TOC required

228.300 Record Reviews 12-1-13

The Division of Medical Services (DMS) of the Arkansas Department of Human Services (DHS) has contracted with ValueOptions® to perform on-site inspections of care (IOC) and retrospective reviews of outpatient mental health services provided by RSPMI providers. **View or print ValueOptions contact information.** The reviews are conducted by licensed mental health professionals and are based on applicable federal and state laws, rules and professionally recognized standards of care.

Field Code Changed

228.311 Purpose of the Review 12-1-13

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

A. Promote RSPMI services being provided in compliance with federal and state laws, rules and professionally recognized standards of care;

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;

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 and

E. Determine the effectiveness of implemented corrective action plans.

The review tool, process and procedures are available on the contractor's website at **http://arkansas.valueoptions.com/provider/prv_forms.htm**. Any amendments to the review tool will be adopted under the Arkansas Administrative Procedures Act.

228.313 Information Available Upon Arrival of the IOC Team 12-1-13

The provider shall make the following available upon the IOC Team's 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 patient care in a manner least disruptive to 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 and similar or related records;

E. Written policies, procedures and quality assurance committee minutes;

F. Clinical Administration, Clinical Services, Quality Assurance, Quality improvement, Utilization Review and Credentialing;

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

H. YOQ documentation and

I. If identified as necessary and as requested, additional documents required by a provider's individual licensing board, child maltreatment checks and adult maltreatment checks.

228.314 Cases Chosen for Review 12-1-13

The contractor will review twenty (20) randomly selected cases during the IOC review. If a provider has fewer than 20 open cases, all cases shall be reviewed.

The review period shall be specified in the provider notification letter. The list of cases to be reviewed shall be given to the provider upon arrival or chosen by the IOC Team from a list for the provider site. The components of the records required for review include:

1. All required assessments, including SED/SMI Certifications where applicable;
2. Master treatment plan and periodic reviews of master treatment plan;
3. Progress notes, including physician notes;
4. Physician orders and lab results and
5. Copies of records. The reviewer shall retain a copy of any record reviewed.

228.316 Beneficiary/Family Interviews 12-1-13

The provider is required to arrange interviews of Medicaid beneficiaries and family members as requested by the IOC team, preferably with the beneficiaries whose records are selected for review. If a beneficiary whose records are chosen for review is not available, then the interviews shall be conducted with a beneficiary on-site whose records are not scheduled for review. Beneficiaries and family members may be interviewed on-site, by telephone conference or both.

228.318 Written Reports and Follow-Up Procedures 12-1-13

The contractor shall provide a written report of the IOC team's findings to the provider, DMS Behavioral Health Unit and Arkansas Office of Medicaid Inspector General within 14 calendar days from the last day of on-site inspection. The written report shall clearly identify any area of deficiency and required submission of a corrective action plan.

The contractor shall provide a notification of either acceptance or requirement of directed correction to the provider, DMS Behavioral Health Unit and Arkansas Office of Medicaid Inspector General within 14 calendar days of receiving a proposed corrective action plan and shall monitor corrective actions to ensure the plan is implemented and results in compliance.

All IOC reviews are subject to policy regarding Administrative Remedies and Sanctions (Section 150.000), Administrative Reconsideration and Appeals (Section 160.000) and Provider Due Process (Section 190.000). DMS will not voluntarily publish the results of the IOC review until the provider has exhausted all administrative remedies. Administrative remedies are exhausted if the provider does not seek a review or appeal within the time period permitted by law or rule.

228.320 DMS/DBHS Work Group Reports and Recommendations 12-1-13

The DMS/DBHS Work Group (comprised of representatives from the Behavioral Health Unit, the Arkansas Office of Medicaid Inspector General, the Division of Behavioral Health Services, the Office of Quality Assurance, the utilization review agency, as well as other units or divisions as required) will meet monthly to discuss IOC reports. When warranted by IOC results, the DMS/DBHS Work Group shall recommend to the DHS Review Team one or more actions in Section 228.322. Recommendations shall be in writing and shall include supporting documentation.

If a deficiency related to safety or potential risk to the beneficiary or others is found, then the utilization review agency shall immediately report this to the DMS Director (or the Director's designee).

228.321 Corrective Action Plans 12-1-13

The provider must submit a Corrective Action Plan designed to correct any deficiency noted in the written report of the IOC. The provider must submit the Corrective Action Plan to the contracted utilization review agency within 30 calendar days of the date of the written report. The contractor shall review the Corrective Action Plan and forward it, with recommendations, to the DMS Behavioral Health Unit, the Arkansas Office of Medicaid Inspector General and Division of Behavioral Health Services.

After acceptance of the Corrective Action Plan, the utilization review agency will monitor the implementation and effectiveness of the Corrective Action Plan via on-site review. DMS, its contractor(s) or both may conduct a desk review of beneficiary records. The desk review will be site-specific and not by organization. If it is determined that the provider has failed to meet the conditions of participation, DMS will determine if sanctions are warranted.

228.322 Actions 12-1-13

Actions that may be taken following an inspection of care review include, but are not limited to:

A. Decertification of any beneficiary determined to not meet medical necessity criteria for outpatient mental health services;

B. Decertification of any provider determined to be noncompliant with the Division of Behavioral Health Services provider certification rules;

C. On-site monitoring by the utilization review agency to verify the implementation and effectiveness of corrective actions;

D. The contractor may recommend, and DMS may require, follow-up inspections of care and/or desk reviews. Follow-up inspections may review the issues addressed by the Corrective Action Plans or may be a complete re-inspection of care, at the sole discretion of the Division of Medical Services;

E. Review and revision of the Corrective Action Plan;

F. Review by the Arkansas Office of Medicaid Inspector General;

G. Formulation of an emergency transition plan for beneficiaries including those in custody of DCFS and DYS;

H. Suspension of provider referrals;

I. Placement in high priority monitoring;

J. Mandatory monthly staff training by the utilization review agency;

K. Provider requirement for one of the following staff members to attend a DMS/DBHS monthly work group meeting: Clinical Director/Designee (at least a master's level mental health professional) or Executive Officer;

L. Recoupment for services that are not medically necessary or that fail to meet professionally recognized standards for health care or

M. Any sanction identified in Section 152.000.

ARKANSAS DEPARTMENT OF HUMAN SERVICES

Division of Medical Services
Program Development & Quality Assurance

P.O. Box 1437, Slot S295 · Little Rock, AR 72203-1437
501-320-6428 · Fax: 501-682-2480
TDD/TTY: 501-682-6789

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

DATE: **December 1, 2013**

SUBJECT: **Provider Manual Update Transmittal RSPMI-3-13**

REMOVE		**INSERT**	
Section	**Date**	**Section**	**Date**
228.300	7-1-10	228.300	12-1-13
228.311	11-1-04	228.311	12-1-13
228.313	11-1-04	228.313	12-1-13
228.314	11-1-04	228.314	12-1-13
228.316	11-1-04	228.316	12-1-13
228.318	11-1-04	228.318	12-1-13
228.320	11-1-04	228.320	12-1-13
___	___	228.320	12-1-13
___	___	228.322	12-1-13

Explanation of Updates

Sections 228.300 and 228.311 are updated to add information about the inspection of care review process.

Section 228.313 is updated to clarify the information that must be available upon the IOC Team's arrival at the site.

Section 228.314 is updated to add information about the case selection process.

Section 228.316 is updated to include additional information about beneficiary and family reviews.

Section 228.318 is updated to clarify follow-up procedures and audit procedures.

Section 228.320 is updated to include new content regarding DMS/DBHS work group reports and recommendations. The information previously included in this section is moved to Section 228.322.

Section 228.321 is added to include information regarding Corrective Action Plans.

Section 228.322 is added to include information regarding the actions taken following an inspection of care review. This information was moved from Section 228.320.

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 501-682-6453 (Local); 1-800-482-5850, extension 2-6453 (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, notices of rule making 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.

Andrew Allison, PhD
Director

ARKANSAS DEPARTMENT OF HUMAN SERVICES

Division of Medical Services
Program Development & Quality Assurance

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TO: **Arkansas Medicaid Health Care Providers – Inpatient Psychiatric Services for Under Age 21**

DATE: **December 1, 2013**

SUBJECT: **Provider Manual Update Transmittal INPPSYCH-1-13**

REMOVE		**INSERT**	
Section	**Date**	**Section**	**Date**
221.600	10-13-03	221.600	12-1-13
241.000	7-1-04	241.000	12-1-13
241.100	7-1-04	241.100	12-1-13
241.200	7-1-04	241.200	12-1-13
241.300	7-1-04	241.300	12-1-13
241.400	7-1-04	241.400	12-1-13
241.500	7-1-04	241.500	12-1-13
241.600	7-1-04	241.600	12-1-13
241.700	7-1-04	241.700	12-1-13
241.800	7-1-04	241.800	12-1-13

Explanation of Updates

Sections 221.600 and 241.000 are updated to change grammar and clarify the Inspection of Care (IOC).

Section 241.100 is updated to explain the purpose of the IOC.

Section 241.200 is updated to explain the information that must be available to the IOC Team upon arrival at the site.

Section 241.300 is updated to explain the IOC written report and follow-up procedures.

Section 241.400 is updated to change grammar.

Section 241.500 is updated to explain the makeup and purpose of the DMS/DBHS Work Group.

Section 241.600 is updated to explain Corrective Action Plans for addressing IOC results.

Section 241.700 is updated to outline actions that may be taken following an IOC review.

Section 241.800 is set to “Reserved” and the content is removed.

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 the Program Development and Quality Assurance Unit at 501-320-6429.

Arkansas Medicaid provider manuals (including update transmittals), official notices, notices of rule making 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.

_____

Andrew Allison, PhD
Director

TOC required

221.600 Inspection of Care (42 CFR Part 456, Subpart I) 12-1-13

All in-state inpatient psychiatric providers will receive an Inspection of Care (IOC) consistent with the Code of Federal Regulations, 42 CFR §§456.600 through 456.614. An IOC will be performed by an independent contractor or team annually, at a minimum. There must be a sufficient number of teams within the State that an on-site IOC can be made at appropriate intervals in each facility.

The inpatient psychiatric provider will be notified of the time of the inspection no more than forty-eight (48) hours before the scheduled arrival of the inspection team. The inspection must include:

A. Personal contact and observation of each Medicaid recipient in the inpatient psychiatric facility and

B. Review of each beneficiary's medical record.

See Section 241.000 for more information regarding inspections of care.

241.000 On-Site Inspection of Care (IOC) 12-1-13

The Department of Human Services (DHS) requires the contractor to conduct annual On-Site Inspections of Care for acute inpatient and residential services provided to Medicaid beneficiaries under age 21.

The inpatient psychiatric provider will be notified of the time of the inspection no more than forty-eight (48) hours before the schedule arrival of the inspection team.

241.100 Purpose of the Review 12-1-13

The on-site inspections of care of Inpatient Psychiatric Services for Under Age 21 providers are intended to:

A. Promote Inpatient Psychiatric Services for Under Age 21 that are provided in compliance with federal and state laws, rules and professionally recognized standards of care;

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;

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 and

E. Determine the effectiveness of implemented corrective action plans.

The review tool, process and procedures are available on the contractor's website at **http://arkansas.valueoptions.com/provider/prv_forms.htm**. Any amendments to the review tool will be adopted under the Arkansas Administrative Procedures Act.

241.200 Information Available Upon Arrival of the IOC Team 12-1-13

The provider shall make the following available upon the IOC Team's arrival at the site:

A. Medical records of all Arkansas Medicaid beneficiaries;

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

C. The opportunity to assess direct patient care in a manner least disruptive to 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, and similar or related records;

E. Written policies, procedures and quality assurance committee minutes;

F. Clinical Administrative, Clinical Services, Quality Assurance, Quality improvement, Utilization Review and Credentialing;

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

H. If identified as necessary and as requested, additional documents required by a provider's individual licensing board, child maltreatment checks and adult maltreatment checks.

241.300 Written Reports and Follow Up Procedures 12-1-13

The contractor shall provide a written report of the IOC team's findings to the provider, DMS Behavioral Health Unit and Arkansas Office of Medicaid Inspector General within 14 calendar days from the last day of on-site inspection. The written report shall clearly identify any area of deficiency and required submission of a corrective action plan.

The contractor shall provide a notification of either acceptance or requirement of directed correction to the provider, DMS Behavioral Health Unit and Arkansas Office of Medicaid Inspector General within 14 calendar days of receiving a proposed corrective action plan and shall monitor corrective actions to ensure the plan is implemented and results in compliance.

All IOC reviews are subject to policy regarding Administrative Remedies and Sanctions (Section 150.000), Administrative Reconsideration and Appeals (Section 160.000) and Provider Due Process (Section 190.000). DMS will not voluntarily publish the results of the IOC review until the provider has exhausted all administrative remedies. Administrative remedies are exhausted if the provider does not seek a review or appeal within the time period permitted by law or rule.

241.400 Resident Interviews 12-1-13

Each resident who is a Medicaid beneficiary under age 21 must be interviewed by the IOC Team. It is the responsibility of the provider to devise a system that allows access to the residents in a way that is minimally disruptive to the treatment process.

If a Medicaid beneficiary will be discharged during the review, the provider is responsible for arranging for the resident to be interviewed prior to discharge.

Interviews should be conducted in a place and manner that respects the resident's right to privacy. The provider must provide private interview space for the interviews.

241.500 DMS/DBHS Work Group Reports and Recommendations 12-1-13

The DMS/DBHS Work Group (comprised of representatives from the Behavioral Health Unit, the Arkansas Office of Medicaid Inspector General, the Division of Behavioral Health Services, the Office of Quality Assurance, the utilization review agency, as well as other units or divisions as required) will meet monthly to discuss IOC reports. When warranted by IOC results, the DMS/DBHS Work Group shall recommend to the DHS Review Team one or more actions in Section 241.700. Recommendations shall be in writing and shall include supporting documentation.

If a deficiency related to safety or potential risk to the beneficiary or others is found, then the utilization review agency shall immediately report this to the DMS Director (or the Director's designee).

241.600 Corrective Action Plans 12-1-13

The provider must submit a Corrective Action Plan designed to correct any deficiency noted in the written report of the IOC. The provider must submit the Corrective Action Plan to the contracted utilization review agency within 14 calendar days of the date of the written report. The contractor shall review the Corrective Action Plan and forward it, with recommendations, to the DMS Behavioral Health Unit, the Arkansas Office of Medicaid Inspector General and Division of Behavioral Health Services.

After acceptance of the Corrective Action Plan, the utilization review agency will monitor the implementation and effectiveness of the Corrective Action Plan via on-site review. DMS, its contractor(s) or both may conduct a desk review of beneficiary records. The desk review will be site-specific and not by organization. If it is determined that the provider has failed to meet the conditions of participation, DMS will determine if sanctions are warranted.

241.700 Actions 12-1-13

Actions that may be taken following an inspection of care review include, but are not limited to:

A. Decertification of any beneficiary determined to not meet medical necessity criteria for outpatient mental health services;

B. Decertification of any provider determined to be noncompliant with the Division of Behavioral Health Services provider certification rules;

C. On-site monitoring by the utilization review agency to verify the implementation and effectiveness of corrective actions;

D. The contractor may recommend, and DMS may require, follow-up inspections of care and/or desk reviews. Follow-up inspections may review the issues addressed by the Corrective Action Plans or may be a complete re-inspection of care, at the sole discretion of the Division of Medical Services;

E. Review and revision of the Corrective Action Plan;

F. Review by the Arkansas Office of Medicaid Inspector General;

G. Formulation of an emergency transition plan for beneficiaries including those in custody of DCFS and DYS;

H. Suspension of provider referrals;

I. Placement in high priority monitoring;

J. Mandatory monthly staff training by the utilization review agency;

K. Provider requirement for one of the following staff members to attend a DMS/DBHS monthly work group meeting: Clinical Director/Designee (at least a master's level mental health professional) or Executive Officer;

L. Recoupment for services that are not medically necessary or that fail to meet professionally recognized standards for health care or

M. Any sanction identified in Section 152.000.

241.800 Reserved 12-1-13