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: **July 1, 2011**

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

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

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 add a third 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 denial of services as the result of a retrospective review.

Section 228.334 is updated to provide information regarding reconsideration of denial of services as the result of a retrospective review.

Section 228.335 is updated to provide information regarding the recoupment process for claims that the contractor denies on retrospective review.

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.

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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

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228.330 Retrospective Reviews 7-1-11

The Division of Medical Services (DMS) of the Arkansas Department of Human Services has contracted with the Quality Improvement Organization (QIO-like), ValueOptions®, 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 7-1-11

The purpose of the review is to:

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

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

C. Ensure that the Arkansas Medicaid program safeguards against unnecessary or inappropriate use of services and excess payments in compliance with 42 CFR 456.3(a).

228.332 Cases Chosen for Review 7-1-11

On a calendar quarterly basis, the contractor will select and review a statistically valid random sample of all RSPMI services billed and paid during the past three months (previous quarter). The written request for record copies will be posted on ProviderConnect and mailed to each provider along with instructions for submitting the medical record. The request will include the beneficiary's name, date of birth, Medicaid identification number, dates of service, type of service, date of request and the medical record. The provider(s) must submit the information to the contractor within 35 calendar days of the request date printed in the record request cover letter. If the requested information is not received within the 35 day timeframe, 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 Audits." Records will not be accepted via email.

228.333 Denial/Due Process 7-1-11

If the retrospective review results in a denial of services, the contractor will send a denial notification letter that outlines the rationale for the denial and includes instructions for requesting reconsideration. The denial notification letter will also be posted on ProviderConnect.

228.334 Reconsideration 7-1-11

A request for administrative reconsideration of the denial of services must be in writing and sent to the contractor within 35 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 the contractor within 35 calendar days of a denial will be deemed timely. Reconsideration requests must be submitted via fax, mail or ProviderConnect. Reconsideration requests will not be accepted via email.

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If the request is received timely, the contractor will review the additional information and determine if the services can be approved. If approved, the contractor will reverse the previous denial. If the services were denied due to lack of medical necessity and the additional information submitted for reconsideration does not support medical necessity, the case will be referred to a physician for final determination.

The contractor may approve or deny all or part of the services. A written notification of the outcome of the reconsideration review will be mailed to all parties and posted on ProviderConnect. This notification will include a case-specific rationale for upholding or overturning the denial.

The decision of the contractor, upon reconsideration, is final.

228.335 Recoupments 7-1-11

DMS will initiate the recoupment process for all claims that the contractor has denied on retrospective review.

DMS will send the provider an Explanation of Recoupment Notice that will include the claim date of service, Medicaid beneficiary name and ID number, service provided, amount paid by Medicaid, amount to be recouped and the reason for the recoupment. (See Sections 150.000, 160.000 and 190.000 for more information.)

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