ARKANSAS DEPARTMENT OF HUMAN SERVICES

Division of Medical Services

Program Development & Quality Assurance

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

DATE: **January 15, 2012**

SUBJECT: **Provider Manual Update Transmittal #RSPMI-3-11**

REMOVE		**INSERT**	
Section	**Date**	**Section**	**Date**
228.330	7-1-10	228.330	1-15-12
228.331	11-1-04	228.331	1-15-12
228.332	7-1-10	228.332	1-15-12
228.333	11-1-04	228.333	1-15-12
228.334	11-1-04	228.334	1-15-12
228.335	11-1-04	228.335	1-15-12

Explanation of Updates

Section 228.330 is updated to include current information about retrospective reviews of outpatient mental health services provided by RSPMI providers.

Section 228.331 is updated to revise the purpose for retrospective reviews of outpatient mental health services provided by RSPMI providers.

Section 228.332 is updated to explain the process of choosing a case for review and instructions for submitting medical records if chosen for review.

Section 228.333 is updated to provide information regarding the review process of a retrospective review.

Sections 228.334 and 228.335 are set to Reserved. The content in these sections is deleted.

The paper version of this update transmittal includes revised pages that may be filed 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 have questions regarding this transmittal, please contact the HP Enterprise Services Provider Assistance Center at 1-800-457-4454 (Toll-Free) within Arkansas or locally and Out-of-State at (501) 376-2211.

If you need this material in an alternative format, such as large print, please contact our Americans with Disabilities Act Coordinator at 501-682-0593 (Local); 1-800-482-5850, extension 2-0593 (Toll-Free) or to obtain access to these numbers through voice relay, 1-800-877-8973 (TTY Hearing Impaired).

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.

Eugene I. Gessow, Director

TOC is required

228.330 Retrospective Reviews 1-15-12

The Division of Medical Services (DMS) of the Arkansas Department of Human Services has contracted with a Quality Improvement Organization (QIO) or QIO-like organization to perform retrospective (post payment) reviews of outpatient mental health services provided by RSPMI providers. **View or print ValueOptions contact information.**

The reviews will be conducted by licensed mental health professionals who will examine the medical record for compliance with federal and state laws and regulations.

228.331 Purpose of the Review 1-15-12

The purpose of the review is to:

A. Ensure that services are delivered in accordance with the plan of care and conform to generally accepted professional standards.

B. Evaluate the medical necessity of services provided to Medicaid beneficiaries.

C. Evaluate the clinical documentation to determine if it is sufficient to support the services billed during the requested period of authorized services.

D. Safeguard the Arkansas Medicaid program against unnecessary or inappropriate use of services and excess payments in compliance with 42 CFR § 456.3(a).

228.332 Review Sample and the Record Request 1-15-12

On a calendar quarterly basis, the contractor will select a statistically valid random sample from an electronic data set of all RSPMI beneficiaries whose dates of service occurred during the three-month selection period. If a beneficiary selected in any of the three calendar quarters prior to the current selection period, then they will be excluded from the sample and an alternate beneficiary will be substituted. The utilization review process will be conducted in accordance with 42 CFR § 456.23.

A written request for medical record copies will be mailed to each provider who provided services to the beneficiaries selected for the random sample along with instructions for submitting the medical record. The request will include the beneficiary's name, date of birth, Medicaid identification number and dates of service. The request will also include a list of the medical record components that must be submitted for review. The time limit for a provider to request reconsideration of an adverse action/decision stated in § 1 of the Medicaid Manual shall be the time limit to furnish requested records. If the requested information is not received by the deadline, a medical necessity denial will be issued.

All medical records must be submitted to the contractor via fax, mail or ProviderConnect. **View or print ValueOptions contact information.** When faxing or mailing records, send them to the attention of "Retrospective Review Process." Records will not be accepted via email.

228.333 Review Process 1-15-12

The record will be reviewed using a review tool based upon the promulgated Medicaid RSPMI manual. The review tool is designed to facilitate review of regulatory compliance, incomplete documentation and medical necessity. All reviewers must have a professional license in nursing or therapy (LCSW, LMSW, LPE, LPC, RN, etc.). The reviewer will screen the record to determine whether complete information was submitted for review. If it is determined that all requested information was submitted, then the reviewer will review the documentation in more

detail to determine whether it meets medical necessity criteria based upon the reviewer's professional judgment.

If a reviewer cannot determine that the services were medically necessary, then the record will be given to a psychiatrist for review. If the psychiatrist denies some or all of the services, then a denial letter will be sent to the provider and the beneficiary. Each denial letter contains a rationale for the denial that is record specific and each party is provided information about requesting reconsideration review or a fair hearing.

The reviewer will also compare the paid claims data to the progress notes submitted for review. When documentation submitted does not support the billed services, the reviewer will deny the services which are not supported by documentation. If the reviewer sees a deficiency during a retrospective review, then the provider will be informed that it has the opportunity to submit information that supports the paid claim. If the information submitted does not support the paid claim, the reviewer will send a denial letter to the provider and the beneficiary. Each denial letter contains a rationale for the denial that is record-specific and each party is provided information about requesting reconsideration review or a fair hearing.

Each retrospective review, and any adverse action resulting from a retrospective review, shall comply with the Medicaid Fairness Act. DMS will ensure that its contractor(s) is/are furnished a copy of the Act.

228.334 Reserved **1-15-12**

228.335 Reserved **1-15-12**