Arkansas Department of Health and Human Services

Division of Medical Services

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TO: **Arkansas Medicaid Health Care Providers – Rehabilitative Services for Persons with Physical Disabilities**

DATE: **March 1, 2006**

SUBJECT: **Provider Manual Update Transmittal #38**

REMOVE		**INSERT**	
Section	**Date**	**Section**	**Date**
201.100 – 201.300	9-1-05	201.100 – 201.300	3-1-06
210.100 – 213.300	10-13-03	210.100 – 213.300	3-1-06
215.000	10-13-03	215.000	3-1-06
217.110 – 217.120	10-13-03	217.110 – 217.120	3-1-06
217.131	10-13-03	217.131	3-1-06
217.133	10-13-03	217.133	3-1-06
217.200 – 240.000	10-13-03	217.136 – 240.000	3-1-06

Explanation of Updates

Sections 201.100 through 201.300 are included to add the new provider participation and enrollment procedures.

Sections 210.100 through 213.300 contain minor wording and grammatical changes.

Section 215.000 contains minor wording changes.

Sections 217.110 through 217.120 are included because the wording in these sections has been updated.

Section 217.131 has been updated with new information and provides clarity about how the Arkansas Foundation for Medical Care (AFMC) reviews extension requests on RSPD admissions.

Section 217.133 is included to correct a minor grammatical error.

Section 217.136 is a new section titled “Administrative Reconsideration of Extension of Benefits Denial“. This section is being added to comply with the Medicaid Fairness Act of 2005.

Section 217.137 is a new section titled “Appealing an Adverse Action”. This section is being added to comply with the Medicaid Fairness Act of 2005. It explains that information about the appeals process is located in Section I of the manual.

Sections 217.200, 217.300 and 218.000 contain minor wording changes.

Section 219.000 has been deleted and replaced by section 217.137 which now discusses the appeals process that was previously located in this section.

Section 240.000 is included to correct a minor grammatical error.

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 have already been 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

SECTION II - REHABILITATIVE SERVICES FOR PERSONS WITH PHYSICAL DISABILITIES (RSPD)

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201.100 Residential Rehabilitation Centers 3-1-06

Residential rehabilitation centers must meet licensure, accreditation and enrollment requirements to participate as RSPD providers in the Arkansas Medicaid Program.

A. A residential rehabilitation center must meet the following licensure requirements:

1. Licensed by the Arkansas Department of Health and Human Services, Office of Long Term Care, as a Post Acute Head Injury Retraining and Residential Care Facility and
2. Licensed by the Arkansas Department of Health and Human Services, Division of Children and Family Services, as a Residential Child Care Facility

or

3. Licensed as a Long-Term Care Facility that:
   a. Provides transitional rehabilitation of pediatric patients as defined in Ark. Code Ann § 20-8-101(7) and
   b. Operates a designated section of the facility for pediatric patients whose anticipated stay at the time of admission is six months or less.

B. A residential rehabilitation center must meet one of the following accreditation requirements:

1. Accredited by the Commission on Accreditation of Rehabilitation Facilities (CARF).

or

2. Accredited by the Joint Commission on Accreditation of Healthcare Organization (JCAHO) as a Residential Treatment Program for Post Acute Head Injury Rehabilitation.

C. A residential rehabilitation center must meet the following provider enrollment requirements:

1. The residential rehabilitation center must complete and submit to the Medicaid Provider Enrollment Unit 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).**
2. A copy of the current licenses and accreditation must accompany the provider application and the Medicaid contract.
3. Enrollment as a Medicaid provider is conditioned upon approval of a completed provider application and the execution of a Medicaid provider contract. Persons and entities that are excluded or debarred under any state or federal law, regulation or rule are not eligible to enroll or to remain enrolled, as Medicaid providers.
4. Subsequent licenses and accreditation must be forwarded to Provider Enrollment within 30 days of issuance. If the renewal document(s) have not been received within this timeframe, the provider will have an additional and final 30 days to comply.
5. Failure to timely submit verification of license and accreditation renewal will result in termination of enrollment in the Arkansas Medicaid Program.

201.200 Extended Rehabilitative Hospital 3-1-06

The extended rehabilitative hospital must meet the following participation requirements in order to be enrolled as an RSPD provider in the Arkansas Medicaid Program:

A. The extended rehabilitative hospital service provider must complete and submit to the Medicaid Provider Enrollment Unit 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).**

B. The extended rehabilitative hospital must be licensed by the Division of Health, Arkansas Department of Health and Human Services, as a Rehabilitative Hospital. A copy of the current license must accompany the provider application and the Medicaid contract. When a beneficiary is dually eligible for Medicare and Medicaid, Medicare must be billed prior to billing Medicaid. The beneficiary may not be billed for the charges. Providers enrolled to participate in the Title XVlll (Medicare) Program must notify the Arkansas Medicaid Program of their Medicare provider number. Claims filed by Medicare "nonparticipating" providers do not automatically cross over to Medicaid for payment of deductibles and coinsurance.

   A copy of subsequent license renewal must be provided when issued.

C. The extended rehabilitative hospital must be certified as a Title XVIII (Medicare) Rehabilitative Hospital provider. A copy of the current certification must accompany the provider application and the Medicaid contract.

D. Enrollment as a Medicaid provider is conditioned upon approval of a completed provider application and the execution of a Medicaid provider contract. Persons and entities that are excluded or debarred under any state or federal law, regulation or rule are not eligible to enroll or to remain enrolled, as Medicaid providers.

E. Renewal documents must be forwarded to the Medicaid Provider Enrollment Unit within 30 days of issuance. If the renewal document(s) have not been received within this timeframe, the provider will have an additional, and final, 30 days to comply.

F. Failure to timely submit verification of license and certification renewals will result in termination of enrollment in the Arkansas Medicaid Program.

201.300 State-Operated Extended Rehabilitative Hospital 3-1-06

The state-operated extended rehabilitative hospital must meet the following participation requirements in order to be enrolled as an RSPD provider in the Arkansas Medicaid Program:

A. The state-operated extended rehabilitative hospital service provider must complete and submit to the Medicaid Provider Enrollment Unit 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).**

B. The state-operated extended rehabilitative hospital must be licensed by the Division of Health, Arkansas Department of Health and Human Services, as a Rehabilitative Hospital. A copy of the current license must accompany the provider application and the Medicaid contract.

   A copy of subsequent license renewal must be provided when issued.

C. The state-operated extended rehabilitative hospital must be certified as a Title XVIII (Medicare) Rehabilitative Hospital provider. A copy of the current certification must accompany the provider application and the Medicaid contract. When a beneficiary is dually eligible for Medicare and Medicaid, Medicare must be billed prior to billing Medicaid. The beneficiary may not be billed for the charges. Providers enrolled to participate in the Title XVlll (Medicare) Program must notify the Arkansas Medicaid Program of their Medicare provider number. Claims filed by Medicare "non-participating" providers do not automatically cross over to Medicaid for payment of deductibles and coinsurance.

D. The state-operated extended rehabilitative hospital must be operated by an Arkansas state agency.

E. Enrollment as a Medicaid provider is conditioned upon approval of a completed provider application and the execution of a Medicaid provider contract. Persons and entities that are excluded or debarred under any state or federal law, regulation or rule are not eligible to enroll or to remain enrolled, as Medicaid providers.

F. Renewal documents must be forwarded to Provider Enrollment within 30 days of issuance. If the renewal document(s) have not been received within this timeframe, the provider will have an additional and final 30 days to comply.

G. Failure to timely submit verification of license and certification renewals will result in termination of enrollment in the Arkansas Medicaid Program.

210.000 PROGRAM COVERAGE 10-13-03

210.100 Introduction 3-1-06

The Medical Assistance Program (Medicaid) is designed to assist eligible Medicaid beneficiaries in obtaining medical care within the guidelines specified in Section I of this manual. *All Medicaid benefits are based upon medical necessity.*

211.000 Scope 3-1-06

Rehabilitative Services for Persons with Physical Disabilities (RSPD) services are provided for Medicaid-eligible beneficiaries when prescribed by a licensed physician and deemed medically necessary by the Quality Improvement Organization (QIO).

"*Rehabilitative services*" include medical or remedial services recommended by a physician or other licensed practitioner of the healing arts, within the scope of his or her practice under state law, for maximum reduction of physical or mental disability and restoration of a beneficiary to his or her best possible functional level. (Throughout this manual, "physician" also includes "other licensed practitioners of the healing arts.")

RSPD services require a medical referral from the beneficiary's primary care physician (PCP), unless the beneficiary's is exempted from the PCP requirements.

RSPD services covered under the Arkansas Medicaid Program must be provided:

A. By a qualified RSPD provider enrolled in the Arkansas Medicaid Program.

B. By an RSPD provider selected by the beneficiary.

C. With certification from the facility-based interdisciplinary team that the beneficiary meets the criteria for RSPD services (see section 212.000).

D. As prescribed by a licensed physician.

E. According to a written plan of care.

F. By a facility that is not part of a hospital. The facility must be organized and operated to provide rehabilitative services to residential patients.

G. To an eligible Medicaid beneficiary who is not an inpatient (see below) of a hospital, nursing facility (NF), intermediate care facility for the mentally retarded (ICF/MR) or other institution.

"*Inpatient*" means a patient who has been admitted to a medical institution on the recommendation of a physician or dentist and is receiving room, board and professional services in the institution on a continuous 24 hours a day basis or who is expected by the institution to receive room, board and professional services for a 24 hour period or longer.

Residential rehabilitation centers provide RSPD services only to individuals who are under age 21 years. There is no age restriction for RSPD services provided in extended rehabilitative hospitals and state-operated extended rehabilitative hospitals.

When the admission criteria and the Medicaid Utilization Management Program (MUMP) procedures have been met, the Medicaid Program will cover RSPD services from the date of admission through the last day before the Medicaid patient is discharged from the facility. The date of the discharge is not covered by Medicaid.

212.000 The Facility-Based Interdisciplinary Team 3-1-06

The RSPD provider must have a facility-based interdisciplinary team consisting of the following medical personnel:

A. Neuropsychologist and/or physician, licensed to practice in the State of Arkansas.

B. At a minimum, at least one of the following must be employed or contracted by the facility to provide services to Medicaid beneficiaries who are admitted to the facility:

1. Registered Nurse, licensed to practice in the State of Arkansas, with at least one year's experience or specialized training in the rehabilitation treatment setting.
2. Occupational Therapist, licensed to practice in the State of Arkansas.
3. Physical Therapist, licensed to practice in the State of Arkansas.

212.100 Responsibilities of the Facility-Based Interdisciplinary Team 3-1-06

The responsibilities of the facility-based interdisciplinary team include the following:

A. Assessing the beneficiary's immediate and long range therapeutic needs.

B. Assessing the beneficiary's developmental priorities, personal strengths and liabilities.

C. Assessing the potential social resources of the beneficiary and the beneficiary's family.

D. Developing the beneficiary's plan of care.

E. Setting treatment objectives.

F. Prescribing therapeutic modalities to achieve the objectives of the individual plan of care.

213.000 Admission Criteria 3-1-06

Medicaid beneficiaries are eligible for RSPD services for up to four (4) days if they meet each of the following admission criteria:

A. Medical necessity (section 213.100)

B. Medical profile (section 213.200)

C. Medical diagnosis (section 213.300)

RSPD admissions are subject to reviews by the Quality Improvement Organization (QIO). If the QIO or the Director of the Medicaid Program later determines that an RSPD admission was not medically necessary, Medicaid will not cover the RSPD services and the patient cannot be liable for payment of the services.

(To certify a Medicaid beneficiary for RSPD services beyond four [4] days, refer to section 217.100).

213.100 Medical Necessity 3-1-06

RSPD services are covered by Medicaid for eligible beneficiaries when medically necessary. The medical necessity criteria include:

A. A prescription from a licensed physician stating that the Medicaid beneficiary needs RSPD services. An individualized plan of care may serve as the prescription for services. The prescription or plan of care must be signed and dated by the physician.

B. The physician must have examined the patient within the thirty (30) days preceding the date of the written prescription or plan of care.

C. The prescription or plan of care will be effective for up to three (3) months from the prescription date and must be renewed before services may continue beyond three (3) months.

Persons needing rehabilitative services on a less intensive basis than those provided in the inpatient setting may receive outpatient rehabilitative services through other appropriate Medicaid services, e.g., outpatient hospital, physical therapy, occupational therapy, speech therapy, rehabilitative services for persons with mental illness (RSPMI) and home health.

213.200 Medical Profile 3-1-06

Medicaid beneficiaries must meet the following medical profile prior to admission to an RSPD facility:

A. Ability to communicate through spoken, written, gestural/environmental cues.

B. Absence of acute medical problems.

C. Adequate nutrition maintained without intravenous (IV) administration.

D. Does not require treatment for drug or alcohol abuse, unless secondary to their injury.

E. Does not require a ventilator.

F. Free from any communicable disease that would require total isolation.

G. Mentally and physically able to participate in an intensive rehabilitation program (minimum of 3 hours daily).

H. Motivated to live in the community.

I. Must be medically stable.

J. Must depend on others for self-care, mobility or safety.

K. Requires at least two (2) rehabilitation services, one of which must be a restorative therapy. (Refer to section 215.000.)

213.300 Medical Diagnosis 3-1-06

As part of the admission process to an RSPD facility, Medicaid beneficiaries must meet the medical diagnosis criteria specified below.

A. Residential Rehabilitation Center

Persons eligible for admission to a residential rehabilitation center must have at least one of the following neurological conditions:

Post acute traumatic or acquired brain injury. This includes and is limited to viral encephalitis, meningitis, aneurysms, cerebral vascular accident/stroke, post-operative tumors, anoxia, hypoxias, toxic encephalopathies, refractory seizure disorders and congenital neurological brain disorders. These conditions can be with or without moderate to severe behavioral disorders secondary to a brain injury.

B. Extended Rehabilitative Hospital

Persons eligible for admission must have at least one of the following neurological conditions:

Post acute traumatic or acquired brain injury. This includes and is limited to viral encephalitis, meningitis, aneurysms, cerebral vascular accident/stroke, post-operative tumors, anoxia, hypoxias, toxic encephalopathies, refractory seizure disorders and congenital neurological brain disorders. These conditions can be with or without moderate to severe behavioral disorders secondary to a brain injury.

C. State-Operated Extended Rehabilitative Hospital

Persons eligible for admission must have at least one of the following neurological conditions:

1. Post acute traumatic or acquired brain injury. This includes and is limited to viral encephalitis, meningitis, aneurysms, cerebral vascular accident/stroke, post-operative tumors, anoxia, hypoxias, toxic encephalopathies, refractory seizure disorders and congenital neurological brain disorders. These conditions can be with or without moderate to severe behavioral disorders secondary to a brain injury.
2. Post acute traumatic injuries or congenital disorders of the spinal cord.

215.000 Covered Services 3-1-06

RSPD is a global service, covering all rehabilitative, psychological and/or social services required of the admitting facility for licensure, certification and/or accreditation. This includes evaluations, therapies and visits by a licensed practitioner that are directly related to the beneficiary's rehabilitative adjustment.

Licensed practitioners visiting the beneficiary for reasons related to the beneficiary's rehabilitation treatment and/or the plan of care might not bill Medicaid for the services separately. However, medical visits and treatment not related to the beneficiary's rehabilitation and/or plan of care might be billed separately by the practitioner, if the service is a Medicaid covered service.

Specialty services are not included in the RSPD global service coverage. Therefore, Medicaid-enrolled specialists, such as neurologists, who see a beneficiary due to an injury may bill the Medicaid Program for any Medicaid covered service rendered.

A provider who renders medical services (e.g., physician, hospital, etc.) that are not included in the RSPD global service coverage must be an Arkansas Medicaid provider and bill the Arkansas Medicaid Program before they can be reimbursed.

The following services are included in the RSPD global coverage:

A. Restorative Therapies – Restorative therapies include physical, occupational, speech and cognitive therapy. These therapies are provided in an individual or group setting.

B. Behavioral Rehabilitation – Behavioral rehabilitation includes diagnosis, evaluation and treatment of aggression, depression, denial and other common behavioral problems. Behavioral rehabilitation shall address the needs of individuals who have experienced significant personality changes as a result of stroke, illness or serious accident. These services help decrease and control disruptive behaviors and improve coping skills.

C. Life Skills Training – Activities of daily living that are rehabilitative in nature.

D. Individual and Group Counseling – These services shall be provided for individuals who are suffering from psychological/adjustment disorders, or substance abuse secondary to their injury or illness. Family counseling may be included in this service when the services are directed exclusively to the effective treatment of the beneficiary and are included in the beneficiary's plan of care.

E. Assessment Services – These services assess an individual's potential for functional improvement. Under the direction of a neuropsychologist and/or physician, a team of specialists provides an evaluation of the beneficiary. The team provides continuous testing during the residential stay as determined medically necessary by the neuropsychologist and/or physician.

F. Nursing Care – This service provides the availability of registered nursing services 24 hours a day.

217.110 MUMP Applicability 3-1-06

Medicaid beneficiaries are allowed up to four (4) days of RSPD services as long as the admission criteria (refer to sections 213.000 through 213.300) are met. If a patient is not discharged before or during the fifth day of the residential stay, *AFMC must certify any additional days beyond the initial four (4) days.*

When a patient is transferred from one RSPD facility to another, the stay must be certified by AFMC from the first day of transfer. (See Transfer Admissions, section 217.132.)

217.120 MUMP Exemption 3-1-06

Individuals in all Medicaid eligibility categories and all age groups, except beneficiaries under age 1, are subject to MUMP procedures. Medicaid beneficiaries under age 1 at the time of admission are exempt from the MUMP procedures for dates of service before their first birthday. (For MUMP procedures *on* and *after* a child's first birthday, see section 217.131, item D.)

217.131 Extension of RSPD Admissions 3-1-06

A. When the RSPD provider's neuropsychologist and/or physician determines that a patient (age 1 year or older) should not be discharged by the fifth day of residential stay due to the need for continued services, an RSPD medical staff member must contact AFMC and request an extension of the RSPD admission. To request an extension, an RSPD medical staff member must call AFMC. **View or print AFMC contact information.** The following information is required:

1. Patient's name and address (including ZIP code).
2. Patient's date of birth.
3. Patient's Medicaid ID number.
4. Admission date.
5. Name of the RSPD provider.
6. RSPD Medicaid provider number.
7. Principal diagnosis and other diagnoses influencing this stay.
8. The number of days being requested for continued residential stay.
9. All available medical information justifying or supporting the necessity for continued stay in the RSPD facility.

B. AFMC may be contacted at 1-800-426-2234 between the hours of 8:30 a.m. and 12:00 noon and 1:00 and 5:00 p.m., Monday through Friday, with the exception of holidays. View or print AFMC contact information. All calls are limited to 10 minutes to allow equal access to all providers and they will be monitored for quality assurance purposes.

C. Calls requesting an extension of the RSPD admission may be made at any time during the stay (except in the case of a transfer from another RSPD facility, refer to section 217.132). However, the following will apply:

1. RSPD providers initiating their request after the fourth day must accept the financial liability should the stay not meet the medical criteria for continued RSPD services.
2. If the provider delays calling for an extension and the services are denied based on the lack of medical necessity, the patient will not be held liable.

D. For a Medicaid patient under age 1, the days from the admission date through the day **before** the patient's first birthday are exempt from the MUMP procedures. MUMP procedures become 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, the RSPD medical staff must apply for MUMP certification to extend the RSPD admission.

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

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

G. Additional extensions may be requested if more days are needed beyond AFMC's original extension.

H. If the extension request is denied by a physician advisor with AFMC, the RSPD provider may request an expedited reconsideration review by sending the medical record (through regular mail or by overnight express) to AFMC for review and determination. The provider must specify that an expedited reconsideration is being requested. The RSPD provider will

be notified of the decision by the next working day. **View or print the AFMC contact information.**

I. Providers may request administrative reconsideration of an adverse decision or they can appeal as provided in section 190.003 of this manual.

J. If the denial is because of incomplete documentation, but complete documentation that supports medical necessity is submitted with the reconsideration request, the nurse may approve the extension of benefits without referral to a physician advisor.

K. If the denial is because there is no proof of medical necessity or the documentation does not allow for approval by the nurse, the original documentation, reason for denial and new information submitted will be referred to a different physician advisor for reconsideration.

L. All parties will be notified in writing of the outcome of the reconsideration.

M. Medicaid claims submitted without calling AFMC for an extension request will result in automatic denials of any days billed beyond the fourth day. The only exception is claims involving third party liability. (See section 217.134.)

217.133 Retroactive Medicaid Eligibility 3-1-06

A. If retroactive Medicaid eligibility is determined prior to discharge of the patient, the RSPD provider may call AFMC to request post-certification of the days beyond the first four (4) days (or all days if the admission was by transfer) and a concurrent extension for additional days, if needed.

B. If the retroactive Medicaid eligibility is determined after discharge, the RSPD provider may call AFMC to request post-certification of the days beyond the first four (4) days (or all days if the admission was by transfer). If the certification is requested for a length-of-stay longer than thirty (30) days, the provider must submit the entire medical record to AFMC for review. (Refer to section 217.200 for the annual benefit limit on the length-of-stays.)
View or print the AFMC contact information.

217.136 Administrative Reconsideration of Extension of Benefits Denial 3-1-06

A request for administrative reconsideration of an extension of benefits denial must be in writing and sent to AFMC within 30 calendar days of the denial. The request must include a copy of the denial letter and additional supporting documentation.

The deadline for receipt of the reconsideration request will be enforced pursuant to sections 190.012 and 190.013 of this manual. A request received by AFMC within 35 calendar days of a denial will be deemed timely. A request received later than 35 calendar days will be considered on an individual basis.

217.137 Appealing an Adverse Action 3-1-06

Please see section *190.003* for information regarding administrative appeals.

217.200 Facility Limitation 3-1-06

The benefit limits will apply to each of the RSPD facilities as specified below:

A. Residential Rehabilitation Center

1. RSPD services provided in a residential rehabilitation center are limited to Medicaid-eligible beneficiaries who are under the age of 21 years.
2. Medicaid beneficiaries who are under the age of 21 years and in the Child Health Services (EPSDT) Program are not limited to a thirty (30) day annual benefit limit.

B. Extended Rehabilitative Hospital

1. RSPD services provided in an extended rehabilitative hospital are not age limited.
2. RSPD services provided in an extended rehabilitative hospital are limited to thirty (30) days per state fiscal year, July 1 through June 30, for ages 21 and older. **No extensions will be considered.** However, beneficiaries who are under the age of 21 years and in the Child Health Services (EPSDT) Program are not limited to the thirty (30) day annual benefit limit.
3. The thirty (30) day annual benefit limit only applies to services provided in an RSPD facility and does not include days counted toward any other Medicaid Program benefit limit, e.g., hospital, nursing home, etc.

C. State-Operated Extended Rehabilitative Hospital

1. RSPD services provided in a state-operated extended rehabilitative hospital are not age limited.
2. RSPD services provided in a state-operated extended rehabilitative hospital are limited to thirty (30) days per state fiscal year, July 1 through June 30, for ages 21 and older. **No extensions will be considered.** However, beneficiaries who are under the age of 21 years and in the Child Health Services (EPSDT) Program are not limited to the thirty (30) day annual benefit limit.
3. The thirty (30) day annual benefit limit only applies to services provided in an RSPD facility and does not include days counted toward any other Medicaid Program benefit limit, e.g., hospital, nursing home, etc.

217.300 Services Limitation 3-1-06

Because certain services would either result in a duplication (i.e., the service is included in the RSPD global coverage) or would not be appropriate for persons residing in an RSPD facility, services in the below listed Medicaid Programs are not available to Medicaid beneficiaries who have received RSPD services on the same date of service. These include:

A. Developmental Day Treatment Clinic Services (DDTCS).

B. Developmental Disabilities Services (DDS) Alternative Community Services (ACS) Waiver Services.

C. ElderChoices.

D. Home Health.

E. Hospice.

F. Hyperalimentation (Parenteral Nutrition).

G. Individual or Group Psychological Therapy/Counseling or Testing.

H. Inpatient Hospital (Acute Care/General and/or Rehabilitative).

I. Inpatient Psychiatric Services for Under Age 21.

J. Nursing Home.

K. Personal Care.

L. Occupational, Physical, or Speech Therapy, including evaluations.

M. Private Duty Nursing Services.

N. Rehabilitative Services for Persons with Mental Illness (RSPMI).

O. Targeted Case Management.

P. Ventilator Equipment.

218.000 Absent Days from the RSPD Facility 3-1-06

The Arkansas Medicaid Program will not cover the days the beneficiary is absent from the facility, regardless of the reason for absenteeism. When a beneficiary is absent from the facility, the RSPD provider must document when the beneficiary left the facility, if possible, why the beneficiary left, where the beneficiary was going and, when applicable, the beneficiary's expected return date.

When a beneficiary is absent, the RSPD provider must follow one of the following procedures:

A. Formally discharge the beneficiary, regardless of the length of absenteeism. If the beneficiary is to be readmitted, the RSPD provider must formally admit the beneficiary upon return by following all normal admission policies as stated in this manual.

or

B. Allow the beneficiary up to seven (7) days to return to the RSPD facility.

1. If the beneficiary returns to the RSPD facility within seven (7) days, the RSPD provider must conduct a plan of care review within three (3) days of the beneficiary's return and modify the plan of care as necessary.
2. If the beneficiary does not return to the RSPD facility within seven (7) days, the RSPD provider must formally discharge the beneficiary. If the beneficiary is to be readmitted, the RSPD provider must formally admit the beneficiary by following the normal procedures, as stated in this manual.

240.000 PRIOR AUTHORIZATION 3-1-06

Prior authorization does not apply to RSPD services. Extended RSPD services after the initial four (4) days must follow the MUMP procedures in sections 217.100 through 217.135.