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

TO: **Arkansas Medicaid Health Care Providers – Rehabilitative Services for Persons with Mental Illness (RSPMI)**

DATE: **June 1, 2005**

SUBJECT: **Provider Manual Update Transmittal No. 48**

REMOVE		**INSERT**	
Section	**Date**	**Section**	**Date**
202.000	10-13-03	202.000	6-1-05
216.000 – 217.000	10-1-04	216.000 – 217.000	6-1-05
217.111 – 217.113	10-13-03	217.111 – 217.113	6-1-05
218.100	10-1-04	218.100	6-1-05
219.120	10-1-04	219.120 – 219.123	6-1-05
223.000	10-13-03	223.000	6-1-05
226.200	10-13-03	226.200	6-1-05

Explanation of Updates

Section 202.000 is included to explain that certain persons may not be enrolled or remain enrolled as Medicaid providers.

Section 216.000 and 217.000 are included to clarify when claims may be made.

Section 217.111 is included to delete the local procedure codes that are no longer valid.

Sections 217.112 and 217.113 are included to state that a retroactive PCP referral, if obtained, must be received within 45 days after the date of service.

Section 218.100 explains that the next treatment plan review 90-day clock begins to run on the earliest date set forth on the form that contains the treatment plan.

Section 219.120 is included to clarify when claims for restricted services may be made.

Sections 219.121 through 219.123 have been added to explain the process for providing restricted services.

Section 223.000 is included to more clearly explain that reimbursement for other RSPMI services is not allowed for the period of time the Medicaid recipient is in transport.

Section 226.200 is included to correct an error regarding progress notes.

Paper versions of this update transmittal have updated pages attached to file in your provider manual. See Section I for instructions on updating the paper version of the manual. For electronic versions, these changes will be automatically incorporated.

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

If you have questions regarding this transmittal, please contact the EDS Provider Assistance Center at 1-800-457-4454 (toll free) within Arkansas or locally and out of state at (501) 376-2211.

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.

Thank you for your participation in the Arkansas Medicaid Program.

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Roy Jeffus, Director

202.000 Arkansas Medicaid Participation Requirements for RSPMI 6-1-05

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), a Medicaid contract (form DMS-653) and a Request for Taxpayer Identification Number and Certification (Form W-9) with the Arkansas Medicaid Program. **View or print a provider application (form DMS-652), Medicaid contract (form DMS-653) and Request for Taxpayer Identification Number and Certification (Form W-9).**

C. A provider must be certified by the Division of Behavioral Health Services (DBHS). (See section 202.100 for certification requirements.)

D. A copy of the current DBHS certification as an RSPMI provider must accompany the provider application and Medicaid contract. Subsequent certifications must be provided when issued.

Enrollment as a Medicaid provider is conditioned upon approval of a completed provider application and the execution of a Medicaid Provider Contract.

DMS shall exclude providers for the reasons stated in 42 U.S.C. §1320c-7(a) and implementing regulations and may exclude providers for the reasons stated in 42 U.S.C. §1320c-7(b) and implementing regulations. The following factors shall be considered by DHS in determining whether sanction(s) should be imposed:

A. Seriousness of the offense(s)

B. Extent of violation(s)

C. History of prior violation(s)

D. Whether an indictment or information was filed against the provider or a related party as defined in DHS Policy 1088, titled DHS Participant Exclusion Rule.

216.000 Scope 6-1-05

A range of mental health rehabilitative or palliative services is 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. Approved by a physician within 14 calendar days of entering care,

C. Provided according to a written treatment plan/plan of care, and

D. Provided to outpatients only except as described in section 252.130.

E. In order to be valid, the treatment plan/plan of care must:

1. Be prepared according to guidelines developed and stipulated by the organization's accrediting body and
2. Be signed and dated by the physician who certifies medical necessity.

If the beneficiary receives care under the treatment plan, the initial treatment plan/plan of care must be approved by the physician within 14 calendar days of the initial receipt of care.

The physician's signature is not valid without the date signed.

217.000 RSPMI Program Entry 6-1-05

Prior to providing treatment services, 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 recipient's diagnosis, determines whether treatment in the RSPMI Program would be appropriate. The assessment must be made a part of the recipient's records.

The intake evaluation must be conducted by a mental health professional qualified by licensure and experienced in the diagnosis and treatment of mental illness.

For each recipient served through the RSPMI Program, the treatment team must certify that the program is appropriate to meet the recipient's needs. This certification must be documented in the recipient record within 14 calendar days of the person's entering continued care (first billable service), through treatment team signatures on the treatment plan/plan of care. The treatment team must include, at a minimum, a physician and an individual qualified, by licensure and experience, in diagnosis and treatment of mental illness. (Both criteria may be satisfied by the same individual, if appropriately qualified.)

217.111 Procedure Codes Not Requiring PCP Referral for Recipients Under Age 21 6-1-05

Services designated by the following HCPCS procedure codes **do not** require PCP referral:

A. 90801 – Diagnosis;

B. 90885 – Treatment Plan;

C. 90887 – Interpretation of Diagnosis;

D. H2011 – Crisis Intervention and

E. T1023 – Assessment/Reassessment and Plan of Care.

217.112 Medicaid Eligible at the Time the Service is Provided 6-1-05

As stated above, a PCP referral is required for Medicaid beneficiaries under age 21. It is recommended that the provider obtain the PCP referral prior to providing service to Medicaid-eligible children. However, a PCP is given the option of providing a referral after a service is provided. If a PCP chooses to make a referral after a service has been provided, the referral must be received by the RSPMI provider no later 45 calendar days after the date of service. The PCP has no obligation to give a retroactive referral.

The RSPMI provider may not file a claim and will not be reimbursed for any services provided that require a PCP referral unless the referral is received.

217.113 Medicaid Ineligible at the Time the Service is Provided 6-1-05

A. When a child who is not eligible for Medicaid receives an outpatient mental health service, an application for Medicaid eligibility may be filed by the child or his or her representative.

B. If the application for Medicaid coverage is approved, a PCP referral is not required for the period prior to the Medicaid authorization date. This period is considered retroactive eligibility and does not require a referral.

C. A PCP referral is required no later than forty-five calendar days after the authorization date. If the PCP referral is not obtained within forty-five calendar days of the Medicaid authorization date, reimbursement will begin (if all other requirements are met) the date the PCP referral is received.

   A PCP is given the option of providing a referral after a service is provided. However, the PCP has no obligation to give a retroactive referral. The RSPMI provider may not file a claim and will not be reimbursed for any services provided that require a PCP referral unless the referral has been received.

   To verify the authorization date, a provider may call EDS or the local DHS office. **View or print EDS PAC contact information.** **View or print the DHS office contact information.**

218.100 Periodic Plan of Care Review 6-1-05

The RSPMI treatment plan/plan of care must be periodically reviewed by the treatment team in order to determine the recipient's progress toward the rehabilitative treatment and care objectives, the appropriateness of the rehabilitative services provided and the need for the enrolled recipient's continued participation in the RSPMI Program. The reviews must be performed on a regular basis (at least every 90 calendar days), documented in detail in the enrolled recipient's record, kept on file and made available as requested for state and federal purposes. If provided more frequently, there must be documentation of significant acuity or change in clinical status requiring an update in the recipient's treatment plan/plan of care. The clock for the 90-day review begins to run on the earliest date set forth on the form that contains the treatment plan.

219.120 Restricted RSPMI Services 6-1-05

Restricted RSPMI services may be provided only to individuals certified as having a serious mental illness (for individuals age 18 or older) or serious emotional disturbance (children and adolescents under the age of 18). The definition and certification process for serious mental illness and serious emotional disturbance is determined by the Division of Behavioral Health Services (DBHS). For individuals who receive any restricted services during the first 14 calendar days after entering care, the physician certification form must be completed, signed and dated by the physician within 14 calendar days of the individual's entering care (first billable service).

219.121 Determining Eligibility for Restricted Services for Recipients Age 21 and Over 6-1-05

A form to be completed and filed in the patient record to establish the need for restricted services for Medicaid recipients age 21 and over may be found on the DBHS web site. The form must be completed and filed in the patient record.

219.122 Determining Eligibility for Restricted Services for Recipients Under Age 21 6-1-05

A form to be completed and filed in the patient record to establish the need for restricted services for Medicaid recipients under age 21 may be found on the DBHS web site. The form must be completed and filed in the patient record.

219.123 The Division of Behavioral Services Web Site 6-1-05

Forms for the determination of eligibility to receive restricted services are available for downloading from the DBHS Web site (**http://www.arkansas.gov/dhs/dmhs/**).

223.000 Exclusions 6-1-05

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

A. Room and board residential costs;

B. Educational services;

C. Telephone contacts with patient or collateral;

D. Transportation services, including time spent transporting a recipient for services **(reimbursement for other RSPMI services is not allowed for the period of time the Medicaid recipient is in transport)**;

E. Services to individuals with developmental disabilities that are non-psychiatric in nature, except for testing purposes;

F. RSPMI services which are found not to be medically necessary and

G. RSPMI services provided to nursing home residents other than those specified in section 252.150.

226.200 Documentation 6-1-05

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:

A. The specific services provided,

B. 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.),

C. Name and title of the person who provided the services,

D. The setting in which the services were provided,

E. The relationship of the services to the treatment regimen described in the plan of care and

F. 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.

For Therapeutic Day/Acute Day and Rehabilitative Day Services, daily progress notes must be entered the day the service is delivered. Daily notes may be brief; however, they must meet requirement of item F 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.