beneficiary outside the State of Arkansas, hold either:
 - 1. A current license to practice as a physical therapist assistant in the state where services are being performed; or
 - 2. Compact privileges to practice as a physical therapist assistant from the licensing board in the state where services are being performed.

201.700 Services by an Unlicensed Student 7-1-26

Occupational therapy and physical therapy rehabilitative services carried out by an unlicensed student may be covered only when a licensed provider of the service is present and engaged in student oversight during the entirety of the encounter. The licensed provider is considered to be providing the service under this condition.

201.800 **Supervision** **7-1-26**

201.900 **Physical Therapy** **7-1-26**

- A. A physical therapist is morally, ethically, and legally responsible for the quality of work performed by each physical therapist assistant under the physical therapist's supervision.
 - 1. A supervising therapist must be immediately available to provide assistance and direction throughout the time the service is being performed. Availability by telecommunication is sufficient to meet this requirement.
 - 2. A supervising therapist must be consulted for changes in treatment, plan of care, or the identified goals.
 - 3. A supervising therapist must be consulted for recommendations before prescription of durable medical equipment (DME) or assistive devices.
 - 4. A supervising therapist must provide one (1) billable unit of service and write a progress report every ten (10) visits.
- B. A supervising therapist is responsible for ensuring documentation completed by a therapist assistant under their supervision is sufficient to claim reimbursement for each date of service.
- C. A physical therapist may not supervise more than five (5) therapist assistants at any given time.

202.000 **Occupational Therapy** **7-1-26**

- A. An occupational therapist is morally, ethically, and legally responsible for the quality of work performed by each occupational therapy assistant under the occupational therapist's supervision.
 - 1. A supervising therapist must be immediately available to provide assistance and direction throughout the time the service is being performed. Availability by telecommunication is sufficient to meet this requirement.
 - 2. A supervising therapist must be consulted for changes in treatment, plan of care, or the identified goals.
 - 3. A supervising therapist must be consulted for recommendations before prescription of durable medical equipment (DME) or assistive devices.
 - 4. A supervising therapist must provide one (1) billable unit of service and write a progress report every ten (10) visits.
- B. A supervising therapist is responsible for ensuring documentation completed by a therapy assistant under their supervision is sufficient to claim reimbursement for each date of service.
- C. An occupational therapist may not supervise more than five (5) occupational therapy assistants at any given time.

202.100 **Documentation Requirements** **7-1-26**

202.200 Documentation Requirements for all Medicaid Providers 7-1-26

See Section 140.000 of this manual for the documentation that is required for all Medicaid Program providers.

202.300 Rehabilitative Occupational Therapy and Physical Therapy Services Documentation Requirements 7-1-26

- A. Rehabilitative occupational therapy and physical therapy service providers are required to maintain the following documentation in each beneficiary's service record:
1. A written referral, plan of care document, or prescription for rehabilitative occupational therapy or physical therapy treatment services, or both, signed and dated by the beneficiary's primary care provider, attending physician, or certified nurse practitioner within the past three (3) months (unless the prescription specifies a shorter period). (See Section 210.400)
 2. The evaluation and treatment prescription may be obtained at the same time and provided on the same prescription signed by the beneficiary's PCP or attending physician or nurse practitioner.
 3. A treatment plan for the prescribed occupational therapy or physical therapy rehabilitative services, or both, developed and signed by a provider licensed in the prescribed discipline(s) or the prescribing provider.
 4. Rehabilitative occupational therapy or physical therapy services delivery documentation, which must include for each individual session:
 - a. The beneficiary's name;
 - b. The date and the beginning and ending times of each therapy session;
 - c. A description of the specific services provided, and the activities rendered during each therapy session;
 - d. The rendering service provider's full name, his or her credentials, and his or her signature for each therapy session; and
 - e. The supervising therapist's progress report assessing improvements at least every ten (10) visits (Refer to Section 201.400 of this manual).
 5. All other evaluation reports, progress notes, and related correspondence.
 6. Discharge notes and summary, if applicable.
- B. Providers of occupational therapy and physical therapy rehabilitative services must maintain:
1. Verification of their required qualifications. Refer to Section 201.000 of this manual; and
 2. Any written contract between the individual provider and the group provider on behalf of which they provide services.
- C. Group providers of occupational therapy and physical therapy rehabilitative services must maintain appropriate employment, certification, and licensure records for individuals employed or contracted by the group to provide occupational therapy or physical therapy services the group's behalf. If an individual practitioner provides services to a group provider pursuant to a contract, a copy of the contractual agreement must be maintained.

202.400 Electronic Signatures**7-1-26**

The Arkansas Medicaid Program will accept electronic signatures in compliance with the Arkansas Electronic Records and Signatures Act found at Arkansas Code § 25-31-103 et seq.

210.000 PROGRAM COVERAGE

210.100 Introduction 7-1-26

The Arkansas Medicaid Program will reimburse enrolled providers for covered occupational therapy and physical therapy rehabilitative services (also referred to as “rehabilitative therapy services”) when such services are provided pursuant to a plan of care to Medicaid-eligible individuals twenty-one (21) years of age and older. Medicaid reimbursement for medically necessary rehabilitative therapy service claims is conditional upon compliance with this manual, manual update transmittals, and official program correspondence.

Rehabilitative therapy services are medically necessary services designed to help beneficiaries regain or improve physical skills lost due to illness or injury. Key elements include intensive therapy with skilled therapist involvement and primary care provider, attending physician, or certified nurse practitioner oversight focused on restoring independence.

Sources for information about other outpatient occupational therapy, physical therapy, and speech-language pathology services available through Medicaid, are listed in Section 201.000 of this manual.

210.200 Beneficiary Eligibility Requirements 7-1-26

210.300 Referral to Evaluate 7-1-26

- A. Rehabilitative therapy evaluation services require a written referral signed by the beneficiary’s primary care provider, attending physician, or certified nurse practitioner, as appropriate.
 - 1. The original referral must be maintained by the referring provider.
 - 2. A copy of the referral must be maintained in the beneficiary’s service record by the rehabilitative therapy provider.
- B. An evaluation referral and a prescription for rehabilitative therapy treatment may be prescribed simultaneously by the appropriate practitioner listed in (A) above. It is not required for the beneficiary to return to the referring or prescribing practitioner if both evaluation and treatment are medically necessary and ordered by the practitioner.

210.400 Treatment Prescription 7-1-26

- A. Rehabilitative therapy services require a written prescription signed by the beneficiary’s primary care or attending physician or certified nurse practitioner.
 - 1. The original prescription must be maintained by the prescribing provider.
 - 2. A copy of the prescription must be maintained in the rehabilitative therapy provider’s beneficiary’s service record.
- B. A prescription for rehabilitative therapy services is valid for the shorter of:
 - 1. The length of time specified on the prescription; or
 - 2. Three (3) months.
- C. The prescription must demonstrate the medical necessity of rehabilitative therapy services.

1. The beneficiary's diagnosis must clearly establish and support the prescribed occupational therapy or physical therapy rehabilitative services, or both.
2. The prescription diagnosis codes and nomenclature must comply with the coding conventions and requirements established in the International Classification of Diseases Clinical Modification for the edition certified by the Arkansas Medicaid Program for the beneficiary's dates of service.
3. Some diagnosis codes are not specific enough to identify the medical necessity for occupational therapy and physical therapy rehabilitative services and shall not be used. ([View ICD codes.](#))

210.500**Rehabilitative Therapy Services Comprehensive Evaluation**

7-1-26

- A. Rehabilitative therapy services must be medically necessary as demonstrated by the results of a comprehensive evaluation in the suspected area(s) of deficit.
 1. A diagnosis alone is not sufficient documentation to demonstrate medical necessity.
 2. The comprehensive evaluation must indicate the following:
 - a. The provision of occupational therapy or physical therapy rehabilitative services, or both, will be an effective treatment for the beneficiary's condition under accepted standards of practice;
 - b. The prescribed rehabilitative therapy services are of a level of complexity, or the beneficiary's condition is such that the services can only be safely and effectively performed by or under the supervision of a licensed occupational therapist or physical therapist, as appropriate; and
 - c. There is a reasonable expectation the rehabilitative therapy services will result in meaningful improvement or prevent a worsening of the beneficiary's condition.
 3. The frequency, intensity, and duration of the prescribed rehabilitative therapy services must be medically necessary based on the results of the comprehensive evaluation and realistic for the age and physical condition of the beneficiary.
- B. Each comprehensive evaluation must include an evaluation report with the following information. There is not a required order or format in which the evaluation report must be prepared:
 1. The beneficiary's name and age or date of birth;
 2. The prescribing providers name and credentials;
 3. The diagnosis specific to the service(s) and suspected area(s) of deficit;
 4. Background information on the beneficiary including pertinent medical history;
 5. One (1) or more standardized evaluations of the beneficiary specific to the suspected area(s) of deficit, including all relevant scores, quotients, and indexes, if applicable;
 - a. Each comprehensive evaluation used to establish medical necessity for occupational therapy and physical therapy rehabilitative services must include objective information describing the beneficiary's gross and fine motor abilities and deficits, such as range of motion measurements, manual muscle testing, muscle tone, or a narrative description of the beneficiary's functional mobility skills.
 - b. If administration of a standardized evaluation instrument is inappropriate or unavailable, an in-depth narrative of the functional profile describing the beneficiary's abilities and deficits may be used as a substitute for a standardized evaluation. The narrative must include the following:
 - i. The reason a standardized evaluation is inappropriate, or cannot be used with the beneficiary;

- ii. The beneficiary's functional impairment(s), including specific skills and deficits;
 - iii. A list of supplemental assessments, evaluations, tools, and tests conducted to document deficits and develop the in-depth functional profile; and
 - iv. The rationale, contributing factors, and specific results of any supplemental assessments, evaluations, tools, tests, clinical observation, and clinical analysis procedures conducted that indicate rehabilitative therapy services are medically necessary for the beneficiary.
 6. An interpretation of the results of the standardized evaluation and in-person clinical observations, including recommendations for the frequency, duration, and intensity of the rehabilitative therapy services;
 7. A description of the functional strengths and limitations of the beneficiary, a suggested treatment plan, and goals to address each identified problem; and
 8. The dated signature and credentials of the qualified practitioner that performed the standardized evaluation.
- C. All aspects of a comprehensive evaluation for rehabilitative therapy services, including the administration of the standardized evaluation, must be communicated and conducted in the beneficiary's primary or preferred language.
- D. Supplemental screeners, evaluations, tools, assessments, clinical observation, and clinical analysis procedures used as part of the comprehensive evaluation to support the qualifying standardized evaluation may not be used to replace the qualifying standardized evaluation except as provided in Section 210.500(B)(5)(b).

210.600 Non-Covered Services

7-1-26

A beneficiary who is currently admitted as an inpatient to a hospital or is residing in a nursing care facility is not eligible for occupational therapy or physical rehabilitative therapy services under this manual.

Occupational therapy or physical rehabilitative therapy services provided under this manual and under the Home Health manual which are duplicative in nature are not allowed for the same time period. However, if a beneficiary is receiving only nursing care services under the home health manual, rehabilitative occupational or physical therapy services may be provided to the beneficiary.

210.700 Covered Services

7-1-26

- A. Arkansas Medicaid will only reimburse those services listed in Section 210.800 through 211.000 of this manual, as well as corresponding manual update transmittals, and relevant official program correspondence. Covered services are subject to all applicable limits.
- B. Covered services are only reimbursable if medically necessary.
- C. Please refer to the [Home Health program manual](#) for patients twenty-one (21) years of age and older who are receiving physical rehabilitative therapy in the home setting.
- D. Please refer to the [Home Health program manual](#) for specific coverage rules for patients twenty-one (21) years of age and older who are receiving physical or occupational rehabilitative therapy while under Hospice care.

210.800 Occupational Therapy and Physical Therapy Rehabilitative Evaluation and Treatment Planning Services

7-1-26

- A. A provider may be reimbursed for medically necessary rehabilitative therapy evaluation and treatment planning services. Rehabilitative therapy evaluation and treatment planning services are a component of the process for determining a beneficiary's eligibility for rehabilitative therapy treatment services and developing the treatment plan.
- B. Need for rehabilitative therapy services is demonstrated by a referral from the beneficiary's primary care provider or attending physician or nurse practitioner validating the medical necessity of the services.
- C. The treatment plan must be developed and signed by an enrolled provider who is licensed in the prescribed service discipline or by the beneficiary's primary care provider or attending physician or nurse practitioner. The treatment plan must include functional, measurable, and specific goals for each individual beneficiary.
- D. Medically necessary rehabilitative therapy evaluation and treatment planning services are reimbursed on a per-unit basis according to complexity. The billable unit includes time spent administering and scoring a standardized evaluation, clinical observation, administering supplemental tests and tools, writing a comprehensive evaluation report, along with time spent developing the treatment plan. [View or print billable occupational therapy and physical therapy evaluation and treatment planning complexity codes and descriptions.](#)

210.900 Rehabilitative Therapy Treatment Services

7-1-26

- A. An enrolled provider may be reimbursed for rehabilitative therapy treatment services. Occupational therapy or physical therapy rehabilitative treatment services must be medically necessary in accordance with Section 210.500 of this manual.
- B. A group rehabilitative therapy provider may contract with or employ its practitioners. The group provider must identify the individual physical therapist, physical therapist assistant, occupational therapist, or occupational therapy assistant as the performing provider on the claim according to their respective therapy discipline when the group therapy provider bills the Arkansas Medicaid Program for rehabilitative therapy services. The individual physical therapist, physical therapist assistant, occupational therapist, or occupational therapy assistant performing the rehabilitative therapy must be enrolled with the Arkansas Medicaid Program and the criteria for individual providers of therapy services shall apply. See Section 202.000 of this manual.
- C. All rehabilitative therapy treatment services furnished by a therapy provider must be provided according to a treatment plan developed by a licensed therapist. All rehabilitative therapy treatment services must be provided, documented, and billed in accordance with this manual.
- D. Medically necessary rehabilitative therapy services are covered for up to twelve (12) rehabilitative therapy visits per state fiscal year (SFY). A maximum of two (2) units of therapy evaluation per discipline per SFY is also allowed. See Section 220.000 of this manual regarding how to request an extension of benefits. Refer to Section 211.000 of this manual regarding rehabilitative therapy services via telecommunication.
 - 1. [View or print the billable occupational therapy codes and descriptions.](#)
 - 2. [View or print the billable physical therapy codes and descriptions.](#)

211.000 Telemedicine Services

7-1-26

- A. An enrolled provider may be reimbursed for medically necessary rehabilitative therapy services delivered through telemedicine.

1. Rehabilitative therapy evaluation and treatment planning services may not be conducted through telemedicine. The evaluation and treatment planning services must be performed using traditional in-person methods.
 2. The plan of care and beneficiary service record for treatment services delivered by telemedicine must include the following:
 - a. A detailed assessment of the beneficiary that determines they are an appropriate candidate for rehabilitative therapy treatment service delivery by telemedicine based on the beneficiary's age and functioning level;
 - b. A detailed explanation of all on-site assistance or participation procedures the therapist is implementing to ensure the effectiveness of service delivery via telemedicine. The detailed explanation must ensure:
 - i. The effectiveness of telemedicine service delivery is equivalent to face-to-face service delivery; and
 - ii. Telemedicine service delivery will address the unique needs of the beneficiary.
 - c. A plan and estimated timeline for returning service delivery to in-person if the beneficiary is not adequately progressing towards goals and outcomes using telemedicine service delivery.
 3. All telemedicine services must be delivered in accordance with the Arkansas Telemedicine Act, found at Ark. Code Ann § 17-80-401 et seq.
- B. The service provider is responsible for ensuring service delivery through telemedicine is equivalent to in-person service delivery.
1. The service provider is responsible for ensuring the calibration of clinical instruments and the proper functioning of telecommunications equipment.
 2. Rehabilitative therapy services delivered through telemedicine must be delivered in a synchronous manner, meaning through real-time interaction between the practitioner and beneficiary via a telecommunication link.
 3. A store and forward telecommunication method of service delivery where either the beneficiary or practitioner records and stores data in advance for the other party to review at a later time is prohibited as a service delivery mechanism. Correspondence, faxes, emails, and other non-real time interactions may supplement synchronous telemedicine service delivery.
 4. Telemedicine services must be provided using HIPAA compliant technology and in a manner that ensures the beneficiary's privacy is protected as required by HIPAA, HITECH, or other applicable privacy laws.
- C. Services delivered through telemedicine are reimbursed in the same manner as in-person service delivery. [View or print the billable telecommunication codes and descriptions.](#)

220.000	BENEFIT LIMITS
----------------	-----------------------

220.100	Extension of Benefits for Rehabilitative Therapy Services
----------------	--

7-1-26

- A. Rehabilitative therapy services are subject to a benefit limit of twelve (12) visits per state fiscal year (SFY).
- B. Extension of this benefit is automatic for patients whose primary diagnosis for the service furnished is in the following list:
 1. Malignant neoplasm ([View ICD Codes.](#))
 2. HIV infection and AIDS ([View ICD Codes.](#))

3. Renal failure ([View ICD Codes.](#))
 4. Pregnancy ([View ICD Codes.](#))
- C. For range of benefits, see the following procedure codes: [View or print the procedure codes for therapy services.](#)
- D. Requests for benefit extensions for rehabilitative therapy services for beneficiaries twenty-one (21) years of age or older must comply with Section 220.200.

220.200 **Process for Requesting Extended Rehabilitative Therapy Services** **7-1-26**

- A. Requests for extended rehabilitative therapy services must be submitted to [DHS or its designated vendor](#) via the provider portal.
- B. The request must meet medical necessity requirements for the services provided, and adequate documentation must be submitted to support the request.
 1. A request for extended rehabilitative therapy services is considered only after a claim is denied because regular benefits were exceeded.
 2. The request must be received within ninety (90) calendar days of the date of the denial for exceeding benefits. The count begins on the next working day after the date of the Remittance and Status Report (RA) on which the benefits-exceeded denial appears.
 3. The provider must submit a copy of the Medical Assistance Remittance and Status Report (RA) reflecting the denial for exceeding benefits with the extension request. Do not send a claim.
 4. Requests for extension submitted by facsimile (FAX) or email will not be accepted for review.
- C. Form DMS-671, "Request for Extension of Benefits for Clinical, Outpatient, Diagnostic Laboratory, and Radiology/Other Services," must be used when requesting extended rehabilitative therapy services. [View or print Form DMS-671](#). Correct completion of all fields on this form is required for consideration of the request. The instructions for completion of this form are located on the back of the form. The provider must sign, include his or her credentials, and date the Form DMS-671. All relevant documentation that supports the medical necessity of the request must be attached to be considered.

220.300 **Request for Extension of Benefits Documentation Requirements** **7-1-26**

A request for extension of benefits must include, at a minimum, the:

- A. PCP or attending provider referral and prescription for the amount of service requested;
- B. Documentation to demonstrate the medical necessity of the request for extension of benefits. Appropriate documentation may include without limitation: comprehensive evaluation(s), diagnosis(es), clinical records, or progress reports; and
- C. Signature of the performing provider, including credentials, and date signed.

220.400 **Review Process for Request for Extension of Benefits** **7-1-26**

- A. Requests for extension of benefits are initially screened for completeness and researched to determine the beneficiary's eligibility for Medicaid.
- B. All documentation submitted with the request is reviewed by an appropriately licensed clinician.

1. If the reviewing clinician determines the documentation demonstrates the medical necessity of the request, then an approval letter is mailed to the requesting provider the following business day;
2. If the reviewing clinician determines the documentation does not demonstrate medical necessity, the request is referred to a physician for review.
 - a. If the reviewing physician determines the documentation demonstrates medical necessity, an approval letter is mailed to the requesting provider the following business day.
 - b. If the reviewing physician determines the documentation does not demonstrate medical necessity, then a denial letter that includes the physician's rationale for denial of the request is mailed to the provider and the beneficiary the following business day.
3. A provider may request an administrative reconsideration of any denial of a request for extension of benefits in accordance with Section 220.500 of this manual.

220.500 Administrative Reconsideration and Appeals

7-1-26

- A. Medicaid allows only one (1) reconsideration of an adverse decision. Reconsideration requests of denied benefit extensions or prior authorizations must be submitted in accordance with Section 160.000 of Section I of this manual.
- B. When the state Medicaid agency or its designee denies a reconsideration request or issues any adverse decision, the beneficiary or provider may appeal and request a fair hearing. A request for a fair hearing must be submitted in accordance with Sections 160.000, 190.000, and 191.000 of Section I of this manual.

230.000 REIMBURSEMENT

230.100 Method of Reimbursement

- A. Occupational therapy and physical therapy rehabilitative services use fee schedule reimbursement methodology. Under the fee schedule methodology, reimbursement is made at the lower of the billed charge for the service or maximum allowable reimbursement for the service under the Arkansas Medicaid Program.
 1. A full unit of service must be rendered in order to bill a unit of service.
 2. Partial units of service may not be rounded up and are not reimbursable.
- B. The maximum group size for occupational therapy or physical therapy rehabilitative services is four (4) beneficiaries.

230.200 Fee Schedules

7-1-26

- A. The Arkansas Medicaid Program provides fee schedules on the Arkansas Medicaid website. [View or print the occupational therapy and physical therapy services fee schedule.](#)
- B. Fee schedules do not address coverage limitations or special instructions applied by the Arkansas Medicaid Program before final payment is determined.
- C. Fee schedules and [therapy category codes](#) do not guarantee payment, coverage, or the reimbursement amount. Fee schedule and procedure code information may be changed or updated at any time to correct a discrepancy or error.