13. Other diagnostic, screening, preventive and rehabilitative services, i.e., other than those provided elsewhere in this plan. (Continued)

d. Rehabilitative Services (Continued)

1. Rehabilitative Services for Persons with Mental Illness (RSPMI) - (Continued)

b. Acute Day Treatment *

c. Restricted RSPMI Services

Assessment-Reassessment and Plan of Care
Crisis Stabilization Intervention*
On-Site Intervention*
Off-Site Intervention*
Rehabilitation Day Services*

d. Other RSPMI Services

Crisis Intervention
Physical Examination
Medication Maintenance by a Physician*
Periodic Review of Plan of Care
Routine Venipuncture for Collection of Specimen
Catheterization for Collection of Specimen
Medication Administration by a Licensed Nurse
Collateral Intervention
Inpatient Visits in Acute Care Hospitals by Board Certified Psychiatrists

* Effective April 1, 2000, these services require prior authorization for eligible Medicaid recipients age 21 and over to determine and verify the patient's need for services.

13. Other diagnostic, screening, preventive and rehabilitative services, i.e., other than those provided elsewhere in this plan. (Continued)

d. Rehabilitative Services (Continued)

1. Rehabilitative Services for Persons with Mental Illness (RSPMI) - (Continued)

b. Acute Day Treatment*

c. Restricted RSPMI Services

Assessment-Reassessment and Plan of Care
Crisis Stabilization Intervention*
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Crisis Intervention
Physical Examination
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Inpatient Visits in Acute Care Hospitals by Board Certified Psychiatrists

* Effective April 1, 2000, these services require prior authorization for eligible Medicaid recipients age 21 and over to determine and verify the patient's need for services.

12. Prescribed drugs, dentures, and prosthetic devices; and eyeglasses prescribed by a physician skilled in diseases of the eye or by an optometrist (Continued)

d. Eyeglasses

Negotiated statewide contract bid.

13. Other diagnostic, screening, preventive and rehabilitative services, i.e., other than those provided elsewhere in this plan. (Continued)

a. Diagnostic Services - Not provided.
b. Screening Services - Not provided.
c. Preventive Services - Not provided.
d. Rehabilitative Services

1. Rehabilitative Services for Persons with Mental Illness

Reimbursement is based on the lower of the amount billed or the Title XIX (Medicaid) maximum allowable.

The Title XIX maximum was established based on a survey by the Division of Mental Health of the usual and customary charges used by community based programs. Rates include the professional and administrative components.

For acute outpatient services and acute day treatment previously found in the Mental Health Clinic option, reimbursement is based on the lower of: (a) the provider's actual charge for the services or (b) the allowable fee from the State's fee schedule based on average cost. The average cost of each mental health service was calculated based on 1978 cost data. A 20 per cent inflation factor was applied to arrive at the "fee schedule" rate.

Effective April 1, 1988, reimbursement rates were increased 78% to reflect rates comparable to those charges found in the private sector for comparable mental health services. Effective July 1, 1991, a 20% increase was applied.

Effective for dates of service on or after December 1, 2001, reimbursement for inpatient visits in acute care hospitals by board certified psychiatrists is based on 66% of the Physician's Blue Shield Fee Schedule dated October 1, 1993.

Arkansas Department of Human Services
Division of Medical Services
Donaghey Plaza South
P.O. Box 1437
Little Rock, Arkansas 72203-1437
Internet Website: www.medicaid.state.ar.us
Telephone (501) 682-8292 TDD (501) 682-6789 or 1-877-708-8191
FAX (501) 682-1197

TO: Health Care Provider - RSPMI

DATE: December 1, 2001

SUBJECT: Update Transmittal No. 39

REMOVE		INSERT	
Page	**Date**	**Page**	**Date**
Table of Contents	7-1-01	Table of Contents	12-1-01
II-1 through II-22	Dates Vary	II-1 through II-28	12-1-01
III-37 through III-46	7-1-01	III-37 through III-46	12-1-01

Explanation of Updates

All the pages of Section II of the RSPMI manual have been revised to change the numbering system to be consistent with other provider manuals and to incorporate information previously disseminated to providers in official notices and RAs. Changes were made for the sake of clarity, because of repagination and to be consistent with current practices.

Pages II-1 and II-2, sections 202.000 through 202.100, are included to clarify the requirements necessary for Medicaid enrollment and DMHS certification.

Page II-3, section 211, is included to rephrase the coverage of services policy to apply to all RSPMI providers.

Page II-4 through II-6, sections 213.000 through 215, are included because of repagination.

Pages II-7 and II-8, sections 216 through 218.100, are included to move information from pages II-18 and II-19 in the current manual. There are no changes in content.

Pages II-8 through II-14, sections 219.000 through 219.143, are included to reformat information regarding outpatient services. Procedure codes were removed from these pages because they are now found in Section III of the manual.

Pages II-14 through II-19, sections 220.000 through 221.260, are included to add policy regarding visits to patients in acute care hospitals by board-certified or board eligible psychiatrists and to add the Medicaid Utilization Management Program (MUMP) requirements for inpatient admissions.

Pages II-20 and II-21, sections 222 through 226.200, are added because of repagination.

Explanation of Updates (con't)

Page II-22, sections 227.000 through 227.110, is added to add information regarding medical necessity and benefit extensions for speech therapy services.

Pages II-23 and II-24 are added to add Form DMS-640 and Form DMS-699 to this manual.

Page II-25, section 229, is added to include a section to explain the Medicaid recipient appeal process.

Page II-26, section 230, is included to explain that prior authorization for certain services is the responsibility of First Health rather than the Division of Mental Health Services. The substance abuse diagnosis codes that were on page II-29 have been moved to Section III with an explanation the section applies to all Medicaid recipients of RSPMI services regardless of age.

Page II-27, section 240, is included because of repagination and to add the reimbursement information for inpatient services.

Page II-28, section 241, is included because of repagination.

Pages III-37 and III-38, sections 312.000 and 312.300, are included to reformat the lists of outpatient procedure codes, remove redundant information that is available in Section II of this manual and to move the substance abuse diagnosis codes from Section II of this manual to the billing section.

Page III-39, section 312.400, is included to add procedure codes for inpatient hospital visits by board-certified or board eligible psychiatrists.

Pages III-39 through III-41, sections 312.500 and 312.600, are included because of repagination.

Pages III-42 through II-46 are added because of repagination.

The following Official Notices should be deleted. The content, where appropriate, has been incorporated into this update:

DMS-2000-YY-4
DMS-2000-YY-5
DMS-2001-YY-1

Explanation of Updates (con't)

The following Remittance Advice (RA) Messages should be deleted. The content, where appropriate, has been incorporated into this update:

March 6, 1997	IRS Form #1099
May 29, 1997	IRS Form #1099
June 19, 1997	AEVCS Submission Access Numbers
February 12, 1998	Prior Authorization
June 28, 2001	Official Notice DMS-2001-C-1, DMS-2001-F-1, DMS-2001-I-2, DMS-2001-L-6, DMS-2001-KK-3, DMS-2001-FF-1, DMS-2001-R-4, DMS-2001-EE-1, DMS-2001-Y-3, DMS-2001-YY-1
July 26, 2001	Clarification in Reference to Official Notice DMS-2001-C-1, DMS-2001-F-1, DMS-2001-I-2, DMS-2001-L-6, DMS-2001-KK-3, DMS-2001-FF-1, DMS-2001-R-4, DMS-2001-EE-1, DMS-2001-Y-3, DMS-2001-YY-1

A change bar in the left margin denotes a revision.

Attached are updated pages to file in your provider manual.

If you need this material in an alternative format, such as large print, please contact our Americans with Disabilities Act Coordinator at (501) 682-1461 (voice) or (501) 682-6789 and 1-877-708-8191 (TDD).

Thank you for your participation in the Arkansas Medicaid Program.

If you have questions regarding this notice, please contact the EDS Provider Assistance Center at In-State Wats 1-800-457-4454, locally and Out-of-State at (501) 376-2211.

Ray Hanley, Director
Division of Medical Services

Arkansas Medicaid provider manuals (including update transmittals), official notices and remittance advice (RA) messages are available for downloading from the Arkansas Medicaid website: **www.medicaid.state.ar.us.**

200 REHABILITATIVE SERVICES FOR PERSONS WITH MENTAL ILLNESS (RSPMI) GENERAL INFORMATION

201 Introduction

Medicaid (Medical Assistance) is designed to assist eligible Medicaid recipients in obtaining medical care within the guidelines specified in Section I of this manual. Rehabilitative Services for Persons with Mental Illness (RSPMI) are covered by Medicaid when provided to eligible Medicaid recipients by enrolled providers.

Rehabilitative Services for Persons with Mental Illness (RSPMI) may be provided to eligible Medicaid recipients at the provider facility. Certain RSPMI services may be provided off site from the provider facility.

202.000 Arkansas Medicaid Participation Requirements for RSPMI

In order to ensure quality and continuity of care, all mental health providers approved to receive Medicaid reimbursement for services to Medicaid recipients must meet specific qualifications for their services and staff.

To enroll as an RSPMI Medicaid provider, the following must occur:

A. Providers must be located within the State of Arkansas.

B. A provider must complete a provider application (Form DMS-652) and a Medicaid contract (Form DMS-653) with the Arkansas Medicaid Program. (See Section I of this manual.)

C. A provider must be certified by the Division of Mental Health Services (DMHS). (See section 202.100 for certification requirements.) A copy of the current DMHS certification as an RSPMI provider must accompany the provider application and Medicaid contract. Subsequent certifications must be provided when issued.

D. The Arkansas Medicaid Program must approve the provider application and the Medicaid contract.

202.100 Certification Requirements by the Division of Mental Health Services (DMHS)

Providers of RSPMI Services must furnish documentation of certification from the Division of Mental Health Services (DMHS) establishing that the provider is accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), the Commission on Accreditation of Rehabilitation Facilities (CARF), Council on Accreditation (COA) or other national accreditation approved by DMHS, and that the accreditation encompasses the RSPMI services to be furnished.

Certification requirements are as follows:

A. Providers must submit a written request from the organization's Chief Executive Officer (CEO) to DMHS for certification by DMHS as an RSPMI Provider.

B. The request for certification by DMHS must include a copy of the provider's accreditation, most recent accreditation survey, and correspondence between the provider and the accrediting organization since the most recent accreditation survey.

C. A list of service delivery sites, including each site's address, telephone number, and fax number must be submitted.

D. The provider must notify its accrediting organization in writing of all new or additional RSPMI services implemented subsequent to the provider's most recent accreditation survey; provide DMHS with a copy of the notification letter; and affirm in writing to DMHS that the new service(s) will be included in the provider's next regularly scheduled accreditation survey if not surveyed before that time.

E. The provider must maintain accreditation with JCAHO, CARF or COA in order to remain certified by DMHS and must provide DMHS with copies of any correspondence with the accrediting organization that is relative to the accreditation.

F. Accreditation by CARF, JCAHO, COA or other national accreditation approved by DMHS is required, but not necessarily the only condition for DMHS certification. It is the responsibility of DMHS to ascertain the accreditation status of those organizations it certifies. DMHS may establish additional standards or require organizations to meet additional standards that have a basis in law or regulation, in the event that these requirements are not addressed by the accrediting body.

210 PROGRAM COVERAGE

211 Coverage of Services

Rehabilitative Services for Persons with Mental Illness (RSPMI) are limited to certified providers who offer core mental health services for the treatment and prevention of mental disorders. The provider must be certified as an RSPMI provider by the Division of Mental Health Services.

An RSPMI provider must have 24-hour emergency response capability to meet the emergency treatment needs of the RSPMI clients they are serving.

212 Quality Assurance

Each RSPMI provider must establish and maintain a quality assurance committee, that will examine the clinical records for completeness, adequacy and appropriateness of care, and quality of care and efficient utilization of provider resources. The quality assurance documentation should be filed separately from the clinical records.

213.000 Staff Requirements

Each RSPMI provider shall ensure mental health professionals are available to provide appropriate, adequate supervision of all clinical activities. Minimal staff requirements for RSPMI provider participation in the Arkansas Medicaid Program are:

A. A Chief Executive Officer (CEO) with professional qualifications and experience as established by the provider's governing body.

B. Mental health professionals shall meet all professional requirements as defined in the state licensing and certification laws relating to their prospective professions. Mental health professionals include the following:

1. Psychiatrist
2. Physician
3. Psychologist
4. Psychological Examiner

213.000 Staff Requirements (Continued)

C. In addition to the above professionals, the following staff may also provide services in accordance with licensing and certification laws:

1. Master of Social Work (Licensed in the State of Arkansas).

2. Registered Nurse (Licensed in the State of Arkansas) with one (1) year supervised experience in a mental health setting.

3. Licensed Professional Counselor (Licensed in the State of Arkansas).

4. Persons in a related profession who are licensed in the State of Arkansas and practicing within the bounds of their licensing authority, with a master's degree and appropriate experience in a mental health setting, including documented, supervised training and experience in diagnosis and therapy of a broad range of mental disorders.

D. The staff of the RSPMI provider requires the services of a medical records librarian. The medical records librarian (or person performing the duties of the medical records librarian) shall be responsible for ongoing quality controls, for continuity of patient care and patient traffic flow. The librarian shall assure that records are maintained, completed and preserved, and that required indexes and registries are maintained and statistical reports prepared. This staff member will be personally responsible for ensuring that information on enrolled patients is immediately retrievable; for establishing a central records index; and for maintaining service records in such a manner as to enable a constant monitoring of continuity of care.

E. A mental health paraprofessional is defined as a person with a Bachelor's Degree or a person licensed by the Arkansas State Board of Nursing who does not meet the definition of mental health professional, but who is licensed and certified by the State of Arkansas in a related profession and is practicing within the bounds as permitted by his or her licensing authority, or a person employed by a certified RSPMI provider with a high school diploma and documented training in the area of mental health. A mental health paraprofessional may provide certain Rehabilitative Services for Persons with Mental Illness under supervision of a mental health professional.

213.100 Mental Health Paraprofessional Training

The RSPMI Provider is responsible for ensuring all mental health paraprofessionals successfully complete training in mental health service provision from a licensed medical person experienced in the area of mental health, a certified RSPMI Medicaid provider, or a facility licensed by the State Board of Education before providing care to Medicaid recipients.

A. The mental health paraprofessional must receive orientation to the RSPMI Provider agency.

B. The mental health paraprofessional training course must total a minimum of forty (40) hours and must be successfully completed within a maximum time period of two (2) months.

C. The training curriculum must include, but is not limited to:

1. communication skills
2. knowledge of illnesses
3. how to be an appropriate role model
4. behavior management
5. handling emergency situations
6. record keeping: observing recipient; and reporting or recording observations and time or employment records
7. knowledge of clinical limitations
8. knowledge of appropriate relationships with recipient
9. group interaction
10. identification of real issues
11. listening techniques
12. confidentiality
13. knowledge of medications and side effects
14. daily living skills
15. hospitalization procedures single-point-of-entry
16. knowledge of the Supplemental Security Income (SSI) application process
17. knowledge of day treatment models proper placement levels
18. awareness of options

D. A written examination of the mental health paraprofessional's knowledge of the forty (40) hour classroom training curriculum must be successfully completed.

E. Evaluation of the mental health paraprofessional's ability to perform daily living skills (DLS) for mental health services must be successfully completed by means of a skills test.

213.100 Mental Health Paraprofessional Training (Continued)

F. The paraprofessional who successfully completes the training must be awarded a certificate. This certificate must state the person is qualified to work in an agency under professional supervision as a mental health paraprofessional.

G. In-service training sessions are required at a minimum of once per twelve month period after the successful completion of the forty (40) hour training course. The in-service training must total a minimum of eight (8) hours each twelve (12) month period beginning with the date of certification as a paraprofessional and each twelve (12) month period thereafter. The in-service training may be conducted, in part, in the field setting. Documentation of in-service hours will be maintained in the employee's personnel record and will be available for inspection by regulatory agencies.

A mental health paraprofessional who can provide documentation of training or experience in mental health service delivery may be exempt from the forty (40) hour classroom training. This does not exclude the paraprofessional from the requirement of successfully completing an examination and skills test.

All mental health paraprofessionals who provided mental health services for a Medicaid certified RSPMI provider on or before October 1, 1989, and since November 1, 1988, will be certified as mental health paraprofessionals. These mental health paraprofessionals may be exempt from the forty (40) hour classroom training. However, a written examination of the mental health paraprofessional's knowledge of the 40 hour training course must be successfully completed and an evaluation of his or her ability to perform the daily living skills must be successfully completed by means of a skills test. A certificate must be awarded to the mental health paraprofessional and available for review by the Division of Medical Services staff upon request.

214 Facility Requirements

The administration of the program shall be responsible for providing physical facilities which are structurally sound and meet all applicable federal, state and local regulations for adequacy of construction, safety, sanitation and health.

215 Non-Refusal Requirement

The RSPMI provider may not refuse services to a Medicaid eligible recipient unless, based upon the primary mental health diagnosis, the provider does not possess the services or program to adequately treat the recipient's mental health needs.

216 Scope

A range of mental health rehabilitative or palliative services provided by a duly certified RSPMI provider to Medicaid eligible recipients suffering from mental illness as described in the American Psychiatric Association Diagnostic and Statistical Manual (DSM-IV and subsequent revisions).

Rehabilitative Services for Persons with Mental Illness may be covered only when:

A. provided by qualified providers;

B. prescribed by a physician; and

C. provided according to a written plan of care.

The rehabilitation plan of care must be prepared according to guidelines developed and stipulated by the organization's accrediting body. The plan of care must be signed by the physician certifying medical necessity.

217 RSPMI Program Entry

An intake evaluation must be performed for each recipient being considered for entry into a RSPMI Program. The evaluation is a written assessment that evaluates the recipient's mental condition and, based on the patient's diagnosis, determines whether treatment in the RSPMI Program would be appropriate.

The evaluation team must include, at a minimum, a physician and an individual experienced in diagnosis and treatment of mental illness (both criteria may be satisfied by the same individual, if appropriately qualified). For each recipient who enters the program, the assessment must include a certification by the evaluation team that the program is appropriate to meet the recipient's treatment needs. The assessment must be made a part of the patient records.

218.000 Plan of Care

For each recipient who enters the RSPMI program, the evaluation team must develop an individual plan of care (PoC) or treatment plan. This consists of a written, individualized plan to improve the patient's condition to the point where the patient's continued participation in the program (beyond occasional maintenance visits) is no longer necessary. The PoC must be included in the patient records, and contain a written description of the treatment objectives for that patient. It also must describe:

A. The treatment regimen—the specific medical and remedial services, therapies and activities that will be used to meet the treatment objectives;

218.000 Plan of Care (Continued)

B. A projected schedule for service delivery—this includes the expected frequency and duration of each type of planned therapeutic session or encounter;

C. The type of personnel that will be furnishing the services; and

D. A projected schedule for completing reevaluations of the patient's condition and updating the PoC.

The RSPMI plan of care must be completed by a Mental Health Professional and approved by a psychiatrist or physician. Subsequent revisions in the plan of care will be approved in writing by the psychiatrist or physician verifying continued medical necessity.

218.100 Periodic Plan of Care Review

The RSPMI plan of care must be periodically reviewed by the evaluation team in order to determine the patient's progress toward the rehabilitative treatment and care objectives, the appropriateness of the rehabilitative services provided and the need for the enrolled patient's continued participation in the RSPMI Program. The reviews must be performed on a regular basis (at least every 90 days) and the reviews must be documented in detail in the enrolled patient's record, kept on file and made available as requested for state and federal purposes.

219.000 Covered Services

The RSPMI services listed below are available to Medicaid eligible recipients whose primary diagnosis is mental illness. When the primary diagnosis is other than mental illness, example: substance abuse, RSPMI services are not covered by Arkansas Medicaid.

219.100 Outpatient Services

RSPMI outpatient services, based on a plan of care, include a broad range of services to Medicaid eligible recipients. They are described in the following pages as Acute/Outpatient, Acute Day Treatment, Restricted Services and Other Services.

219.110 Acute/Outpatient Services

Diagnosis	The purpose of this service is to determine the existence, type, nature and most appropriate treatment of a mental illness or related disorder as prescribed in DSM-IV. This psychodiagnostic process must be provided by a Mental Health professional and must be supervised by a psychiatrist. It may include, but is not limited to, a psychosocial and medical history, a mental status examination, diagnostic findings and recommendations.
Diagnosis-Psychological Test/Evaluation	This service allows for the administration of a single diagnostic test to a client by a Psychologist or Psychological Examiner. This procedure should reflect the mental abilities, aptitudes, interests, attitudes, motivation, emotional and personality characteristics of the client as prescribed by the purpose of the evaluation.
Diagnosis-Psychological Testing Battery	This service allows for the administration of two (2) or more diagnostic tests to a client by a Psychologist or Psychological Examiner. This battery should assess the mental abilities, aptitudes, interests, attitudes, emotions, motivation and personality characteristics of the client.
Treatment Plan	The plan of treatment is to be developed by a Mental Health Professional at the direction of the responsible physician in accordance with DMHS program standards and Section 224 of this manual. It must include short and long term goals for treatment of the client's mental health needs and must be reviewed every ninety (90) days. (See Section 224.)
Interpretation of Diagnosis	This is a direct service provided by a Mental Health Professional for the purpose of interpreting the results of diagnostic activities to the patient and/or significant others. If significant others are involved, appropriate consent forms may need to be obtained.
Diagnosis-Speech Evaluation	Direct outpatient service delivered by a licensed speech pathologist under the supervision of a licensed physician to a Medicaid eligible recipient for the purposes of determining the existence, type, nature and appropriate treatment of a communicative disorder or condition.
Individual Outpatient-Therapy Session	Scheduled individual outpatient care provided by a Mental Health Professional to a patient for the purposes of treatment and remediation of a condition described in DSM-IV and subsequent revisions.

219.110 Acute/Outpatient Services (Continued)

Marital/Family Therapy	Family therapy shall be treatment provided to two or more family members and conducted by a Mental Health Professional for the purpose of alleviating conflict and promoting harmony. The identified patient does not have to be present at each session. However, sessions may not devolve to the point they become a means of treating others rather than, or in addition to, the primary recipient. All sessions must be directed exclusively toward the treatment of the identified patient. Documentation to support the appropriateness of excluding the identified patient must be maintained in the recipient's record.
Individual Outpatient-Speech Therapy	Scheduled individual outpatient care provided by a licensed speech pathologist supervised by a physician to a Medicaid eligible recipient for the purpose of treatment and remediation of a communicative disorder deemed medically necessary.
Group Outpatient-Speech Therapy	Contact between a group of Medicaid eligible recipients and a speech pathologist for the purpose of speech therapy and remediation.
Group Outpatient-Group Therapy	A direct service contact between a group of patients and one or more Mental Health Professionals for the purposes of treatment and remediation of a psychiatric condition. This procedure does not include psychosocial group activities.
Group Outpatient-Medication Maintenance (Physician)	Group outpatient care by a licensed physician involving evaluation and maintenance of the Medicaid eligible recipient on a medication regimen with simultaneous supportive psychotherapy in a group setting.

219.120 Therapeutic Day/Acute Day Treatment

A structured therapeutic day program of at least two hours duration provided to eligible recipients for the purposes of treatment and symptom remission, and prevention of premature and/or inappropriate use of psychiatric inpatient hospitalization.

Services provided to patients who have any psychiatric symptoms that medically require the client to receive a more structured form of care than outpatient. It differs from the traditional outpatient program in that it requires more structured care for a longer period of time. It is intended for maximum reduction of psychiatric symptoms and for eventual assimilation into the community. The intent is to prevent the need for acute inpatient hospitalization. Day treatment will primarily be provided in the clinic setting, however, it may be provided away from the facility when necessary as a part of the treatment program.

219.130 Restricted RSPMI Services

Restricted RSPMI services may be provided only to individuals certified as having a serious illness. The definition and certification process for serious mental illness is determined by the Division of Mental Health Services.

RSPMI/Assessment-Reassessment and Plan of Care	The purpose of the service is to certify the enrolled patient is eligible for RSPMI services based on diagnosis, past psychiatric history, level of functioning and present support needs, and to delineate the rehabilitative treatment and care to be provided during the certification period. This procedure must be completed by a Mental Health Professional and includes the initial assessment of rehabilitative treatment and care needs, the reassessment of such needs each 180 days and the development and/or updating of an individual RSPMI plan of care for a patient.
Crisis Stabilization Intervention	A scheduled direct service contact between an enrolled patient and a mental health professional or paraprofessional for the purpose of ameliorating a situation which places the client at risk of 24-hour inpatient care or other more restrictive 24-hour placement. The service may be provided within the client's permanent place of residence, temporary domicile or on-site.
On-Site Intervention	A direct service contact occurring on-site between a mental health professional or paraprofessional and an enrolled patient. The purposes of this service are to obtain the full range of needed services, monitor and supervise the patient's functioning, establish support for the patient and gather information relevant to the patient's plan of care.
Off-Site Intervention	A direct service contact occurring off-site between a mental health professional or paraprofessional and an enrolled patient. The purposes of this service are the same as those for on-site intervention.
Rehabilitative Day Service	A direct service rendered to enrolled patients who have psychiatric symptoms that require medical rehabilitation in a more structured form of care than outpatient care for the purposes of maximum reduction of psychiatric symptoms, increased functioning and eventual assimilation into the community. This service is provided primarily in a day program setting by a mental health professional or a mental health paraprofessional supervised by a mental health professional. Services may be provided off-site when necessary as a part of the treatment program.

219.140 Other RSPMI Services

Crisis Intervention	The purposes of this service are to prevent an inappropriate or premature more restrictive placement and/or to maintain the eligible patient in an appropriate outpatient modality. This procedure is an unscheduled direct service contact occurring either on or off-site between an eligible patient with a diagnosable psychiatric disorder and a mental health professional.
Physical Examination	A direct service contact provided to an enrolled RSPMI patient by a psychiatrist or a physician to review a patient's medical history and to examine the patient's organ and body systems functioning for the purposes of determining the status of the patient's physical health. This procedure may occur either on or off-site and must be billed by the RSPMI provider. The physician may not bill for an office visit, nursing home visit or any other outpatient medical services procedure for the same date-of-service.
Medication Maintenance by a Physician	A direct service contact by a psychiatrist or a physician to an enrolled patient for the purposes of determining symptom remission and medication regimen to initiate and/or maintain the enrolled patient's RSPMI plan of care. This service may be provided on or off-site.
Medication Administration by a Licensed Nurse	A direct service contact by a licensed nurse under the supervision of a psychiatrist or physician to an enrolled patient for the purpose of monitoring and/or administering psychotropic medication prescribed by a licensed psychiatrist or physician to maintain the enrolled patient's RSPMI plan of care. This service may be provided on or off-site.
Periodic Plan of Care Review	The periodic review of the RSPMI plan of care by a mental health professional to determine the patient's progress toward the treatment and care objectives, appropriateness of the services provided and need for the enrolled patient's continued participation in the RSPMI program.
Catheterization for Collection of Specimen	A specimen collection may only be provided to patients taking prescribed psychotropic drugs or who are involved in drug abuse as verified through the diagnosis procedure. This service must be performed by a physician or a licensed nurse under the direction of a physician. A specimen collection fee may be allowed only in circumstances which include collecting a urine sample by catheterization.

219.140 Other RSPMI Services (Continued)

Collateral Intervention	A face-to-face service contact by a mental health professional or paraprofessional with other professionals not associated with the RSPMI provider, caregivers, gatekeepers, or other parties on behalf of an identified patient to obtain or share relevant information necessary to the enrolled patient's assessment, plan of care and/or rehabilitation. This service may be provided on or off-site.

219.141 Routine Venipuncture for Collection of Specimen

A specimen collection may only be provided to patients taking prescribed psychotropic drugs or who are involved in drug abuse as verified through the diagnosis procedure.

This service must be performed by a physician or a licensed nurse under the direction of a physician. Arkansas Medicaid policy regarding collection, handling and/or conveyance of specimens is as follows:

A. Reimbursement is not available for specimen handling fees.

B. A specimen collection fee is covered only for:

1. Drawing a blood sample through venipuncture (i.e., inserting into a vein, a needle with syringe or vacutainer, to draw the specimen) or

2. Collecting a urine sample by catheterization.

C. Specimen collection is covered only when the specimen collected is sent to a reference laboratory for tests. Reimbursement for collection of specimen is included in the reimbursement for lab tests when the practitioner, clinic or facility that collects the specimen performs the tests.

219.142 Telemedicine (Interactive Electronic Transactions) RSPMI Services

RSPMI telemedicine services are interactive electronic transactions performed "face-to-face" in real time, via two-way electronic video and audio data exchange.

Effective for claims with dates of service on or after July 1, 2000, the mental health professional may provide certain treatment services from a remote site to the Medicaid eligible recipient age 21 or over who is located in a mental health clinic setting. There must be an employee of the clinic in the same room with the recipient. **Refer to Section III of this manual for billing instructions.**

219.142 Telemedicine (Interactive Electronic Transactions) RSPMI Services (Continued)

The following is a list of services that may be provided electronically by a mental health professional:

1. Diagnosis
2. Interpretation of Diagnosis
3. Individual Outpatient - Therapy Session
4. Marital/Family Therapy
5. Crisis Intervention
6. Assessment/Reassessment and Plan of Care
7. Crisis Stabilization Intervention
8. On-Site Intervention
9. Medication Maintenance by a Physician
10. Collateral Intervention

219.143 Services Available to Nursing Home Residents

The following RSPMI services may be provided to residents of nursing homes who are Medicaid eligible when the services are prescribed according to policy guidelines detailed in this manual:

1. Diagnosis
2. Diagnosis - Psychological Test/Evaluation
3. Diagnosis - Psychological Testing Battery
4. Treatment Plan
5. Interpretation of Diagnosis
6. Individual Outpatient - Therapy Session
7. Crisis Intervention
8. Medication Maintenance by a Physician. (Limited to the administration of psychotropic drugs)

Services provided to nursing home residents may be provided on or off site from the RSPMI provider. The services may be provided in the Long Term Care (LTC) facility if necessary.

220.000 Inpatient Hospital Services

"Inpatient" means a patient who has been admitted to a medical institution on recommendation of a licensed practitioner authorized to admit patients and who is receiving room, board and professional services in the institution on a continuous 24-hour-a-day basis, or who is expected by the institution to receive room, board and professional services for 24-hours or longer.

220.100 Hospital Visits

Inpatient hospital visits are Medicaid covered only for board certified or board eligible psychiatrists employed by the RSPMI provider. Each attending physician is limited to billing one day of care for an inpatient hospital Medicaid covered day, regardless of the number of hospital visits made by the physician.

A "Medicaid covered day" is defined as a day for which the recipient is Medicaid eligible, the patient's inpatient benefit limit has not been exhausted, the patient's inpatient stay is medically necessary, the day is not part of a hospital stay for a non-payable procedure or non-authorized procedure and the claim is filed on time. (See Section III of this manual for information regarding "Timely Filing".)

RSMPI providers may be reimbursed for the following visits made to patients of acute care inpatient hospitals by board certified or board eligible psychiatrists.

1. Initial Observation Care (substitute face-to-face observation for daily rounds)
2. Initial Observation Care (substitute face-to-face observation for daily rounds)
3. Initial Observation Care (substitute face-to-face observation for daily rounds)
4. Initial Hospital Care (Admit-limited)
5. Initial Hospital Care (Admit-intermediate)
6. Initial Hospital Care (Admit-extended visit)
7. Subsequent Hospital Care (daily rounds)
8. Subsequent Hospital Care (daily rounds)
9. Subsequent Hospital Care (daily rounds)
10. Observation or Inpatient Care (admit and discharge the same day)
11. Observation or Inpatient Care (admit and discharge the same day)
12. Observation or Inpatient Care (admit and discharge the same day)
13. Hospital Discharge Day management (Discharge after more than 1 day)
14. Initial Inpatient Consultation
15. Initial Inpatient Consultation
16. Initial Inpatient Consultation
17. Initial Inpatient Consultation
18. Initial Inpatient Consultation

220.200 Inpatient Hospital Services Benefit Limit

There is no inpatient benefit limit for Medicaid eligible individuals under age 21. The benefit limit for general and rehabilitative hospital inpatient services is 24 paid inpatient days per state fiscal year (July 1 through June 30) for Medicaid recipients aged 21 and older. Extension of this benefit is not available.

221.000 Medicaid Utilization Management Program (MUMP)

The Medicaid Utilization Management Program (MUMP) determines covered lengths of stay in inpatient, general and rehabilitative hospitals, in state and out-of-state. The MUMP does not apply to lengths of stay in psychiatric facilities.

Lengths-of-stay determinations are made by the Professional Review Organization (PRO), Arkansas Foundation for Medical Care, Inc. (AFMC), under contract to the Arkansas Medicaid Program.

221.100 MUMP Applicability

A. Medicaid covers up to four (4) days of inpatient service with no certification requirement, except in the case of a transfer (see subpart B, below). If a patient is not discharged before or during the fifth day of hospitalization, additional days are covered only if certified by AFMC.

B. When a patient is transferred from one hospital to another, the stay in the receiving hospital must be certified from the first day.

221.110 MUMP Exemptions

A. Individuals in all Medicaid eligibility categories and all age groups, except recipients under age one (1), are subject to this policy. Medicaid recipients under age one (1) at the time of admission are exempt from the MUMP policy for dates of service before their first birthday.

B. MUMP policy does not apply to inpatient stays for bone marrow, liver, heart, lung, skin and pancreas/kidney transplant procedures.

221.200 MUMP Procedures

MUMP procedures are detailed in the following subsections of this manual:

A. Direct (non-transfer) admissions – subsection 221.210

B. Transfer admissions – subsection 221.220

C. Certifications of inpatient stays involving retroactive eligibility – subsection 221.230

D. Inpatients with third party or Medicare coverage – subsection 221.240

E. Reconsideration reviews of denied extensions – subsection 221.250

221.210 Direct Admissions

A. When the attending physician determines the patient should not be discharged by the fifth day of hospitalization, a hospital medical staff member may contact AFMC and request an extension of inpatient days. The following information is required:

1. Patient name and address (including zip code)
2. Patient birth date
3. Patient Medicaid number
4. Admission date
5. Hospital name
6. Hospital Medicaid provider number
7. Attending physician Medicaid provider number
8. Principal diagnosis and other diagnosis influencing this stay
9. Surgical procedures performed or planned
10. The number of days being requested for continued inpatient stay
11. All available medical information justifying or supporting the necessity of continued stay in the hospital

B. AFMC may be contacted between 8:30 a. m. and 5:00 p.m., Monday through Friday, except holidays, at:

In-state and out-of-state Toll Free: 1-800-426-2234
Fort Smith Exchange: (501) 649-0715

C. Calls for extension of days may be made at any time during the inpatient stay (except in the case of a transfer from another hospital–refer to subsection 221.220).

1. Providers initiating their request after the fourth day must accept the financial liability should the stay not meet necessary medical criteria for inpatient services.

2. When the provider delays calling for extension verification and the services are denied based on medical necessity, the beneficiary may not be held liable.

3. If the fifth day of admission falls on a Saturday, Sunday, or holiday, it is recommended that the hospital provider call for an extension prior to the fifth day if the physician has recommended a continued stay.

221.210 Direct Admissions (Continued)

D. When a Medicaid recipient reaches age one (1) during an inpatient stay, the days from the admission date through the day **before** the patient's birthday are exempt from the MUMP policy. MUMP policy becomes effective on the one-year birthday. The patient's birthday is the first day of the four days not requiring MUMP certification. If the stay continues beyond the fourth day following the patient's first birthday, hospital staff must apply for MUMP certification of the additional days.

E. AFMC utilizes Medicaid guidelines and the medical judgment of its professional staff to determine the number of days to allow.

F. AFMC assigns an authorization number to an approved extension request and sends written notification to the hospital.

G. Additional extensions may be requested as needed.

H. **The certification process under the MUMP is separate from prior authorization requirements.** Prior authorization for medical procedures thus restricted must be obtained by the appropriate providers. Hospital stays for restricted procedures may be disallowed if required prior authorizations are not obtained.

I. **Claims submitted without calling for an extension request will result in automatic denials of any days billed beyond the fourth day. There will be no exceptions granted except for claims reflecting third party liability.**

221.220 Transfer Admissions

If a patient is transferred from one hospital to another, the receiving facility must contact AFMC within 24 hours of admitting the patient to certify the inpatient stay. If admission falls on a weekend or holiday, the provider may contact AFMC on the first working day following the weekend or holiday.

221.230 Retroactive Eligibility

A. If eligibility is determined while the patient is still an inpatient, the hospital may call to request post-certification of inpatient days beyond the first four (4) (or all days if the admission was by transfer) and a concurrent certification of additional days, if needed.

B. If eligibility is determined after discharge the hospital may call AFMC for post-certification of inpatient days beyond the first four (4) (or all days if the admission was by transfer). If certification sought is for a stay longer than 30 days, the provider must submit the entire medical record to AFMC for review.

221.240 Third Party and Medicare Primary Claims

A. If a provider has not requested MUMP certification of inpatient days because there is apparent coverage by insurance or Medicare Part A, but the other payer has denied the claim for non-covered service, lost eligibility, benefits exhausted, etc., post-certification required by the MUMP may be obtained as follows:

1. Send a copy of the third party payer's denial notice to:

AFMC
PO Box 180001
Fort Smith, AR 72918-0001
Attention: Pre-Certification Supervisor

2. Include a written request for post-certification.

3. Include complete provider contact information: full name and title, telephone number and extension.

4. An AFMC coordinator will call the provider contact for the certification information.

B. If a third party insurer pays the provider for an approved number of days, Medicaid will not grant an extension for days beyond the number of days approved by the private insurer.

221.250 Request for Reconsideration

Reconsideration reviews of denied extensions may be expedited by faxing the medical record to AFMC. AFMC will advise the hospital of its decision by the next working day.

AFMC Fax Number:	(501) 649-0004
AFMC Mailing Address:	Arkansas Foundation for Medical Care, Inc. PO Box 180001 Fort Smith, AR 72918
AFMC Physical Site Location:	2201 Brooken Hill Drive Fort Smith, AR 72908

221.260 Post Payment Review

A post payment review of a 30% random sample is conducted on all admissions, including inpatient stays of four days or less, to ensure that medical necessity for the services is substantiated.

222 Approved Service Locations

Rehabilitative Services for Persons with Mental Illness (RSPMI) are covered by Medicaid only in the outpatient setting except for inpatient hospital visits by board-certified psychiatrists.

The services and procedure codes available for billing for RSPMI providers are listed in Section III of this manual.

223 Exclusions

Services not covered under the RSPMI Program include, but are not limited to:

1. room and board residential costs
2. educational services
3. telephone contacts with patient or collateral
4. transportation services, including time spent transporting a recipient for services
5. services to individuals with developmental disabilities that are non-psychiatric in nature, except for testing purposes
6. RSPMI services which are found to be not medically necessary and
7. RSPMI services provided to nursing home residents other than those specified in Section III.

224 Physician's Role

A physician will supervise and coordinate all psychiatric and medical functions as indicated in all patient diagnosis and treatment plans. Medical responsibility shall be vested in a physician, preferably one specializing in psychiatry, who is licensed to practice medicine in Arkansas. If medical responsibility is not vested in a psychiatrist, then psychiatric consultation must be available on a regular basis. For RSPMI enrolled patients, medical supervision responsibility shall include, but is not limited to, the following:

A. The physician will see the patient and review and approve the RSPMI plan of care at least once within 45 days of enrollment of the patient, unless the patient discontinues service prior to being seen by the psychiatrist and it is so documented in the enrolled patient's record.

B. The physician will review and approve the enrolled patient's RSPMI plan of care each 90 days thereafter.

C. The physician will review and approve changes in the enrolled patient's RSPMI plan of care and document approval in the enrolled patient's record.

225 Diagnosis and Clinical Impression

Diagnosis and clinical impression is required in the terminology of the ICD-9-CM.

226.000 Documentation/Record Keeping Requirements

226.100 Retention of Records

All medical records of RSPMI recipients must be completed promptly, filed and retained for a minimum of five (5) years from the date of service or until all audit questions, appeal hearings, investigations or court cases are resolved, whichever is longer. The records must be available, upon request, for audit by authorized representation of the Arkansas Division of Medical Services, the State Medicaid Fraud Control Unit and representatives of the Department of Health and Human Services.

226.200 Documentation

The RSPMI provider must develop and maintain sufficient written documentation to support each medical or remedial therapy, service, activity or session for which Medicaid reimbursement is sought. This documentation, at a minimum, must consist of:

1. the specific services provided,
2. the date and actual time the services were provided (Time frames may not overlap between services. All services must be outside the time frame of other services.),
3. name and title of the person who provided the services,
4. the setting in which the services were provided,
5. the relationship of the services to the treatment regimen described in the plan of care, and
6. updates describing the patient's progress.

Documentation must be legible and concise. The name and title of the person providing the service must reflect the appropriate professional level in accordance with the staffing requirements found in section 213.000. Progress notes must be entered daily. Daily notes may be brief; however, they must meet requirement of item #6 above. Providers may enter weekly progress notes that summarize the recipient's progress in relationship to the plan of care.

All documentation must be available to representatives of the Division of Medical Services at the time of an audit by the Medicaid Field Audit Unit. All documentation must be available at the provider's place of business. No more than thirty (30) days will be allowed after the date on the recoupment notice in which additional documentation will be accepted. Additional documentation will not be accepted after the 30 day period.

227.000 Medical Necessity

RSPMI services are covered by Medicaid only when a determination of medical necessity is certified by the enrolled patient's psychiatrist or physician. In accordance with RSPMI requirements, the psychiatrist or physician must review the RSPMI Assessment and proposed plan of care and evaluate the enrolled patient and identify the recommended medical or remedial services. The medical necessity of the recommended services will be documented by the psychiatrist's or physician's written approval of the RSPMI plan of care. Subsequent revisions of the patient's RSPMI plan of care will also be documented by the psychiatrist's or physician's written approval in the enrolled patient's medical record.

227.100 Medical Necessity for Speech Therapy

Speech therapy services are available to Medicaid eligible recipients. Providers of speech therapy services are required to have in each patient's record a physician prescription for services.

A written prescription is required for speech therapy services signed and dated by the PCP or the attending physician. Form DMS-640 (See page II-23) is required for the prescription. The form must be in the patient's record.

A. The recipient's PCP or attending physician must sign the prescription.

B. A prescription for speech therapy services is valid for 1 year unless the prescribing physician specifies a shorter period of time.

227.110 Extension of Speech Therapy Benefits

All requests for extension of speech therapy benefits must be submitted on the Form DMS-699 (See page II-25). Send the form to:

Division of Medical Services
Utilization Review Section
P.O. Box 1437, Slot S413
Little Rock, AR 72203

Arkansas Division of Medical Services

Occupational, Physical and Speech Therapy for Medicaid Eligible Recipients Under Age 21

PRESCRIPTION/REFERRAL

The PCP or attending physician must use this form to prescribe medically necessary Medicaid therapy services, or may use this form to make a referral for therapy services. The provider shall check the appropriate box to indicate if this form is being used as a 'prescription and referral' or as a 'referral only'.

Prescription and Referral Referral Only

Patient Name: _____ Medicaid ID # _____

Date of Last Physical Examination: _____

Medical Diagnosis: _____

Developmental Diagnosis: _____

Other Diagnosis: _____

Other Diagnosis: _____

Complete this block, if this form is a prescription

Occupational Therapy	**Physical Therapy**	**Speech Therapy**
_____ Minutes per week	_____ Minutes per week	_____ Minutes per week
_____ Duration (months)	_____ Duration (months)	_____ Duration (months)

Other Information: _____

_____

_____

_____

_____ _____

Primary Care Physician Name *(Please Print)* Medicaid Provider Number

_____ _____

Attending Physician Name *(Please Print)* Medicaid Provider Number

_____ _____

Physician Signature *(PCP or attending Physician)* Date

DIVISION OF MEDICAL SERVICES

Benefit Extension Requests
PO Box 1437 Slot S413
Little Rock AR 72203-1437

Request for Extension of Benefits

Provider
Address
Address
City _____ State _____ Zip Code _____

Patient's Name _____

Address _____

City _____ State _____ Zip Code _____

Medicaid ID Number _____ Birthdate _____ Sex _____

Diagnoses _____

Benefit Extensions Requested

Procedure Code	Type of Service Code	Service From Date	Service To Date	Units

Attach a summary and medical records as needed to justify medical necessity.

Medicaid Provider Number _____

Provider's Signature _____ Date _____

Request Disposition

(To be completed by Utilization Review Section)

Approved _____ Denied _____ Control Number _____

Procedure Code	Type of Service Code	Service From Date	Service To Date	Units

228 Utilization Review

The Utilization Review Section of the Arkansas Division of Medical Services has the responsibility for assuring quality medical care for its recipients along with protecting the integrity of both state and federal funds supporting the Medical Assistance Program. These tasks have been mandated by federal regulations. The Utilization Review Team shall:

A. Conduct on-site medical audits for the purpose of verifying the nature and extent of service paid for by the Medicaid Program;

B. Research all inquiries from recipients in response to the Explanation of Medicaid Benefits; and

C. Retrospectively evaluate medical practice patterns and providers' patterns by comparing each provider's pattern to norms and limits set by all the providers of the same specialty.

229 Medicaid Recipient Appeal Process

When an adverse decision is received, the recipient may request a fair hearing of the denial decision.

The appeal request must be in writing and received by the Appeals and Hearings Section of the Department of Human Services within thirty days of the date on the letter explaining the denial of services. Appeal requests must be submitted to:

Department of Human Services
Appeals and Hearings Section
P.O. Box 1437, Slot N401
Little Rock, AR 72203-1437

230 PRIOR AUTHORIZATION

RSPMI services for individuals under age 21 do not require prior authorization. However, certain RSPMI Services must be prior authorized by First Health for individuals age 21 and over. Prior authorization requests must be sent to:

First Health
501 Great Circle Road, Suite 300
Nashville, TN 37228-1310

Telephone: 1-800-770-3084 or (615) 256-3400
Fax: 1-800-639-8982 or (615) 256-0772

Procedure codes requiring prior authorization:

Z0568	Z1541
Z0574	Z1542
Z0577	Z1543
Z1539	Z1545
Z1540	Z1549

240 REIMBURSEMENT

Reimbursement is based on the lesser of the billed amount or the Title XIX (Medicaid) maximum allowable for each procedure.

Reimbursement is contingent upon eligibility of both the recipient and provider at the time the service is provided and upon accurate completeness of the claim filed for the service. The provider is responsible for verifying that the recipient is eligible for Medicaid prior to rendering services.

A. Outpatient Services

RSPMI services are billed on a per unit basis. A unit of service for an outpatient service is fifteen (15) minutes unless otherwise stated in Section III. Any unit less than five (5) minutes in duration is not considered a valid length of service and should not be submitted to Medicaid for payment. To determine how many units should be submitted on the claim, follow these steps. Begin by totaling the number of minutes of service rendered and divide by fifteen (15). If the remainder is five (5) or greater, round up to the next highest unit, but if the remainder is less than five (5), the quotient will be the valid units of service.

Providers may collectively bill for a single date of service but may not collectively bill for spanning dates of service. For example, an RSPMI service may occur on behalf of a recipient on Monday and then again on Tuesday. The RSPMI provider may bill for the total amount of time spent on Monday and the total amount of time spent on Tuesday but may not bill for the total amount of time spent both days as a single date of service. The maximum allowable for a procedure is the same for all RSPMI providers.

B. Inpatient Services

The length of time and number of units that may be billed for inpatient hospital visits are determined by the description of the service in *Current Procedural Terminology (CPT).*

241 Rate Appeal Process

A provider may request reconsideration of a Program decision by writing to the Assistant Director, Division of Medical Services. This request must be received within 20 calendar days following the application of policy and/or procedure or the notification of the provider of its rate. Upon receipt of the request for review, the Assistant Director will determine the need for a Program/Provider conference and will contact the provider to arrange a conference if needed. Regardless of the Program decision, the provider will be afforded the opportunity for a conference, if he/she so wishes, for a full explanation of the factors involved and the Program decision. Following review of the matter, the Assistant Director will notify the provider of the action to be taken by the Division within 20 calendar days of receipt of the request for review or the date of the Program/Provider conference.

If the decision of the Assistant Director, Division of Medical Services is unsatisfactory, the provider may then appeal the question to a standing Rate Review Panel established by the Director of the Division of Medical Services which will include one member of the Division of Medical Services, a representative of the provider association and a member of the Department of Human Services (DHS) Management Staff who will serve as chairman.

The request for review by the Rate Review Panel must be postmarked within 15 calendar days following the notification of the initial decision by the Assistant Director, Division of Medical Services. The Rate Review Panel will meet to consider the question(s) within 15 calendar days after receipt of a request for such appeal. The question(s) will be heard by the panel and a recommendation will be submitted to the Director of the Division of Medical Services.

312.000 Covered Services Codes

312.100 Substance Abuse Diagnosis Codes

RSPMI services are not covered by Arkansas Medicaid for an individual of any age whose primary diagnosis is substance abuse. When a claim is filed for any RSPMI service, if the primary diagnosis code is listed below, the claim will deny.

291.0	303.00	305.20
291.4	303.90	305.30
291.8	304.00	305.40
292.0	304.10	305.50
292.11	304.20	305.60
292.12	304.30	305.70
292.81	304.40	305.90
292.82	304.50	317
292.83	304.60	318.0
292.84	304.90	318.1
292.89	305.00	318.2
292.9	305.10	319

312.200 Non-Restricted Outpatient Procedure Codes

PROCEDURE CODE	DESCRIPTION	MAXIMUM UNITS PER DAY
Z0560	Diagnosis	8
Z0561	Diagnosis - Psychological Test/Evaluation	8
Z0562	Diagnosis - Psychological Testing Battery	8
Z0563	Treatment Plan	2
Z0564	Interpretation of Diagnosis	4
Z0568	Individual Outpatient - Therapy Session	4
Z0571	Marital/Family Therapy	6
92506	Diagnosis - Speech Evaluation – 1 unit=30 minutes Maximum units per SFY (July 1-June 30)=4 units	4
Z1926	Individual Outpatient - Speech Therapy, Speech Language Pathologist	4
Z2265	Individual Outpatient - Speech Therapy, Speech Language Pathologist Assistant	4
Z1927	Group Outpatient - Speech Therapy, Speech Language Pathologist	4
Z2266	Group Outpatient - Speech Therapy, Speech Language Pathologist Assistant	4
Z0574	Group Outpatient - Group Therapy	6
Z0575	Group Outpatient - Medication Maintenance by a Physician	6
Z0577	Therapeutic Day - Acute Day Treatment – 8 units minimum	32

312.200 Non-Restricted Outpatient Procedure Codes (Continued)

PROCEDURE CODE	DESCRIPTION	MAXIMUM UNITS PER DAY
Z1536	Crisis Intervention	8
Z1544	Physical Examination - Psychiatrist or Physician	3
Z1545	Medication Maintenance by a Physician	2
Z1546	Medication Administration by a Licensed Nurse	Per routine
Z1578	Periodic Review of Plan of Care	2
Z1913	Routine Venipuncture for Collection of Specimen	Per routine
P9615	Catheterization for Collection of Specimen	Per routine
Z1547	Collateral Intervention, Mental Health Professional	4
Z1548	Collateral Intervention, Mental Health Paraprofessional	4

312.300 Restricted Outpatient Procedure Codes

PROCEDURE CODE	DESCRIPTION	MAXIMUM UNITS PER DAY
Z1537	RSPMI/Assessment - Reassessment and Plan of Care, billed as 1 unit	As necessary
Z1538	Crisis Stabilization Intervention, Mental Health Professional	12
Z1539	Crisis Stabilization Intervention, Mental Health Paraprofessional	12
Z1540	On-Site Intervention, Mental Health Professional	6
Z1541	On-Site Intervention, Mental Health Paraprofessional	6
Z1542	Off-Site Intervention, Mental Health Professional	6
Z1543	Off-Site Intervention, Mental Health Paraprofessional	6
Z1549	Rehabilitative Day Service, 192 units per week maximum	none

312.400 Inpatient Hospital Procedure Codes

RSMPI providers may be reimbursed for the following visits made to patients of acute care inpatient hospitals by board-certified or board eligible psychiatrists. **These procedure codes must be billed using type of service (TOS) 1.**

Procedure Code	Description
99218	Initial Observation Care (substitute face-to-face observation for daily rounds)
99219	Initial Observation Care (substitute face-to-face observation for daily rounds)
99220	Initial Observation Care (substitute face-to-face observation for daily rounds)
99221	Initial Hospital Care (Admit-limited)
99222	Initial Hospital Care (Admit-intermediate)
99223	Initial Hospital Care (Admit-extended visit)
99231	Subsequent Hospital Care (daily rounds)
99232	Subsequent Hospital Care (daily rounds)
99233	Subsequent Hospital Care (daily rounds)
99234	Observation or Inpatient Care (admit and discharge the same day)
99235	Observation or Inpatient Care (admit and discharge the same day)
99236	Observation or Inpatient Care (admit and discharge the same day)
99238	Hospital Discharge Day management; 30 minutes or less (Discharge after more than one day in hospital)
99251	Initial Inpatient Consultation
99252	Initial Inpatient Consultation
99253	Initial Inpatient Consultation
99254	Initial Inpatient Consultation
99255	Initial Inpatient Consultation

312.500 Telemedicine RSPMI Services Billing Information

A. Procedure Codes

Effective for claims with dates of service on or after July 1, 2000, the mental health professional may provide certain treatment services from a remote site to the Medicaid eligible recipient age 21 or over who is located in a mental health clinic setting.

312.500 Telemedicine RSPMI Services Billing Information (Continued)

The following is a list of services that may be provided electronically by a mental health professional:

Z0560 Diagnosis
Z0564 Interpretation of Diagnosis
Z0568 Individual Outpatient - Therapy Session
Z0571 Marital/Family Therapy
Z1536 Crisis Intervention
Z1537 Assessment/Reassessment and Plan of Care
Z1538 Crisis Stabilization Intervention
Z1540 On-Site Intervention
Z1545 Medication Maintenance by a Physician
Z1547 Collateral Intervention

B. Billing Instructions

RSPMI Medicaid providers who provide covered telemedicine services must comply with the definitions and coding requirements outlined below when billing Medicaid.

1. Telemedicine transactions involve interaction between a mental health professional and a recipient who are in different locations. The recipient must be in a mental health clinic setting.

Telemedicine Site Definitions

Local Site: The local site is the patient's location.
Remote Site: The remote site is the location of the mental health professional performing a telemedicine service for the recipient at the local site.

2. The mental health professional at the remote site must use the following type of service code to bill Medicaid for telemedicine services.

Telemedicine (Remote Site) Type of Service Codes

V Services provided by the Mental Health Professional at the remote site.

3. The place of service code is determined by the patient's location (the local site). The remote site is *never* the place of service.

Telemedicine Place of Service Codes

H RSPMI Clinic (Telemedicine)

312.600 Services Available to Nursing Home Residents

The following RSPMI procedure codes are payable to an RSPMI provider for services provided to residents of nursing homes who are Medicaid eligible when prescribed according to policy guidelines detailed in this manual:

Z0560	Diagnosis
Z0561	Diagnosis - Psychological Test/Evaluation
Z0562	Diagnosis - Psychological Testing Battery
Z0563	Treatment Plan
Z0564	Interpretation of Diagnosis
Z0568	Individual Outpatient - Therapy Session
Z1536	Crisis Intervention
Z1545	Medication Maintenance by a Physician. (Limited to the administration of psychotropic drugs)

Services provided to nursing home residents may be provided on or off site from the RSPMI provider. The services may be provided in the Long Term Care (LTC) facility if necessary.

Reserved

Reserved

Reserved

Reserved

Reserved