ARKANSAS DEPARTMENT OF HUMAN SERVICES

**Division of Medical Services**
**Program Development & Quality Assurance**

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**TO:** **Arkansas Medicaid Health Care Providers – Substance Abuse Treatment Services**

**DATE:** **July 1, 2011**

**SUBJECT:** **Provider Manual Update Transmittal #SATS-New-11**

| **REMOVE** | | **INSERT** | |
|---|---|---|---|
| **Section** | **Date** | **Section** | **Date** |
| ___ | ___ | ALL | 7-1-11 |

**Explanation of Updates**

A new Substance Abuse Treatment Services (SATS) policy manual is available for all SATS providers.

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

# SECTION II – SUBSTANCE ABUSE TREATMENT SERVICES (SATS)

## CONTENTS

# 200.000 SUBSTANCE ABUSE TREATMENT SERVICES (SATS) GENERAL INFORMATION

## 201.000 Introduction 7-1-11

Medicaid (Medical Assistance) is designed to assist eligible Arkansas Medicaid beneficiaries in obtaining medical care within the guidelines specified in Section I of this manual. Substance Abuse Treatment Services (SATS) are covered by Arkansas Medicaid when provided to eligible Arkansas Medicaid beneficiaries by enrolled providers.

SATS may be provided to eligible Arkansas Medicaid beneficiaries at all provider facility certified sites. Allowable places of service are found in Section 252.200.

## 201.100 Electronic Signatures 7-1-11

Medicaid will accept electronic signatures provided the electronic signatures comply with Arkansas Code 25-31-103.

## 202.000 Arkansas Medicaid Participation Requirements for SATS 7-1-11

In order to ensure quality and continuity of care, all SATS providers approved to receive Arkansas Medicaid reimbursement for services to Arkansas Medicaid beneficiaries must meet specific qualifications for their services and staff. Providers with multiple service sites must enroll each site separately and reflect the actual service site on billing claims.

SATS providers must meet the Provider Participation and Enrollment requirements contained within Section 140.000 of this manual, as well as the following criteria, to be eligible to participate in the Arkansas Medicaid Program as a SATS provider.

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

B. A provider must be certified by the Division of Behavioral Health Services (DBHS) as a SATS provider, unless otherwise stated in this manual. (See Section 202.100 for certification requirements.)

C. A copy of the current DBHS certification as a SATS provider must accompany the provider application and Arkansas Medicaid contract, unless otherwise stated in this manual.

**NOTE: For participation in the SATS Program, both the billing provider and the performing provider must be certified by DBHS and enrolled in the Arkansas Medicaid program. Enrollment criteria are as follows:**

**BILLING PROVIDERS** – Arkansas Medicaid provider application and Arkansas Medicaid contract, along with the SATS certification issued by DBHS.

**PERFORMING PROVIDERS** – Arkansas Medicaid provider application and Arkansas Medicaid contract, along with the SATS certification issued by DBHS AND a document verifying the employer/employee relationship between a certified SATS billing provider and the individual professional/paraprofessional. Documentation may be an employer/employee contract or a W-4 form.

**EXCEPTION: Physicians and Advance Practice Nurses *enrolled in the Arkansas Medicaid Program* are not required to be certified by DBHS; however, they must verify their employer/employee relationship with a certified SATS billing provider as described above and submit a copy of their current professional license.**

### 202.100 Certification Requirements by the Division of Behavioral Health Services (DBHS) 7-1-11

SATS providers must furnish documentation of certification from the Division of Behavioral Health Services (DBHS) establishing that the provider is accredited in the delivery of substance abuse treatment services to be furnished by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), the Commission on Accreditation of Rehabilitation Facilities (CARF), the Council on Accreditation (COA) or other national accreditation approved by DBHS. Providers must meet all other certification requirements in addition to accreditation.

Certification requirements for SATS providers may be found at **www.arkansas.gov/dhs/dmhs/**.

## 210.000 PROGRAM COVERAGE

### 211.000 Coverage of Services 7-1-11

Substance Abuse Treatment Services (SATS) are limited to providers who offer evidence-based practices of Substance Abuse Treatment Services as approved by the Division of Behavioral Health Services (DBHS). The provider must be certified as a SATS provider by DBHS, unless otherwise stated in this manual.

### 212.000 Quality Assurance 7-1-11

Each SATS provider must establish and maintain a quality assurance committee that will examine the clinical records for completeness, adequacy and appropriateness of care, 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 7-1-11

Each SATS provider shall ensure that a Certified Clinical Supervisor (CCS) recognized by the Arkansas Substance Abuse Certification Board or a Registered Clinical Supervisor recognized by the Arkansas Board of Examiners of Alcoholism and Drug Abuse Counselors (BEADAC) is available to provide supervision of all clinical activities. SATS staff members must provide services only within the scope of their individual licensure and according to established policy in the SATS Medicaid program. It is the responsibility of the facility to credential each clinical staff member, specifying the areas in which he or she can practice based on training, experience and demonstrated competence. All staff must have a contractual or salaried employee relationship with the certified SATS provider.

The following are eligible to provide SAT services (see Section 252.110-252.120) in the Arkansas Medicaid Program.

Contracted and salaried staff must meet all professional requirements as defined in the state licensing and certification laws relating to their respective professions. Professionals include the following:

1. Board certified or board eligible Psychiatrist
2. Arkansas Medicaid enrolled licensed Physician in the state of Arkansas
3. Advanced Practice Nurse (APN) who has a collaborative agreement with a Physician licensed in the state of Arkansas
4. Physician Assistant
5. Licensed Alcoholism and Drug Abuse Counselor (LADAC)
6. Advanced Certified Alcoholism and Drug Abuse Counselor (ACADC)

7. Certified Co-Occurring Disorder Professional – Diplomate Level (CCDP-D)

With the addition of substance abuse credentials (LADAC, ACADC, CCDP-D), the following may provide substance abuse clinical services:

1. Licensed Certified Social Worker (LCSW) and Licensed Master Social Worker (LMSW), which must have approved supervision
2. Licensed Professional Counselor (LPC) and Licensed Marriage and Family Therapist (LMFT) and Licensed Associate Counselor (LAC), which must have approved supervision
3. Psychologist
4. Psychological Examiner (LPE-I) licensed to practice independently
5. Psychological Examiner (LPE) under the supervision of a Psychologist

Effective for dates of service on and after July 1, 2011, when a SATS provider files a claim with Arkansas Medicaid, the staff member who actually performed the service on behalf of the SATS provider must be identified on the claim as the performing provider. SATS staff members must be enrolled in the Arkansas Medicaid program and be identified on claims.

This action is taken in compliance with the federal Improper Payments Information Act of 2002 (IPIA), Public Law 107-300 and the resulting Payment Error Rate Measurement (PERM) program initiated by the Centers for Medicare and Medicaid Services (CMS).

Certain types of practitioners who perform services on behalf of a SATS provider are paraprofessionals that will be required to be certified by DBHS as a SATS paraprofessional and enroll in the Arkansas Medicaid program. The following persons may provide Substance Abuse Care Coordination (H0006) while under the supervision of a Certified Clinical Supervisor (CCS) recognized by the Arkansas Substance Abuse Certification Board or a Registered Clinical Supervisor recognized by the Arkansas Board of Examiners of Alcoholism and Drug Abuse Counselors (BEADAC):

1. Certified Alcohol and Drug Counselor (CADC)
2. Certified Co-Occurring Disorder Professional – Bachelors Level (CCDP-B)
3. Certified Co-Occurring Disorder Professional – Associate Level (CCDP-A)
4. Licensed Associate Alcoholism and Drug Abuse Counselor (LAADAC)
5. Counselor in Training (CIT) as defined by ADAP licensing standards

## 214.000 Facility Requirements 7-1-11

The administrator of the program shall be responsible for providing physical facilities that are structurally sound and meet all applicable federal, state and local regulations for adequacy of construction, safety, sanitation, health and compliance with the Americans with Disabilities Act.

## 215.000 Scope 7-1-11

A range of substance abuse treatment services is provided by a duly certified SATS provider to Medicaid-eligible beneficiaries with a substance abuse diagnosis, as described in the American Psychiatric Association Diagnostic and Statistical Manual (DSM-IV and subsequent revisions).

Substance Abuse Treatment Services are covered when:

A. Provided by qualified providers

B. Approved by the psychiatrist or physician identified, contracted or employed by the SATS facility

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

D. Provided to outpatients only

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

2. Be signed and dated by the psychiatrist or physician who certifies medical necessity

Services provided prior to the date of the psychiatrist's or physician's signature are not reimbursable through the SATS Program. Until the treatment plan is signed and dated by the psychiatrist or physician, no SATS are considered covered, other than Addiction Assessment – H0001.

The psychiatrist's or physician's signature is not valid without the date signed. The treatment plan must be signed by a psychiatrist or physician participating in the treatment of the beneficiary. The psychiatrist or physician provides supervision and oversight for all medical and treatment services provided by the agency. A psychiatrist or physician will supervise and coordinate all services as indicated in treatment plans. Medical responsibility shall be vested in the psychiatrist or physician.

## 216.000 SATS Program Entry 7-1-11

Eligibility for the SATS Program will be determined by American Society of Addiction Medicine (ASAM) criteria.

Prior to providing treatment services, an Addiction Assessment for a new beneficiary (H0001) must be completed for each beneficiary considered for entry into a SATS Program.

The Addiction Assessment is a written evaluation that identifies and evaluates the nature and extent of the beneficiary's use/abuse/addiction to alcohol and/or other substances and identifies any co-morbid conditions. The Addiction Assessment must result in the assignment of a diagnostic impression and support effective treatment in the SATS Program. The Addiction Assessment also results in the patient placement recommendation for the treatment regimen appropriate to the condition and situation presented by the beneficiary. The Addiction Assessment must be available in the beneficiary's records.

The Addiction Assessment must be conducted face-to-face by a substance abuse professional qualified by licensure and experienced in the diagnosis of substance abuse and according to SATS Program policy guidelines. An Addiction Assessment must include the components set forth in the DBHS SATS Manual.

## 216.100 Primary Care Physician (PCP) Referral 7-1-11

A PCP referral is **NOT** required for SAT services. However, continuity of care and the medical home model is encouraged by Arkansas Medicaid.

## 217.000 Treatment Planning (T1007) 7-1-11

For each beneficiary entering the SATS Program, the treatment team must develop an individualized treatment plan. This consists of a written, individualized plan to treat, ameliorate, diminish, stabilize, or maintain remission of symptoms of substance abuse that threaten life, or cause pain or suffering, resulting in diminished or impaired functional capacity. The treatment plan must include goals and objectives based on individualized service needs identified in the completed Addiction Assessment. The treatment plan must be included in the beneficiary records and contain a written description of the treatment objectives for that beneficiary.

The treatment plan is a person-centered plan and developed in cooperation with the individual (parent or guardian if the individual is under 18) to deliver specific addiction services to the

individual to restore, improve or stabilize the individual's condition. The plan must be based on individualized service needs identified in the completed Addiction Assessment.

For each beneficiary served through the SATS Program, the treatment team must certify that the program can meet the beneficiary's needs, based on established program policy guidelines. This certification must be documented in the beneficiary record within 14 calendar days of the initial contact 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 substance abuse. Both criteria may be satisfied by the same individual, if qualified.

**NOTE: All beneficiaries diagnosed with both a mental health and substance abuse diagnosis require an integrated treatment approach, including both mental health and substance abuse treatment. If the beneficiary is receiving services in both the RSPMI and SATS Program, the RSPMI provider will bill for the assessment, treatment planning, etc., and not the SATS provider. A provider cannot bill for both RSPMI and SATS assessments and treatment planning for the same beneficiary. A beneficiary receiving services in the RSPMI program may not have a separate treatment plan in the SATS Program. These billing rules apply to all providers involved in the mental health and substance abuse treatment for the beneficiary. Clinical records must be integrated to provide a cohesive treatment course with no duplication of services from one program to the next. Providers are required to share treatment documentation.**

The treatment plan must also describe:

A. Beneficiary identification information, including full name and address, date of birth, Medicaid ID number, effective date of SATS eligibility (indicated by psychiatrist's or physician's signature and the date signed on the treatment plan) and expiration date of the treatment plan

B. The treatment regimen—the specific individualized medical and remedial services, therapies and activities determined and designed to meet the treatment objectives

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

D. The credentials of personnel that will be furnishing the services

E. A projected schedule for completing reevaluations of the patient's condition and updating the treatment plan

Substance Abuse services, other than the initial assessment, are not reimbursable prior to the development of the treatment plan, signed and dated by a psychiatrist or physician. The effective date of the treatment plan is the date of the psychiatrist's or physician's signature. The effective date and the expiration date must be reflected on the treatment plan. Medicaid expenditures paid for services rendered and billed prior to the date of the psychiatrist's or physician's signature on the treatment plan are subject to recoupment.

**Provisional (no billable procedure code) and Comprehensive Treatment Plans (T1007)**

At the time of the initial Addiction Assessment, a provisional treatment plan for the beneficiary is to be developed. This provisional treatment plan must be signed and dated by the professional who conducted the Addiction Assessment. The provisional treatment plan determines if the SAT services will meet the beneficiary's current needs. The provisional treatment plan also identifies placement recommendation for treatment regimen appropriate to the condition and situation presented by the beneficiary and referral into a service appropriate to effectively treat the condition(s) identified. The assessment process results in the assignment of a diagnostic impression if applicable, patient placement recommendation for treatment regimen appropriate to

the condition and situation presented by the beneficiary, provisional treatment plan recommendations until the comprehensive treatment plan is completed (including physician signature and date) and referral to a service appropriate to effectively treat the condition(s) identified. This service may or may not be provided by a psychiatrist or physician.

If signed by a professional other than a psychiatrist or physician, the plan of care is not reimbursable and is considered a provisional plan of care. No later than 14 days from the development of the provisional plan of care, a comprehensive treatment plan must be developed and signed by a psychiatrist or physician. The development of the comprehensive treatment plan is reimbursable.

The provisional treatment plan may be used to request prior authorization for services; however, until the comprehensive treatment plan is signed and dated by the psychiatrist or physician (Treatment Planning – New Beneficiary – T1007), no SATS will be reimbursed.

The SATS comprehensive treatment plan must be completed and signed by a psychiatrist or physician prior to the delivery of any substance abuse outpatient services (other than the Addiction Assessment – H0001).

The SATS comprehensive treatment plan must be completed by a professional and approved by a psychiatrist or physician, within 14 calendar days of the beneficiary's first contact and must include the components set forth in the DBHS Licensure Standards for Alcohol and/or Other Drug Abuse Treatment Programs (Pg. 29: CTP1).

The comprehensive treatment plan developed for a new beneficiary may be effective for no more than one (1) year from the date of the psychiatrist's or physician's signature. The expiration date of the comprehensive treatment plan will be entered on the first page of the plan. Backdating treatment plans is not allowed and is subject to recoupment.

**Periodic Revisions to the Treatment Plan (no billable procedure code)**

While the comprehensive treatment plan may be effective for one (1) year from the date of the psychiatrist's or physician's signature, the plan may be revised at any time, based on need and medical necessity established through the prior authorization process.

**A SATS treatment plan must be reviewed once every 90 days in order to continue providing SAT services through the Arkansas Medicaid program. The 90-day review must be documented in the beneficiary's medical file.** Subsequent revisions in the treatment plan will be approved in writing (signed and dated) by the psychiatrist or physician verifying continued medical necessity prior to services being rendered. All revisions to the treatment plan become effective on the date of the psychiatrist's or physician's signature next to the change on the treatment plan. Backdating treatment plans is not allowed and is subject to recoupment.

**IMPLEMENTATION PLAN**

The SATS provider must develop an implementation plan that ensures services are:

A. Individualized to the beneficiary's unique circumstances

B. Provided in the least restrictive environment possible

C. Developed using a process that ensures participation of those concerned with the beneficiary's welfare

D. Monitored and revised as needed and substantiated according to program policy

E. Provided using a system that safeguards the beneficiary's rights

F. Documented with assurance that records will be maintained

**NOTE: Each service included on the SATS treatment plan must be justified by the physician certifying medical necessity. This justification is based on medical necessity; the beneficiary's physical, mental and functional status; other support services available to the beneficiary and other factors deemed appropriate by the SATS provider and approved through the PA process.**

Each SATS service must be provided according to the beneficiary's treatment plan. As detailed in the Arkansas Medicaid Program provider contract, providers may bill only after services are provided.

## 218.000 Exclusions 7-1-11

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

A. Room and board residential costs

B. Educational services

C. Telephone contacts with beneficiary or collateral

D. Transportation services, including time spent transporting a beneficiary for services **(Reimbursement for SAT services is not allowed for the period of time the Medicaid beneficiary is in transport.)**

F. SAT services that are determined as not medically necessary

G. SAT services that duplicate integral and inseparable parts of other Arkansas Medicaid services when provided on the same date of service

## 219.000 Documentation 7-1-11

The SATS 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. Notes individualized to the beneficiary and specific to the services provided (Duplicated notes are not allowed.)

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 credentials of the person who provided the services

D. The relationship of the services to the treatment regimen described in the treatment plan/plan of care

E. Updates describing the beneficiary's progress

F. For services that require contact with anyone other than the beneficiary, evidence of conformance with HIPAA regulations, including presence in documentation of specific authorizations, is required.

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.

All documentation must be available to representatives of the Division of Medical Services (DMS) at the time of an audit. All documentation must be available at the provider's place of business. No more than 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.

If more than one SATS service is provided on the same date of service, the documentation must specifically delineate items A through D above for each service billed. For audit purposes, the auditor must readily be able to discern which service was billed in a particular time period based upon supporting documentation for that particular billing.

A provider's failure to maintain sufficient documentation to support his or her billing practices may result in recoupment of Medicaid payment.

**No documentation for SAT services, as with all Medicaid services, may be made in pencil.**

### 220.000 Medical Necessity 7-1-11

All Substance Abuse Treatment Services must be medically necessary.

### 221.000 Prescription for SATS 7-1-11

Medicaid will not cover any SATS without a current prescription signed by a psychiatrist or physician. Prescriptions shall be based on consideration of the Addiction Assessment and Treatment Plan and an evaluation of the enrolled beneficiary (directly or through review of the medical records and consultation with the treatment staff). The prescription of the services will be documented by the psychiatrist's or physician's signature and date on the SATS treatment plan. Approval of all updates or revisions to the treatment plan must be documented by the psychiatrist's or physician's dated signature on the revised document. All beneficiaries diagnosed with both a mental health and substance abuse diagnosis require an integrated treatment approach including both mental health and substance abuse treatment. If the provider of the mental health treatment is the provider of the substance abuse treatment, the RSPMI provider will bill for the assessment, treatment planning, etc, and not the SATS. Providers cannot bill for both RSPMI and SATS assessments and treatment planning for the same beneficiary. Clinical records must be integrated to provide a cohesive treatment course with no duplication of services from one program to the next. When it is necessary for two separate SATS providers to be involved with treatment, the same billing rules apply. Providers are required to share treatment documentation as appropriate.

Services cannot begin prior to the date of the psychiatrist's or physician's signature on the treatment plan (except Addiction Assessment – H0001). Medicaid expenditures paid for services rendered and billed prior to the date of the psychiatrist's or physician's signature on the treatment plan are subject to recoupment.

### 222.000 Provider Reviews 7-1-11

The Utilization Review Section of the Arkansas Division of Medical Services has the responsibility for assuring quality medical care for beneficiaries, along with protecting the integrity of both state and federal funds supporting the Medical Assistance Program.

### 223.000 On-Site Inspections of Care (IOC) 7-1-11

### 223.100 Purpose of the Review 7-1-11

The on-site inspections of care of SATS providers are intended to:

A. Promote SAT services being provided in compliance with federal and state laws, rules and professionally recognized standards of care as outlined in the DBHS SATS supplemental manual

B. Identify and clearly define areas of deficiency where the provision of services is not in compliance with federal and state laws, rules and professionally recognized standards of care as outlined in the DBHS SATS supplemental manual

C. Require provider facilities to develop and implement appropriate corrective action plans to remediate all deficiencies identified

D. Provide accountability that corrective action plans are implemented

E. Determine the effectiveness of implemented corrective action plans

### 223.110 Provider Notification of IOC 7-1-11

The provider will be notified no more than 48 hours before the scheduled arrival of the inspection team. It is the responsibility of the provider to provide a reasonably comfortable place for the team to work. When possible, this location will provide reasonable access to the outpatient care areas and the medical records.

### 223.120 Information Available Upon Arrival of the IOC Team 7-1-11

The provider will make the following available to the IOC team upon arrival at the site:

A. Medical records of Arkansas Medicaid beneficiaries who are identified by the reviewer

B. One or more knowledgeable administrative staff member(s) to assist the team

C. The opportunity to assess direct outpatient care, which does not disrupt or distract from the actual provision of care

D. Staff personnel records, complete with hire dates, dates of credentialing and copies of current licenses, credentials, criminal background checks, etc.

And, if identified as necessary to clarify specific chart-audit questions:

E. Written policies, procedures and committee minutes

F. Data collected for Clinical Administration, Clinical Services, Quality Assurance, Quality Improvement, Utilization Review and Credentialing

G. Program descriptions, manuals, schedules, staffing plans and evaluation studies

### 223.130 Cases Chosen for Review 7-1-11

The cases are chosen by a case selection procedure that combines random sampling and cases identified as “high utilization” and “outliers.”

A. High Utilizers are beneficiaries who meet pre-defined levels of service utilization within an identified period of time.

B. Outliers are any providers or beneficiaries whose provision of services or service utilization meets pre-defined criteria of variance from the norm.

C. Cases chosen for review for On-Site Inspections of Care (IOC) are subject to the purpose, policies and procedures specified in Sections 224.100 (Purpose of the Review), 224.120 (Denial/Due Process), 224.130 (Reconsideration) and 224.140 (Recoupments).

The review period will be specified in the provider notification letter. The list of cases to be reviewed will be given to the provider upon arrival or chosen by the IOC team from a list for that location with a request for certain components of the records. The information requested includes, but is not limited to:

1. Treatment plans (plan of care) and PoC reviews
2. Progress notes, including physician notes
3. Physician orders and lab results
4. Copies of records

The reviewer may request a copy of any record.

### 223.140 Program Activity Observation 7-1-11

The reviewer will observe at least one program activity.

### 223.150 Beneficiary/Family Interviews 7-1-11

The provider is required to arrange interviews of Medicaid beneficiaries and family member(s) as requested by the reviewer, preferably with the beneficiaries whose records are being reviewed. If the beneficiaries whose records are being reviewed are not available, interviews will be conducted with beneficiaries on-site whose records are not scheduled for review and the records for those beneficiaries will be added to the review. Family members may be interviewed on-site or by telephone conference call.

### 223.160 Exit Conference 7-1-11

The IOC team will conduct an exit conference summarizing their findings and recommendations. Providers are free to involve staff in the exit conference.

### 223.170 Written Reports 7-1-11

A written report of the inspection team's conclusions will be forwarded to the facility and to the Program Integrity Unit of the Division of Medical Services within 14 calendar days of the last day of inspection. The written report will clearly identify any area of deficiency that requires submission of a Corrective Action Plan.

### 223.180 Corrective Action Plans 7-1-11

The provider is required to submit a Corrective Action Plan designed to rectify any area of deficiency noted in the written report of the Inspection of Care review. The Corrective Action Plan must be submitted to the contracted utilization review agency within 30 calendar days of the date of the written report. The contractor will review the Corrective Action Plan and forward it, with recommendations, to the Program Integrity Unit of the Division of Medical Services.

### 223.190 Other Actions 7-1-11

Other actions that may be taken as part of the Inspection of Care include, but are not limited to:

A. Beneficiaries determined to no longer meet medical necessity criteria for substance abuse services will no longer be eligible for SATS.

B. Follow-up Inspections of Care may be recommended by the contracted utilization review agency and required by Division of Medical Services to verify the implementation and effectiveness of corrective actions. Follow-up inspections may be focused on the issues addressed by the Corrective Action Plan or may be a complete re-Inspection of Care, at the sole discretion of the Division of Medical Services.

C. Review by the Program Integrity Unit of the Division of Medical Services.

### 224.000 Retrospective Reviews 7-1-11

The Division of Medical Services 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.

### 224.100 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)

### 224.110 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 SAT 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® information.** When faxing or mailing records, send them to the attention of "Retrospective Review Team." Records will not be accepted via email.

### 224.120 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.

### 224.130 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.

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.

### 224.140 Recoupments 7-1-11

The Division of Medical Services will initiate the recoupment process for all claims that the contractor has denied on retrospective review.

The Division of Medical Services 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 Arkansas Medicaid, amount to be recouped and the reason for the recoupment.

## 230.000 PRIOR AUTHORIZATION (PA) AND EXTENSION OF BENEFITS

### 231.000 Introduction to Prior Authorization and Extension of Benefits 7-1-11

The Division of Medical Services contracts with a utilization review agency to complete the prior authorization (PA) and extension of benefit processes.

A request for prior authorization for services to be provided to a foster child must specify that the request is for a foster child. A request for services to be provided to a child in the custody of the Division of Youth Services (DYS) must specify DYS custody.

### 231.100 Prior Authorization and Extension of Benefits 7-1-11

Prior Authorization is required for all SAT services provided to Medicaid-eligible beneficiaries, except codes H0001 (no modifier) and T1007 (no modifier). These two (2) codes represent the Addiction Assessment for the NEW patient and the comprehensive Treatment Planning for a NEW patient. These codes when billed with a modifier and all other SATS procedure codes require PA. Extension of benefits is available for beneficiaries under the age of 21 and is required for all services when the maximum benefit for the service is exhausted. Yearly service benefits are based on the state fiscal year running from July 1 to June 30. Prior authorization and extension requests must be sent to the contracted utilization review agency for beneficiaries under the age of 21. **View or print ValueOptions® contact information.**

Prior authorization requests must be sent to the contracted utilization review agency for all beneficiaries in the SATS Program. **View or print ValueOptions® contact information.**
**Procedure codes requiring prior authorization:**

| National Codes | Required Modifier | Service Title |
|---|---|---|
| H0001 | U8 | Addiction Assessment – Established Beneficiary |
| T1007 | U8 | Treatment Planning – Established Beneficiary |
| H0006 | | Care Coordination |
| H0047 | | Multi-Person (Family) Group Counseling |
| H2019 | | Individual Counseling |

| National Codes | Required Modifier | Service Title |
|---|---|---|
| H0005 | | Group Counseling |
| T1006 | | Marital/Family Counseling |
| H2010 | | Medication Management |

**Note: The initial (provisional) plan of care for the beneficiary developed during the Addiction Assessment can be used to request prior authorization for services. The initial (provisional) plan of care for the beneficiary is to be signed and dated by the professional who conducted the Addiction Assessment. However, a comprehensive treatment plan must be developed for each beneficiary (Treatment Planning – New Beneficiary – T1007) within 14 days of initial contact. The treatment plan becomes effective when the psychiatrist or physician signs and dates the treatment plan.**

**Procedure codes requiring Extension of Benefits (Extension of Benefits is only available for U21 beneficiaries):**

| National Codes | Required Modifier | Service Title | Yearly Maximum |
|---|---|---|---|
| H0001 | | Addiction Assessment – New Beneficiary | 1 |
| H0001 | U8 | Addiction Assessment – Established Beneficiary | 1 |
| T1007 | | Treatment Planning – New Beneficiary | 1 |
| T1007 | U8 | Treatment Planning – Established Beneficiary | 1 |
| H0006 | | Care Coordination | 12 |
| H0047 | | Multi-Person (Family) Group Counseling | 48 |
| H2019 | | Individual Counseling | 48 |
| H0005 | | Group Counseling | 48 |
| T1006 | | Marital/Family Counseling | 48 |
| H2010 | | Medication Management | 12 |

## 240.000 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 beneficiary 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 beneficiary is eligible for Arkansas Medicaid prior to rendering services.

A. Outpatient Services

Fifteen-Minute Units, unless otherwise stated

SATS must be billed on a per unit basis, as reflected in a daily total, per beneficiary, per SAT service.

| | |
|---|---|
| One (1) unit = | 8 - 24 minutes |
| Two (2) units = | 25 - 39 minutes |
| Three (3) units = | 40 - 49 minutes |
| Four (4) units = | 50 - 60 minutes |

Time spent providing services for a single beneficiary may be accumulated during a single, 24-hour calendar day. Providers may accumulatively bill for a single date of service, per beneficiary, per SAT service. Providers are not allowed to accumulatively bill for spanning dates of service.

All billing must reflect a daily total, per SAT service, based on the established procedure codes. No rounding is allowed.

The sum of the days' time, in minutes, per service will determine how many units are allowed to be billed. That number must not be exceeded. The total of minutes per service must be compared to the following grid, which determines the number of units allowed.

| | |
|---|---|
| One (1) unit = | 8 - 24 minutes |
| Two (2) units = | 25 - 39 minutes |
| Three (3) units = | 40 - 49 minutes |
| Four (4) units = | 50 - 60 minutes |

In a single claim transaction, a provider may bill only for service time accumulated within a single day for a single beneficiary. There is no "carryover" of time from one day to another or from one beneficiary to another.

Documentation in the beneficiary's record must reflect exactly how the number of units is determined.

No more than four (4) units may be billed for a single hour per beneficiary or provider of the service.

**NOTE: For services provided by a paraprofessional (PP), the accumulated time for the SAT service, per date of service, is one total, regardless of the number of paraprofessionals seeing the beneficiary on that day. For example, two (2) paraprofessionals see the same beneficiary on the same date of service and provide Care Coordination. The first PP spends a total of 10 minutes. Later in the day, another paraprofessional provides Care Coordination to the same beneficiary and spends a total of 15 minutes. A total of 25 minutes of Care Coordination was provided, which equals (two) 2 allowable units of service. Only one PP may be shown on the claim as the performing provider.**

## 241.000 Rate Appeal Process 7-1-11

A provider may request reconsideration of a Program decision affecting reimbursement by writing to the Assistant Director, Division of Medical Services (DMS).

A. The Program must receive the request within 20 calendar days of the latest of the following events:

1. The implementation date of the new or revised policy or
2. The effective date of the new or revised billing or coding instructions or
3. The date of official provider notification of:

a. New or revised policy or

b. New or revised billing or coding instructions

B. The Assistant Director, DMS, will review the request and will arrange a Program/Provider conference if needed or if the provider so requests.

1. The Assistant Director will advise the provider of the Program decision on the matter within 20 calendar days following receipt of the request.

2. If there is a Program/Provider conference, the Assistant Director will notify the provider within 20 calendar days following the date of that conference.

C. If the decision of the Assistant Director, DMS, is unsatisfactory to the provider, the provider may then appeal the question to a standing Rate Review Panel established by the Director of the DMS.

1. A member of DHS management staff will chair the Rate Review Panel, which will include a member of the DMS and a representative of the medical professional community.

2. The written request for review by the Rate Review Panel must be postmarked within 15 calendar days following the date of notification of the initial decision by the Assistant Director, DMS.

3. The Rate Review Panel will meet within 15 calendar days following receipt of the appeal request. The panel will submit its recommendation to the Director of the DMS.

## 250.000 BILLING PROCEDURES

### 251.000 Introduction to Billing 7-1-11

Substance Abuse Treatment Services (SATS) providers use the CMS-1500 form to bill the Arkansas Medicaid Program on paper for services provided to eligible Medicaid recipients. Each claim may contain charges for only one beneficiary. **View a CMS-1500 sample form.**

Section III of this manual contains information about Provider Electronic Solutions (PES) and other available options for electronic claim submission.

### 252.000 CMS-1500 Billing Procedures

### 252.100 Procedure Codes for Types of Covered Services 7-1-11

Covered SAT services are outpatient services. SAT services are billed on a per-unit basis. Unless otherwise specified in this manual or the appropriate CPT or HCPCS book, one unit equals 15 minutes. All services must be provided by at least the minimum staff within the licensed or certified scope of practice to provide the service. Services are to be congruent with the age, strengths, needed accommodation for any disability and cultural framework of the beneficiary and his/her family.

### 252.110 Outpatient Procedure Codes 7-1-11

**The following services must be provided by performing providers certified by DBHS as a professional SATS provider. Individuals eligible for the required certification are:**

| Credentials | Title/Certification |
|---|---|
| MD, DO | Physician |
| APN | Advance Practice Nurse |

| Credentials | Title/Certification |
|---|---|
| Ph.D., Psy.D., Ed.D | Licensed Psychologist |
| LADAC | Licensed Alcoholism and Drug Abuse Counselor |
| ACADC | Advanced Certified Alcoholism and Drug Abuse Counselor |
| CCDP-D | Certified Co-Occurring Disorder Professional – Diplomate Level |
| LCSW | Licensed Certified Social Worker |
| LMSW | Licensed Master Social Worker (under approved supervision) |
| LPC | Licensed Professional Counselor |
| LMFT | Licensed Marriage and Family Therapist |
| LAC | Licensed Associate Counselor (under approved supervision) |
| LPE-I | Psychological Examiner licensed to practice independently |
| LPE | Psychological Examiner (under the supervision of a Psychologist) |

| National Code | Required Modifier | Definition |
|---|---|---|
| H0001 | | **SERVICE: Addiction Assessment – New Beneficiary**<br><br>**DEFINITION:** The Substance Abuse Addiction Assessment service identifies and evaluates the nature and extent of an individual's use/abuse/addiction to alcohol and/or other drugs and identifies but does not diagnose any existing co-morbid conditions. A standardized assessment instrument, approved by DBHS and DMS, must be used to complete the assessment process. The assessment process results in the assignment of a diagnostic impression, beneficiary placement recommendation for treatment regimen appropriate to the condition and situation presented by the beneficiary and referral into a service appropriate to effectively treat the condition(s) identified. A 9-panel test is part of the assessment to assist in the beneficiary's self-report of the alcohol and drug use and to develop an accurate diagnosis, referral and treatment plan. The 9-panel test is a screening test for marijuana, cocaine, benzoylecgonine, PCP, morphine and its related metabolites derived from opium (opiates), methamphetamines (including Ecstasy), methadone, amphetamines, barbiturates and benzodiazepines.<br><br>**DAILY MAXIMUM OF UNITS THAT MAY BE BILLED:** This service must be billed as one (1) per episode.<br><br>**YEARLY MAXIMUM OF UNITS THAT MAY BE BILLED without extension:** One (1)<br><br>**ALLOWABLE PLACES OF SERVICE:** Office (11)<br><br>**AGE GROUP(S):** Pregnant Women through the last day of the month in which the 60$^{th}$ post-partum day falls; Ages 9 up to 21 years old<br><br>**NOTES and COMMENTS:** For substance abuse services, the |

| National Code | Required Modifier | Definition |
|---|---|---|
| | | Addiction Assessment must be completed within 24 hours of the initial contact. The assessment process results in the assignment of a diagnostic impression, beneficiary recommendation for treatment regimen appropriate to the condition and situation presented by the beneficiary, initial plan (provisional) of care and referral to a service appropriate to effectively treat the condition(s) identified. If indicated, the assessment process must refer the beneficiary for a psychiatric consultation. Alcohol and/or Other Drug Addiction Screening analysis is part of the assessment to assist in the beneficiary's self-report of the alcohol and drug use and to develop an accurate diagnosis, referral and treatment plan. For adults, the Addiction Severity Index must be used for the assessment. The assessment must include the components set forth in the Division of Behavioral Health Services Licensure Standards for Alcohol and/or Other Drug Abuse Treatment Programs (Pg. 28, SA3). For children and adolescents, a nationally recognized addiction assessment tool, approved by DBHS and DMS, that includes a thorough behavioral health assessment based on national accreditation standards, must be used. Every Addiction Assessment must include the signature of the licensed professional that issued the diagnostic impression or assigned the diagnosis to confirm that the information was reviewed by the treating clinician in a face-to-face contact with the beneficiary. An assessment must be completed for each new beneficiary. A new assessment should only be completed upon admission, updated annually, or when there's been a significant change in status and/or a change in provider (beneficiary moves to a new provider). |
| H0001 | U8 | **SERVICE: ADDICTION ASSESSMENT – ESTABLISHED BENEFICIARY**<br>Apply the above definition and requirements.<br>Additional information: Use code H0001 with modifier "U8" to claim for services provided to established beneficiaries. |
| T1007 | | **SERVICE: TREATMENT PLANNING – NEW BENEFICIARY**<br>**DEFINITION:** A developed plan in cooperation with the individual (parent or guardian if the individual is under 18) to deliver specific addiction services to the individual to restore, improve or stabilize the individual's condition. The plan must be based on individualized service needs identified in the completed Addiction Assessment. The plan must include goals for the medically necessary treatment of identified problems, symptoms and addiction issues. The plan must identify individuals or treatment teams responsible for treatment, specific treatment modalities prescribed in the treatment plan for the individual and time limitations for services.<br>**DAILY MAXIMUM OF UNITS THAT MAY BE BILLED:** This service must be billed as one (1) per episode.<br>**YEARLY MAXIMUM OF UNITS THAT MAY BE BILLED without extension:** One (1)<br>**ALLOWABLE PLACES OF SERVICE:** Office (11)<br>**AGE GROUP(S):** Pregnant Women through the last day of the month in which the 60th post-partum day falls; Ages 9 up to 21 years old<br>**NOTES and COMMENTS:** Substance abuse services cannot be |

| National Code | Required Modifier | Definition |
|---|---|---|
| | | billed until the treatment plan is signed and dated by a psychiatrist or physician (except for Addiction Assessment – H0001). The treatment plan becomes effective on the date (indicated on the treatment plan) the psychiatrist or physician signs the treatment plan. All treatment plans for SATS must be signed and dated by a psychiatrist or physician. The SATS treatment plan must be completed prior to the delivery of any substance abuse outpatient services (other than the Addiction Assessment – H0001).<br><br>The SATS treatment plan must be completed by a professional and approved by a psychiatrist or physician within 14 calendar days of the beneficiary's first contact and must include the components set forth in the DBHS Licensure Standards for Alcohol and/or Other Drug Abuse Treatment Programs (Pg. 29: CTP1). Subsequent revisions in the treatment plan will be approved in writing (signed and dated) by the physician verifying continued medical necessity prior to services being rendered. The treatment plan becomes effective on the date that physician signs the treatment plan.<br><br>Please see Section 217.000 of this manual for more information regarding Treatment Planning. |
| T1007 | U8 | **SERVICE: TREATMENT PLANNING – ESTABLISHED BENEFICIARY**<br><br>Apply the above definition and requirements.<br><br>Additional information: Use code T1007 with modifier "U8" to claim for services provided to established beneficiaries. |
| H0047 | | **SERVICE: MULTI-PERSON (FAMILY) GROUP COUNSELING**<br><br>**DEFINITION:** Multi-Person (Family) Counseling services is a group therapeutic intervention using face-to-face verbal interaction between two (2) to a maximum of nine (9) beneficiaries and their family members or significant others. The Multi-Person (Family) Group Counseling Service provided to a group composed of family members/significant others of more than one beneficiary is designed to enhance members' insight into family interactions, facilitate inter-family emotional or practical support and to develop alternative strategies to address familial issues, problems and needs. The goal is to support the rehabilitation and recovery effort. Multi-Family Group Counseling must be prescribed on the Treatment Plan to address familial problems or needs and to achieve goals or objectives specified on the Treatment Plan.<br><br>**DAILY MAXIMUM OF UNITS THAT MAY BE BILLED:** Six (6)<br><br>**YEARLY MAXIMUM OF UNITS THAT MAY BE BILLED without extension:** 48<br><br>**ALLOWABLE PLACES OF SERVICE:** Office (11)<br><br>**AGE GROUP(S):** Pregnant Women through the last day of the month in which the 60th post-partum day falls; Ages 9 up to 21 years old<br><br>**NOTES and COMMENTS:** Multi-Person (Family) Group Counseling is a face-to-face intervention delivered in a manner consistent with the goals outlined in the primary beneficiary's treatment plan. It has an identifiable approach and is used to encourage the engagement or retention of the beneficiary and significant other/family in the recovery process. Services must be scheduled at times convenient for the |

| National Code | Required Modifier | Definition |
|---|---|---|
| | | family members/significant others. Multi-Person (Family) Group Counseling shall include those **approaches that are identified** by the Division of Behavioral Health Services to be evidence-based. Multi-Person (Family) Group Counseling service must be provided in a certified provider location. These services must be rendered by the appropriately credentialed staff of a program certified by ADAP. |
| H2019 | | **SERVICE: INDIVIDUAL COUNSELING**<br><br>**DEFINITION:** Individual Counseling services include the face-to-face psychotherapy services necessary to initiate and support the rehabilitation effort, orient the beneficiary to the treatment process, develop the ongoing treatment plan, augment the treatment process, intervene in a problem area, contingency management, prevent a relapse situation, continuing care or provide ongoing psychotherapy as dictated by the beneficiary's needs.<br><br>**DAILY MAXIMUM OF UNITS THAT MAY BE BILLED:** Six (6)<br><br>**YEARLY MAXIMUM OF UNITS THAT MAY BE BILLED without extension:** 48<br><br>**ALLOWABLE PLACES OF SERVICE:** Office (11)<br><br>**AGE GROUP(S):** Pregnant Women through the last day of the month in which the 60th post-partum day falls; Ages 9 up to 21 years old<br><br>**NOTES and COMMENTS:** Individual Counseling is a direct service that provides intervention for a specific problem identified in the treatment plan and has an identifiable approach. Individual Counseling shall include the **approaches identified** by the Division of Behavioral Health Services to be evidence-based. Annually, the Division will publish a list of these evidence-based clinical approaches to be used by programs for this service. |
| H0005 | | **SERVICE: GROUP COUNSELING**<br><br>**DEFINITION:** Face-to-face interventions provided to a group of beneficiaries to improve one's capacity to deal with problems that are a result of and/or contribute to substance abuse. The professional uses the emotional interactions of the group's members to assist them in implementing each beneficiary's master treatment plan, to orient the beneficiary to the treatment process, to support the rehabilitation effort and to minimize relapse. Services are to be congruent with the age, strengths, needed accommodation for any disability and cultural framework of the beneficiary and his/her family.<br><br>**DAILY MAXIMUM OF UNITS THAT MAY BE BILLED:** Six (6)<br><br>**YEARLY MAXIMUM OF UNITS THAT MAY BE BILLED without extension:** 48<br><br>**ALLOWABLE PLACES OF SERVICE:** Office (11)<br><br>**AGE GROUP(S):** Pregnant Women through the last day of the month in which the 60th post-partum day falls; Ages 9 up to 21 years old<br><br>**NOTES and COMMENTS:** Group Counseling is a direct service that provides intervention for a specific problem identified in the treatment plan and has an identifiable approach. Group Counseling shall include those approaches that are identified by the Division of Behavioral Health Services to be evidence-based. Annually, the |

| National Code | Required Modifier | Definition |
|---|---|---|
| | | Division will publish a list of these evidence-based clinical **approaches to be used** by programs for this service. Documentation must include plan for next group session, including any homework assignments. |
| T1006 | | **SERVICE: MARITAL/FAMILY COUNSELING**<br><br>**DEFINITION:** Face-to-face treatment provided to more than one member of a family simultaneously in the same session or treatment with an individual family member (i.e. Spouse or Single Parent) that is specifically related to achieving goals identified on the beneficiary's master treatment plan. The identified beneficiary must be present for this service. Services are to be congruent with the age, strengths, needed accommodations for disability and cultural framework of the beneficiary and his/her family. These services are to be utilized to identify and address marital/family dynamics and improve/strengthen marital/family interactions and functioning in relationship to the beneficiary, the beneficiary's substance abuse condition and the beneficiary's substance abuse condition's impact on the marital/family relationship.<br><br>**DAILY MAXIMUM OF UNITS THAT MAY BE BILLED:** Six (6)<br><br>**YEARLY MAXIMUM OF UNITS THAT MAY BE BILLED without extension:** 48<br><br>**ALLOWABLE PLACES OF SERVICE:** Office (11)<br><br>**AGE GROUP(S):** Pregnant Women through the last day of the month in which the 60th post-partum day falls; Ages 9 up to 21 years old<br><br>**NOTES and COMMENTS:** Marital/Family Counseling is a direct service that provides intervention for a specific problem identified in the treatment plan and has an identifiable approach. Marital/Family Counseling must target the impact the beneficiary's condition has on the spouse/family and/or improve marital/family interactions between the beneficiary and the spouse/family. Marital/Family Counseling shall include the approaches that are identified by the Division of Behavioral Health Services to be evidence-based. Annually, the Division will publish a list of these evidence-based clinical **approaches to be used** by programs for this service. Documentation must include plan for next group session, including any homework assignments. HIPAA compliant Release of Information form must be completed, signed and dated. |
| H2010 | | **SERVICE: MEDICATION MANAGEMENT**<br><br>**DEFINITION:** Medication Management is a direct service and is provided to the beneficiary by a physician or APN with prescriptive authority. It includes pharmacologic management, including medication assessment, prescription use and review of medication. This service is limited to the prescribing of psychotropic medications and those medications necessary to treat addiction related medical conditions and medication assisted addiction treatment.<br><br>**MONTHLY MAXIMUM OF UNITS THAT MAY BE BILLED:** Two (2)<br><br>**YEARLY MAXIMUM OF UNITS THAT MAY BE BILLED without extension:** 12<br><br>**ALLOWABLE PLACES OF SERVICE:** Office (11)<br><br>**AGE GROUP(S):** Pregnant Women through the last day of the |

| National Code | Required Modifier | Definition |
|---|---|---|
| | | month in which the 60th post-partum day falls; Ages 9 up to 21 years old<br><br>**NOTES and COMMENTS:** Medication Management services are limited to psychotropic medications and those medications necessary to treat addiction-related medical conditions. All medication orders must be issued by a licensed physician or APN with prescriptive authority. All Medication Management activities must be provided face-to-face. At a minimum, Medication Management must be available to beneficiaries during normal business hours. This service cannot be provided in a group setting. |

## 252.120 Other Outpatient Procedure Codes 7-1-11

**The following services are allowed when provided by performing providers certified by DBHS as a paraprofessional SATS provider.**

**Individuals eligible for the required certification are as follows when practicing under the supervision of a Certified Clinical Supervisor:**

| Credentials | Title/Certification |
|---|---|
| CADC | Certified Alcohol and Drug Counselor |
| CCDP-B | Certified Co-Occurring Disorder Professional – Bachelors Level |
| CCDP-A | Certified Co-Occurring Disorder Professional – Associate Level |
| LAADAC | Licensed Associate Alcoholism and Drug Abuse Counselor |
| CIT | Counselor in Training |

**Anyone who can provide professional services can also provide Care Coordination (H0006)**

| National Code | Required Modifier | Definition |
|---|---|---|
| H0006 | | **SERVICE: CARE COORDINATION**<br><br>**DEFINITION:** Care Coordination services are services that will assist the beneficiary and family in gaining access to needed medical, social, educational and other services. Care Coordination will be provided using a wrap-around or recovery model and will include the following activities: input into the treatment planning process, coordination of the treatment planning team, referral to services and resources identified in the treatment plan and monitoring and follow-up activities that are necessary to ensure the goals identified in the treatment plan are met or need to be revised. Care Coordination services ensure communication and collaboration between agencies, |

providers and other individuals necessary to implement the goals identified in the treatment plan.

**YEARLY MAXIMUM OF UNITS THAT MAY BE BILLED without extension:** 12

**ALLOWABLE PLACES OF SERVICE:** Office (11)

**AGE GROUP(S):** Pregnant Women through the last day of the month in which the 60th post-partum day falls; Ages 9 up to 21 years old

**NOTES and COMMENTS:** The care coordinator is responsible for a variety of necessary functions to ensure the beneficiary's goals and needs are identified and the appropriate services are rendered. Using the information from the beneficiary's treatment plan, the care coordinator is responsible for arranging and facilitating for the provision of all services identified in the plan. The care coordinator will be responsible for coordinating meetings with the beneficiary and family to monitor and reevaluate the treatment plan as well as meetings with the program staff and others involved in the delivery of services to the beneficiary to monitor and evaluate progress. The care coordinator is responsible for participating in aftercare planning for the beneficiary prior to discharge. The care coordinator may assist the clinician in the assessment process and in organizing and guiding the development of an individualized treatment plan. The care coordinator will work with the beneficiary and family to identify a Case Planning Team and a Wrap-Around Planning Team. The Case Planning Team will be the source for information needed to form a complete assessment of the beneficiary. The Case Planning Team may include providers, care coordinators from state agencies that provide services to the beneficiary, family members and natural supports such as neighbors, friends and clergy. Care Coordinator activities include: 1) assisting the beneficiary and family to identify appropriate members of the Case Planning Team 2) facilitating the Case Planning Team to identify strengths and needs of the beneficiary and strengths and needs of the beneficiary and family in meeting the individualized needs and 3) collecting background information and plans from other agencies. Using the information collected through an assessment, the care coordinator and the clinician convenes and facilitates the Case Planning Team. The Case Planning Team with the beneficiary and family develops a person and family-centered, individualized Treatment Plan that specifies the goals and actions to address the medical, social, educational and other services needed by the eligible individual, and works directly with the beneficiary, the family (or the individual's authorized health care decision maker) and others to identify the strengths, needs and goals of the beneficiary and the strengths, needs and goals of the family in meeting the beneficiary's needs. At a minimum, the Case Planning Team must meet monthly.

Each beneficiary can have only one (1) care coordinator bill per day.

***REFERRAL AND RELATED ACTIVITIES:***

This will include:

1. Assisting with the convening, coordinating and communicating with the Case Planning Team to implement the treatment plan
2. Working directly with the beneficiary (and family) to implement elements of the treatment plan
3. Coordinating the delivery of available services, including

services reimbursable under 42 USC 1396d(a) and educational, social or other services

4. Assisting with the development of a transition plan when the beneficiary has achieved the goals of the treatment plan
5. Collaborating with other service providers on the beneficiary's (and family's) behalf

***MONITORING AND FOLLOW-UP:***

These activities include reviewing the progress towards the goals in the treatment plan and working with the Care Planning Team to update it to reflect the changing needs of the beneficiary. The Care Coordinator, in conjunction with the Case Planning Team, performs reviews to include

1. Services are provided in accordance with the treatment plan
2. Services in the treatment plan meet the needs of the beneficiary
3. Changes in the needs or status of the beneficiary have been addressed in the treatment plan

The beneficiary receiving care coordination services may only have one care coordinator for all Arkansas Medicaid services.

The staff ratios shall not exceed 30 beneficiaries to 1 care coordinator.

## 252.200 Place of Service Codes 7-1-11

Electronic and paper claims now require the same national place of service codes.

| Place of Service | POS Codes |
|---|---|
| Office (SATS Facility Service Site) | 11 |

## 252.300 Billing Instructions - Paper Only 7-1-11

HP Enterprise Services offers providers several options for electronic billing. Therefore, claims submitted on paper are paid once a month. The only claims exempt from this process are those that require attachments or manual pricing.

To bill for SAT services, use the CMS-1500 form. The numbered items correspond to numbered fields on the claim form. **View a CMS-1500 sample form.**

When completing the CMS-1500, accuracy, completeness and clarity are important. Claims cannot be processed if applicable information is not supplied or is illegible. Claims should be typed whenever possible.

Completed claim forms should be forwarded to HP Enterprise Services. **View or print HP Enterprise Services Claims contact information.**

**NOTE: A provider rendering services without verifying eligibility for each date of service does so at the risk of not being reimbursed for the services.**

## 252.310 Completion of the CMS-1500 Claim Form 7-1-11

| Field Name and Number | | Instructions for Completion |
|---|---|---|
| 1. | (type of coverage) | Not required. |
| 1a. | INSURED'S I.D. NUMBER (For Program in Item 1) | Beneficiary's or participant's 10-digit Medicaid or ARKids First-A or ARKids First-B identification number. |
| 2. | PATIENT'S NAME (Last Name, First Name, Middle Initial) | Beneficiary's or participant's last name and first name. |
| 3. | PATIENT'S BIRTH DATE | Beneficiary's or participant's date of birth as given on the beneficiary's Medicaid or ARKids First-A or ARKids First-B identification card. Format: MM/DD/YY. |
| | SEX | Check M for male or F for female. |
| 4. | INSURED'S NAME (Last Name, First Name, Middle Initial) | Required if insurance affects this claim. Insured's last name, first name, and middle initial. |
| 5. | PATIENT'S ADDRESS (No., Street) | Optional. Beneficiary's or participant's complete mailing address (street address or post office box). |
| | CITY | Name of the city in which the beneficiary or participant resides. |
| | STATE | Two-letter postal code for the state in which the beneficiary or participant resides. |
| | ZIP CODE | Five-digit zip code; nine digits for post office box. |
| | TELEPHONE (Include Area Code) | The beneficiary's or participant's telephone number or the number of a reliable message/contact/ emergency telephone |
| 6. | PATIENT RELATIONSHIP TO INSURED | If insurance affects this claim, check the box indicating the patient's relationship to the insured. |
| 7. | INSURED'S ADDRESS (No., Street) | Required if insured's address is different from the patient's address. |
| | CITY | |
| | STATE | |
| | ZIP CODE | |
| | TELEPHONE (Include Area Code) | |
| 8. | PATIENT STATUS | Not required. |
| 9. | OTHER INSURED'S NAME (Last name, First Name, Middle Initial) | If beneficiary has other insurance coverage as indicated in Field 11d, the other insured's last name, first name, and middle initial. |
| | a. OTHER INSURED'S POLICY OR GROUP NUMBER | Policy and/or group number of the insured beneficiary. |
| | b. OTHER INSURED'S DATE OF BIRTH | Not required. |
| | SEX | Not required. |

| Field Name and Number | Instructions for Completion |
|---|---|
| c. EMPLOYER'S NAME OR SCHOOL NAME | Required when items 9 a-d are required. Name of the insured beneficiary's employer and/or school. |
| d. INSURANCE PLAN NAME OR PROGRAM NAME | Name of the insurance company. |
| 10. IS PATIENT'S CONDITION RELATED TO: | |
| a. EMPLOYMENT? (Current or Previous) | Check YES or NO. |
| b. AUTO ACCIDENT? | Required when an auto accident is related to the services. Check YES or NO. |
| PLACE (State) | If 10b is YES, the two-letter postal abbreviation for the state in which the automobile accident took place. |
| c. OTHER ACCIDENT? | Required when an accident other than automobile is related to the services. Check YES or NO. |
| 10d. RESERVED FOR LOCAL USE | Not used. |
| 11. INSURED'S POLICY GROUP OR FECA NUMBER | Not required when Medicaid is the only payer. |
| a. INSURED'S DATE OF BIRTH | Not required. |
| SEX | Not required. |
| b. EMPLOYER'S NAME OR SCHOOL NAME | Not required. |
| c. INSURANCE PLAN NAME OR PROGRAM NAME | Not required. |
| d. IS THERE ANOTHER HEALTH BENEFIT PLAN? | When private or other insurance may or will cover any of the services, check YES and complete items 9a through 9d. |
| 12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE | Not required. |
| 13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE | Not required. |
| 14. DATE OF CURRENT:<br>ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP) | Required when services furnished are related to an accident, whether the accident is recent or in the past. Date of the accident. |
| 15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE | Not required. |
| 16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION | Not required. |

| Field Name and Number | Instructions for Completion |
|---|---|
| 17. NAME OF REFERRING PROVIDER OR OTHER SOURCE | Primary Care Physician (PCP) referral is not required for SAT services. If services are the result of a Child Health Services (EPSDT) screening/ referral, enter the referral source, including name and title. |
| 17a. (blank) | The 9-digit Arkansas Medicaid provider ID number of the referring physician. |
| 17b. NPI | Not required. |
| 18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES | When the serving/billing provider's services charged on this claim are related to a beneficiary's or participant's inpatient hospitalization, enter the beneficiary's admission and discharge dates. Format: MM/DD/YY. |
| 19. RESERVED FOR LOCAL USE | Not applicable to SATS. |
| 20. OUTSIDE LAB? | Not required. |
| $ CHARGES | Not required. |
| 21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY | Diagnosis code for the primary medical condition for which services are being billed. Up to three additional diagnosis codes can be listed in this field for information or documentation purposes. Use the International Classification of Diseases, Ninth Revision Clinical Modification (ICD-9-CM) diagnosis coding, current as of the date of service. |
| 22. MEDICAID RESUBMISSION CODE | Reserved for future use. |
| ORIGINAL REF. NO. | Reserved for future use. |
| 23. PRIOR AUTHORIZATION NUMBER | The prior authorization or benefit extension control number if applicable. |
| 24. | |
| A. DATE(S) OF SERVICE | The "from" and "to" dates of service for each billed service. Format: MM/DD/YY.<br>1. On a single claim detail (one charge on one line), bill only for services provided within a single calendar month.<br>2. Providers may bill on the same claim detail for two or more sequential dates of service within the same calendar month when the provider furnished equal amounts of the service on each day of the date sequence. |
| B. PLACE OF SERVICE | Two-digit national standard place of service code. See Section 252.200 for codes. |
| C. EMG | Not required. |
| D. PROCEDURES, SERVICES, OR SUPPLIES | |
| CPT/HCPCS | Enter the correct CPT or HCPCS procedure codes from Sections 252.100 through 252.120. |

| Field Name and Number | | | Instructions for Completion |
|---|---|---|---|
| | | MODIFIER | Use applicable modifier. |
| | E. | DIAGNOSIS POINTER | Enter in each detail the single number—1, 2, 3, or 4—that corresponds to a diagnosis code in Item 21 (numbered 1, 2, 3, or 4) and that supports most definitively the medical necessity of the service(s) identified and charged in that detail. Enter only one number in E of each detail. Each DIAGNOSIS POINTER number must be only a 1, 2, 3, or 4, and it must be the only character in that field. |
| | F. | $ CHARGES | The full charge for the service(s) totaled in the detail. This charge must be the usual charge to any beneficiary, patient, or other recipient of the provider's services. |
| | G. | DAYS OR UNITS | The units (in whole numbers) of service(s) provided during the period indicated in Field 24A of the detail. . |
| | H. | EPSDT/Family Plan | Enter E if the services resulted from a Child Health Services (EPSDT) screening/referral. |
| | I. | ID QUAL | Not required. |
| | J. | RENDERING PROVIDER ID # | The 9-digit Arkansas Medicaid provider ID number of the individual who furnished the services billed for in the detail. Must be a certified, enrolled SATS provider. |
| | | NPI | Not required. |
| 25. | FEDERAL TAX I.D. NUMBER | | Not required. This information is carried in the provider's Medicaid file. If it changes, please contact Provider Enrollment. |
| 26. | PATIENT'S ACCOUNT NO. | | Optional entry that may be used for accounting purposes; use up to 16 numeric or alphabetic characters. This number appears on the Remittance Advice as "MRN." |
| 27. | ACCEPT ASSIGNMENT? | | Not required. Assignment is automatically accepted by the provider when billing Medicaid. |
| 28. | TOTAL CHARGE | | Total of Column 24F—the sum all charges on the claim. |
| 29. | AMOUNT PAID | | Enter the total of payments previously received on this claim. Do not include amounts previously paid by Medicaid. Do not include in this total the automatically deducted Medicaid or ARKids First-B co-payments. |
| 30. | BALANCE DUE | | From the total charge, subtract amounts received from other sources and enter the result. |

| Field Name and Number | Instructions for Completion |
|---|---|
| 31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS | The provider or designated authorized individual must sign and date the claim certifying that the services were personally rendered by the provider or under the provider's direction. "Provider's signature" is defined as the provider's actual signature, a rubber stamp of the provider's signature, an automated signature, a typewritten signature, or the signature of an individual authorized by the provider rendering the service. The name of a clinic or group is not acceptable. |
| 32. SERVICE FACILITY LOCATION INFORMATION | Enter the name and street, city, state, and zip code of the facility where services were performed. |
| a. (blank) | Not required. |
| b. Service Site Medicaid ID number | Enter the 9-digit Arkansas Medicaid provider ID number of the service site. |
| 33. BILLING PROVIDER INFO & PH # | Billing provider's name and complete address. Telephone number is requested but not required. |
| a. (blank) | Not required. |
| b. (blank) | Enter the 9-digit Arkansas Medicaid provider ID number of the billing provider. |