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: 501-404-4619

October 14, 2016

Ms. Donna K. Davis, Senior Legislative Analyst
Subcommittee on Administrative Rules and Regulations
Arkansas Legislative Council
Bureau of Legislative Research
#1 Capitol, 5th Floor
Little Rock, AR 72201

Dear Ms. Davis:

Re: Outpatient Behavioral Health Services Update New-16, ARKids 3-16, Inpatient Psychiatric Services for Persons Under Age 21 Update 1-16, School Based Mental Health Update 1-16, Substance Abuse Treatment Services 2-16, Rehabilitative Services for Persons with Mental Illness 4-16, Licensed Mental Health Practitioners 2-16 and State Plan Amendment #2016-008

Attached are:

- **Two copies of the Questionnaire For Filing Proposed Rules and Regulations**
- **Two copies of the Financial Impact Statement**
- **Two copies of the policy summary**
- **Two copies of the mark-up rule**
- **Two copies of revised rule**

The Department of Human Services is establishing the Outpatient Behavioral Health Services Program while also amending the Inpatient Psychiatric Services for Under Age 21 Program and School Based Mental Health Program in Arkansas Medicaid.

Please arrange for the rule to be reviewed by the ALC-Administrative Rules and Regulations Subcommittee. If you have any questions or need additional information, please contact Becky Murphy, Policy Development Coordinator, Division of Medical Services, Program Development and Quality Assurance at 501-320-6429 or emailing becky.murphy@dhs.arkansas.gov.

Sincerely,

Dawn Stehle /TAH

Dawn Stehle
Director

DS:bm

Attachments

QUESTIONNAIRE FOR FILING PROPOSED RULES AND REGULATIONS WITH THE ARKANSAS LEGISLATIVE COUNCIL AND JOINT INTERIM COMMITTEE

DEPARTMENT/AGENCY Department of Human Services
DIVISION Division of Medical Services
DIVISION DIRECTOR Dawn Stehle
CONTACT PERSON Robert Nix
ADDRESS P.O. Box 1437, Slot S295, Little Rock, AR 72203
PHONE NO. 501-686-9871 **FAX NO.** 501-404-4619 **E-MAIL** robert.nix@dhs.arkansas.gov
NAME OF PRESENTER AT COMMITTEE MEETING Tami Harlan
PRESENTER E-MAIL tami.harlan@dhs.arkansas.gov

INSTRUCTIONS

A. Please make copies of this form for future use.
B. Please answer each question completely using layman terms. You may use additional sheets, if necessary.
C. If you have a method of indexing your rules, please give the proposed citation after "Short Title of this Rule" below.
D. Submit two (2) copies of this questionnaire and financial impact statement attached to the front of two (2) copies of the proposed rule and required documents. Mail or deliver to:

Donna K. Davis
Administrative Rules Review Section
Arkansas Legislative Council
Bureau of Legislative Research
One Capitol Mall, 5th Floor
Little Rock, AR 72201

****

1. What is the short title of this rule? Outpatient Behavioral Health Services Update New-16, ARKids 3-16, Inpatient Psychiatric Services for Persons Under Age 21 Update 1-16, School Based Mental Health Update 1-16, Substance Abuse Treatment Services 2-16, Rehabilitative Services for Persons with Mental Illness 4-16, Licensed Mental Health Practitioners 2-16 and State Plan Amendment #2016-008

2. What is the subject of the proposed rule? To establish the Outpatient Behavioral Health Services Program while also amending the Inpatient Psychiatric Services for Under Age 21 Program and School Based Mental Health Program in Arkansas Medicaid.

3. Is this rule required to comply with a federal statute, rule, or regulation? Yes ☐ No ☒
   If yes, please provide the federal rule, regulation, and/or statute citation. _____

4. Was this rule filed under the emergency provisions of the Administrative Procedure Act? Yes ☐ No ☒
   If yes, what is the effective date of the emergency rule? _____

When does the emergency rule expire? _____

Will this emergency rule be promulgated under the permanent provisions of the Administrative Procedure Act? Yes ☐ No ☐

5. Is this a new rule? Yes ☐ No ☒
If yes, please provide a brief summary explaining the regulation. _____

Does this repeal an existing rule? Yes ☐ No ☒
If yes, a copy of the repealed rule is to be included with your completed questionnaire. If it is being replaced with a new rule, please provide a summary of the rule giving an explanation of what the rule does. _____

Is this an amendment to an existing rule? Yes ☒ No ☐
If yes, please attach a mark-up showing the changes in the existing rule and a summary of the substantive changes. **Note: The summary should explain what the amendment does, and the mark-up copy should be clearly labeled "mark-up."**

6. Cite the state law that grants the authority for this proposed rule? If codified, please give the Arkansas Code citation. Arkansas Statute 20-76-201

7. What is the purpose of this proposed rule? Why is it necessary? To establish the Outpatient Behavioral Health Services Program while also amending the Inpatient Psychiatric Services for Under Age 21 Program and School Based Mental Health Program in Arkansas Medicaid.

The proposed rule is necessary to ensure that behavioral health care reimbursed by Medicaid is: (1) Family/consumer-driven and person-centered, to support and promote evidence-based, recovery-oriented practices that guide service delivery and payment efficiency, (2) Provides customized, culturally and linguistically competent, community-based services, (3) Offers the least restrictive care, (4) Utilizes a team-based approach to treatment decisions to address service needs, and (5) Ensures services are high quality based on data from outcomes and evaluation tools.

8. Please provide the address where this rule is publicly accessible in electronic form via the Internet as required by Arkansas Code § 25-19-108(b).
https://www.medicaid.state.ar.us/InternetSolution/general/comment/comment.aspx

9. Will a public hearing be held on this proposed rule? Yes ☒ No ☐

If yes, please complete the following:

Date: October 4, 2016

Time: 4:30 pm

Place: Central Arkansas Library
Lee Room
100 Rock Street
Little Rock, AR 72201

10. When does the public comment period expire for permanent promulgation? (Must provide a date.)

October 14, 2017

11. What is the proposed effective date of this proposed rule? (Must provide a date.)

July 1, 2017

12. Do you expect this rule to be controversial? Yes ☒ No ☐

If yes, please explain. This proposed amendment will transform the Medicaid Behavioral Healthcare system within the State. including the service array and fee schedule.

13. Please give the names of persons, groups, or organizations that you expect to comment on these rules? Please provide their position (for or against) if known.

Medical associations, interested providers and advocacy organizations. Their positions for or against is not known at this time.

FINANCIAL IMPACT STATEMENT

PLEASE ANSWER ALL QUESTIONS COMPLETELY

DEPARTMENT Department of Human Services
DIVISION Division of Medical Services
PERSON COMPLETING THIS STATEMENT Dr. Charlie Green
TELEPHONE NO. 501-686-9164 **FAX NO.** 501-404-4619 **EMAIL:** charlie.green@dhs.arkansas.gov

To comply with Ark. Code Ann. § 25-15-204(e), please complete the following Financial Impact Statement and file two copies with the questionnaire and proposed rules.

SHORT TITLE OF THIS RULE Outpatient Behavioral Health Services Update New-16, ARKids 3-16, Inpatient Psychiatric Services for Persons Under Age 21 Update 1-16, School Based Mental Health Update 1-16, Substance Abuse Treatment Services 2-16, Rehabilitative Services for Persons with Mental Illness 4-16, Licensed Mental Health Practitioners 2-16 and State Plan Amendment #2016-008

1. Does this proposed, amended, or repealed rule have a financial impact? Yes ☒ No ☐

2. Is the rule based on the best reasonably obtainable scientific, technical, economic, or other evidence and information available concerning the need for, consequences of, and alternatives to the rule? Yes ☒ No ☐

3. In consideration of the alternatives to this rule, was this rule determined by the agency to be the least costly rule considered? Yes ☒ No ☐

   If an agency is proposing a more costly rule, please state the following:

   (a) How the additional benefits of the more costly rule justify its additional cost;

   (b) The reason for adoption of the more costly rule;

   (c) Whether the more costly rule is based on the interests of public health, safety, or welfare, and if so, please explain; and;

   (d) Whether the reason is within the scope of the agency's statutory authority; and if so, please explain.

4. If the purpose of this rule is to implement a federal rule or regulation, please state the following:

   (a) What is the cost to implement the federal rule or regulation?

Current Fiscal Year		**Next Fiscal Year**	
General Revenue		General Revenue	

Federal Funds		Federal Funds	
Cash Funds		Cash Funds	
Special Revenue		Special Revenue	
Other (Identify)		Other (Identify)	

Total	$0	Total	$0

(b) What is the additional cost of the state rule?

Current Fiscal Year		Next Fiscal Year	
General Revenue	($24,505,756) Savings	General Revenue	($24,505,756) Savings
Federal Funds	($58,790,491) Savings	Federal Funds	($58,790,491) Savings
Cash Funds		Cash Funds	
Special Revenue		Special Revenue	
Other (Identify)		Other (Identify)	
Total	($83,296,247) Savings	Total	($83,296,247) Savings

5. What is the total estimated cost by fiscal year to any private individual, entity and business subject to the proposed, amended, or repealed rule? Identify the entity(ies) subject to the proposed rule and explain how they are affected.

Current Fiscal Year	Next Fiscal Year
$ 0	$ 0

6. What is the total estimated cost by fiscal year to state, county, and municipal government to implement this rule? Is this the cost of the program or grant? Please explain how the government is affected.

Current Fiscal Year	Next Fiscal Year
$ (24,505,756) Savings	$ (24,505,756) Savings

The above amount will be General Revenue saved by the Behavioral Health transformation.

7. With respect to the agency's answers to Questions #5 and #6 above, is there a new or increased cost or obligation of at least one hundred thousand dollars ($100,000) per year to a private individual, private entity, private business, state government, county government, municipal government, or to two (2) or more of those entities combined?

Yes ☐ No ☒

If YES, the agency is required by Ark. Code Ann. § 25-15-204(e)(4) to file written findings at the time of filing the financial impact statement. The written findings shall be filed simultaneously with the financial impact statement and shall include, without limitation, the following:

(1) a statement of the rule's basis and purpose;

(2) the problem the agency seeks to address with the proposed rule, including a statement of whether a rule is required by statute;

(3) a description of the factual evidence that:

(a) justifies the agency's need for the proposed rule; and

(b) describes how the benefits of the rule meet the relevant statutory objectives and justify the rule's costs;

(4) a list of less costly alternatives to the proposed rule and the reasons why the alternatives do not adequately address the problem to be solved by the proposed rule;

(5) a list of alternatives to the proposed rule that were suggested as a result of public comment and the reasons why the alternatives do not adequately address the problem to be solved by the proposed rule;

(6) a statement of whether existing rules have created or contributed to the problem the agency seeks to address with the proposed rule and, if existing rules have created or contributed to the problem, an explanation of why amendment or repeal of the rule creating or contributing to the problem is not a sufficient response; and

(7) an agency plan for review of the rule no less than every ten (10) years to determine whether, based upon the evidence, there remains a need for the rule including, without limitation, whether:

(a) the rule is achieving the statutory objectives;
(b) the benefits of the rule continue to justify its costs; and
(c) the rule can be amended or repealed to reduce costs while continuing to achieve the statutory objectives.

Summary for
Outpatient Behavioral Health Services Update New-16,
ARKids 3-16, Inpatient Psychiatric Services for Persons Under Age 21 Update 1-16,
School Based Mental Health Update 1-16, Substance Abuse Treatment Services 2-16,
Rehabilitative Services for Persons with Mental Illness 4-16,
Licensed Mental Health Practitioners 2-16 and State Plan Amendment #2016-008

Effective July 1, 2017, Arkansas Medicaid proposes to implement the Medicaid Outpatient Behavioral Health Services Program while also amending the Inpatient Psychiatric Services for Persons Age 21 program and School Based Mental Health program. The proposed rule ensures that behavioral health care reimbursed by Medicaid is: (1) Family/consumer-driven and person-centered, to support and promotes evidence-based, recovery-oriented practices that guide service delivery and payment efficiency, (2) Provides customized, culturally and linguistically competent, community-based services, (3) Offers the least restrictive care, (4) Utilizes a team-based approach to treatment decisions to address service needs, and (5) Ensures services are high quality based on data from outcomes and evaluation tools.

One comment received in "Support" from Arkansas Association for Infant Mental Health

Public Hearing held October 4th – No comments received

Controversial

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: 501-404-4619
TDD/TTY: 501-682-6789

TO: Arkansas Medicaid Health Care Providers – ARKids First-B

EFFECTIVE DATE: July 1, 2017

SUBJECT: Provider Manual Update Transmittal ARKIDS-3-16

PROPOSED

REMOVE		INSERT	
Section	**Effective Date**	**Section**	**Effective Date**
221.100	10-1-15	221.100	7-1-17
221.200	10-1-15	221.200	7-1-17

Explanation of Updates

Section 221.100 is updated to add School-Based Mental Health (SBMH) to the list of ARKids First-B Medical Care Benefits.

Section 221.200 is updated to remove SBMH from the list of exclusions.

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 Hewlett Packard Enterprise 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.

Dawn Stehle
Director

RECEIVED
OCT 14 2016
BUREAU OF
LEGISLATIVE RESEARCH

TOC not required

PROPOSED

221.100 ARKids First-B Medical Care Benefits 7-1-17

Listed below are the covered services for the ARKids First-B program. This chart also includes benefits, whether Prior Authorization or a Primary Care Physician (PCP) referral is required, and specifies the cost-sharing requirements.

Program Services	Benefit Coverage and Restrictions	Prior Authorization/ PCP Referral*	Co-payment/ Coinsurance/ Cost Sharing Requirement**
Ambulance (Emergency Only)	Medical Necessity	None	$10 per trip
Ambulatory Surgical Center	Medical Necessity	PCP Referral	$10 per visit
Audiological Services (only Tympanometry, CPT procedure code 92567, when the diagnosis is within the ICD range (View ICD codes.))	Medical Necessity	None	None
Certified Nurse-Midwife	Medical Necessity	PCP Referral	$10 per visit
Chiropractor	Medical Necessity	PCP Referral	$10 per visit
Dental Care	Routine dental care and orthodontia services	None – PA for inter-periodic screens and orthodontia services	$10 per visit
Durable Medical Equipment	Medical Necessity $500 per state fiscal year (July 1 through June 30) minus the coinsurance/cost-share. Covered items are listed in Section 262.120	PCP Referral and Prescription	10% of Medicaid allowed amount per DME item cost-share
Emergency Dept. Services			
Emergency	Medical Necessity	None	$10 per visit
Non-Emergency	Medical Necessity	PCP Referral	$10 per visit
Assessment	Medical Necessity	None	$10 per visit
Family Planning	Medical Necessity	None	None
Federally Qualified Health Center (FQHC)	Medical Necessity	PCP Referral	$10 per visit

Program Services	Benefit Coverage and Restrictions	Prior Authorization/ PCP Referral*	Co-payment/ Coinsurance/ Cost Sharing Requirement**
Home Health	Medical Necessity (10 visits per state fiscal year (July 1 through June 30)	PCP Referral	$10 per visit
Hospital, Inpatient	Medical Necessity	PA on stays over 4 days if age 1 or over	10% of first inpatient day
Hospital, Outpatient	Medical Necessity	PCP referral	$10 per visit
Inpatient Psychiatric Hospital and Psychiatric Residential Treatment Facility	Medical Necessity	PA & Certification of Need is required prior to admittance	10% of first inpatient day
Immunizations	All per protocol	None	None
Laboratory & X-Ray	Medical Necessity	PCP Referral	$10 per visit
Medical Supplies	Medical Necessity Benefit of $125/mo. Covered supplies listed in Section 262.110	PCP Prescriptions PA required on supply amounts exceeding $125/mo	None
Mental and Behavioral Health, Outpatient	Medical Necessity	PCP Referral PA on treatment services	$10 per visit
School-Based Mental Health	Medical Necessity	PA Required (See Section 250.000 of the School-Based Mental Health provider manual.)	$10 per visit
Nurse Practitioner	Medical Necessity	PCP Referral	$10 per visit
Physician	Medical Necessity	PCP referral to specialist and inpatient professional services	$10 per visit
Podiatry	Medical Necessity	PCP Referral	$10 per visit
Prenatal Care	Medical Necessity	None	None
Prescription Drugs	Medical Necessity	Prescription	Up to $5 per prescription (Must use generic, if*** available)
Preventive Health Screenings	All per protocol	PCP Administration or PCP Referral	None
Rural Health Clinic	Medical Necessity	PCP Referral	$10 per visit

PROPOSED

Program Services	Benefit Coverage and Restrictions	Prior Authorization/ PCP Referral*	Co-payment/ Coinsurance/ Cost Sharing Requirement**
Speech Therapy	Medical Necessity 4 evaluation units (1 unit =30 min) per state fiscal year 4 therapy units (1 unit=15 min) daily	PCP Referral Authorization required on extended benefit of services	$10 per visit
Occupational Therapy	Medical Necessity 4 evaluation units (1 unit = 30 min) per state fiscal year 4 therapy units (1 unit = 15 min) daily	PCP Referral Authorization required on extended benefit of services	$10 per visit
Physical Therapy	Medical Necessity 4 evaluation units (1 unit = 30 min) per state fiscal year 4 therapy units (1 unit = 15 min) daily	PCP Referral Authorization required on extended benefit of services	$10 per visit
Substance Abuse Treatment Services (SATS)	Medical Necessity	Psychiatrist or Physician Prescription (See Section 221.000 of SATS manual) Prior Authorization required for all substance abuse treatment services, except codes H0001 & T1007 when billed with no modifier. Codes H0001 & T1007 require prior authorization when billed with a modifier (See Section 231.100 of SATS manual). Prior Authorization required on extended benefit of services (See Section 230.000 of SATS manual)	$10 per visit

PROPOSED

Program Services	Benefit Coverage and Restrictions	Prior Authorization/ PCP Referral*	Co-payment/ Coinsurance/ Cost Sharing Requirement**
Vision Care			
Eye Exam	One (1) routine eye exam (refraction) every 12 months	None	$10 per visit
Eyeglasses	One (1) pair every 12 months	None	None

PROPOSED

*Refer to your Arkansas Medicaid specialty provider manual for prior authorization and PCP referral procedures.

**ARKids First-B beneficiary cost-sharing is capped at 5% of the family's gross annual income.

***ARKids First-B beneficiaries will pay a maximum of $5.00 per prescription. The beneficiary will pay the provider the amount of co-payment that the provider charges non-Medicaid purchasers up to $5.00 per prescription.

221.200 Exclusions 7-1-17

Services Not Covered for ARKids First-B Beneficiaries:

Audiological Services; EXCEPTION, Tympanometry, CPT procedure code **92567**, when the diagnosis is within the ICD range. (View ICD codes.)

Child Health Management Services (CHMS)

Child Health Services/Early and Periodic Screening, Diagnosis and Treatment (EPSDT)

Developmental Day Treatment Clinic Services (DDTCS)

Diapers, Underpads and Incontinence Supplies

Domiciliary Care

End Stage Renal Disease Services

Hearing Aids

Hospice

Hyperalimentation

Non-Emergency Transportation

Nursing Facilities

Orthotic Appliances and Prosthetic Devices

Personal Care

Private Duty Nursing Services

Rehabilitation Therapy for Chemical Dependency

Rehabilitative Services for Children

Rehabilitative Services for Persons with Physical Disabilities (RSPD)

Targeted Case Management

Ventilator Services

PROPOSED

TOC not required

221.100 ARKids First-B Medical Care Benefits ~~10-1-15~~7-1-17

Listed below are the covered services for the ARKids First-B program. This chart also includes benefits, whether Prior Authorization or a Primary Care Physician (PCP) referral is required, and specifies the cost-sharing requirements.

Program Services	Benefit Coverage and Restrictions	Prior Authorization/ PCP Referral*	Co-payment/ Coinsurance/ Cost Sharing Requirement**
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Durable Medical Equipment	Medical Necessity $500 per state fiscal year (July 1 through June 30) minus the coinsurance/cost-share. Covered items are listed in Section 262.120	PCP Referral and Prescription	10% of Medicaid allowed amount per DME item cost-share
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Emergency	Medical Necessity	None	$10 per visit
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Program Services	Benefit Coverage and Restrictions	Prior Authorization/ PCP Referral*	Co-payment/ Coinsurance/ Cost Sharing Requirement**
Vision Care			
Eye Exam	One (1) routine eye exam (refraction) every 12 months	None	$10 per visit
Eyeglasses	One (1) pair every 12 months	None	None

*Refer to your Arkansas Medicaid specialty provider manual for prior authorization and PCP referral procedures.

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221.200 **Exclusions** ~~10-1-15~~7-1-17

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Nursing Facilities

Orthotic Appliances and Prosthetic Devices

Personal Care

Private Duty Nursing Services

Rehabilitation Therapy for Chemical Dependency

Rehabilitative Services for Children

Rehabilitative Services for Persons with Physical Disabilities (RSPD)

~~School-Based Mental Health Services~~

Targeted Case Management

Ventilator Services

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: 501-404-4619
TDD/TTY: 501-682-6789

TO: **Arkansas Medicaid Health Care Providers – Licensed Mental Health Practitioners**

EFFECTIVE DATE: **July 1, 2017**

SUBJECT: **Provider Manual Update Transmittal LMHP-2-16**

PROPOSED

REMOVE		INSERT	
Section	**Effective Date**	**Section**	**Effective Date**
211.000	10-13-03	211.000	7-1-17

Explanation of Updates

Section 211.000 has been updated with information regarding the transition of the Rehabilitative Services for Persons with Mental Illness (RSPMI) Program, Licensed Mental Health Practitioner (LMHP) Program and the Substance Abuse Treatment Services (SATS) Program to the Outpatient Behavioral Health Services Program.

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 Hewlett Packard Enterprise 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.

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Thank you for your participation in the Arkansas Medicaid Program.

Dawn Stehle /TAH

Dawn Stehle
Director

TOC not required

211.000 Introduction 7-1-17

Medicaid (Arkansas Medical Assistance Program) is designed to assist eligible Medicaid beneficiaries in obtaining medical care within the guidelines specified in Section I of this manual. Reimbursement will be made for allowed services rendered by a Medicaid enrolled provider within the Medicaid Program limitations as outlined in Section II of this manual.

The transition process to eliminate the Rehabilitative Services for Persons with Mental Illness (RSPMI) Program, Licensed Mental Health Practitioner (LMHP) Program and the Substance Abuse Treatment Services (SATS) Program is contingent upon the approval of the implementation of the Outpatient Behavioral Health Services Program. Clients currently served by the RSPMI, LMHP and SATS programs will begin transitioning to the Outpatient Behavioral Health Program starting July 1, 2017. RSPMI, LMHP and SATS will cease to exist on June 30, 2018 and no Arkansas Medicaid payments will occur to any RSPMI, LMHP or SATS provider for services provided after June 30, 2018.

TOC not required

211.000 Introduction 10-13-037-1-17

Medicaid (Arkansas Medical Assistance Program) is designed to assist eligible Medicaid beneficiaries in obtaining medical care within the guidelines specified in Section I of this manual. Reimbursement will be made for allowed services rendered by a Medicaid enrolled provider within the Medicaid Program limitations as outlined in Section II of this manual.

The transition process to eliminate the Rehabilitative Services for Persons with Mental Illness (RSPMI) Program, Licensed Mental Health Practitioner (LMHP) Program and the Substance Abuse Treatment Services (SATS) Program is contingent upon the approval of the implementation of the Outpatient Behavioral Health Services Program. Clients currently served by the RSPMI, LMHP and SATS programs will begin transitioning to the Outpatient Behavioral Health Program starting July 1, 2017. RSPMI, LMHP and SATS will cease to exist on June 30, 2018 and no Arkansas Medicaid payments will occur to any RSPMI, LMHP or SATS provider for services provided after June 30, 2018.

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: 501-404-4619
TDD/TTY: 501-682-6789

TO: Arkansas Medicaid Health Care Providers – School-Based Mental Health Services

EFFECTIVE DATE: July 1, 2017

PROPOSED

SUBJECT: Provider Manual Update Transmittal SBMH-1-16

REMOVE		INSERT	
Section	**Effective Date**	**Section**	**Effective Date**
202.100	10-13-03	202.100	7-1-17
211.000	10-13-03	211.000	7-1-17
211.300	7-1-05	211.300	7-1-17
212.000	10-13-03	212.000	7-1-17
213.000	10-13-03	213.000	7-1-17
214.000	10-13-03	214.000	7-1-17
219.000	10-13-03	219.000	7-1-17
219.100	10-13-03	—	—
—	—	219.100	7-1-17
—	—	228.130	7-1-17
—	—	228.131	7-1-17
—	—	229.000	7-1-17
—	—	229.200	7-1-17
272.100	9-1-13	272.100	7-1-17
—	—	272.110	7-1-17
—	—	272.120	7-1-17
—	—	272.130	7-1-17
—	—	272.140	7-1-17
—	—	272.150	7-1-17

Explanation of Updates

Section 202.100 is updated to remove item E, Licensed School Psychology Specialist (LSPS).

Section 211.000 is updated to replace the word recipients with the word beneficiaries.

Section 211.300 is updated to add three additional introductory paragraphs and to replace the first sentence of the fourth paragraph.

Section 212.000 is updated to replace the word recipients with the word beneficiaries and to include those with ARKids B.

Section 213.000 is updated to remove item G and its note and to modify item H (now item G).

Section 214.000 is updated to provide more detailed information on covered outpatient services, with specific instruction regarding billing units.

Section 219.000 is updated to specify the section of the Arkansas Medicaid Program (Utilization Review Section) and to replace the term Medicaid recipients with the term its beneficiaries.

Section 219.100 is updated to remove information on the Medicaid field audit unit and replace it with information on record reviews performed by the contractor, Beacon Health Options.

Section 228.130 is added to include information on retrospective reviews performed by the contractor, Beacon Health Options.

Section 228.131 is added to provide information on the purpose of the reviews.

Section 229.000 is added to explain the Medicaid beneficiary appeal process.

PROPOSED

Section 229.200 is added to explain the recoupment process.

Section 272.100 is updated to eliminate the existing procedure code chart.

Section 272.110 is added to provide a CPT®/HCPCS procedure code chart with description for mental health diagnosis.

Section 272.120 is added to provide a CPT®/HCPCS procedure code chart with description for psychological evaluation.

Section 272.130 is added to provide a CPT®/HCPCS procedure code chart with description for interpretation of diagnosis.

Section 272.140 is added to provide a CPT®/HCPCS procedure code chart with description for marital/family behavioral health counseling with beneficiary present.

Section 272.150 is added to provide a CPT®/HCPCS procedure code chart with description for crisis intervention.

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 Hewlett Packard Enterprise 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.

Dawn Stehle
Director

TOC required

202.100 Requirements for Certification of Provider Staff or Contracted Professionals Who Provide School-Based Mental Health Services 7-1-17

School-Based Mental Health Services provider employees and contractors will provide services only in those areas in which they are licensed or credentialed.

School-Based Mental Health Services provider employees and contractors will be under the supervision and jurisdiction of the school district and/or ESC and will provide services twelve months of each year.

School district and Educational Services Cooperative (ESC) mental health provider employee and contractor requirements are as follows:

A. Licensed Certified Social Worker (LCSW)

1. The LCSW must possess a master's degree in social work from a graduate school of social work accredited by the Council on Social Work Education (CSWE).
2. The LCSW must be state licensed and certified to practice as a licensed certified social worker in the State of Arkansas and in good standing with the Arkansas Social Work Licensing Board.
3. The LCSW must provide to the school district or ESC proof of two (2) years post-licensure experience treating children and adolescents with mental illness.
4. The LCSW shall not provide services beyond those for which he or she has been trained and are within his or her scope of practice and licensure.

NOTE: A licensed certified social worker employed or contracted with the school district or ESC may not be enrolled in the Targeted Case Management (TCM) Program. He or she must choose only one of these programs in which to participate.

B. Licensed Master Social Worker (LMSW)

1. The LMSW must have a master's degree from an accredited social work program in an accredited institution approved by the Council on Social Work Education (CSWE).
2. The LMSW must be state licensed and certified to practice as a licensed master social worker in the State of Arkansas and in good standing with the Arkansas Social Work Licensing Board.
3. The LMSW must work under the supervision of an LCSW.
4. The LMSW shall not provide services beyond those for which he or she has been trained and are within his or her scope of practice and licensure.

NOTE: A licensed certified social worker employed or contracted with the school district or ESC may not be enrolled in the Targeted Case Management (TCM) Program. He or she must choose only one of these programs in which to participate.

C. Licensed Professional Counselor (LPC)

1. The LPC must have received a graduate (master's) degree that is primarily professional counseling in content from a regionally accredited institution of higher education. The LPC must have accumulated at least 48 graduate semester hours to meet the academic and training content standard established by the Arkansas Board of Examiners in Counseling.
2. The LPC has three (3) years of supervised full-time experience in professional counseling acceptable to the Arkansas Board of Examiners in Counseling. One (1) year of experience may be gained for each 30 graduate semester hours earned

beyond the master's degree provided that the hours are clearly related to the field of counseling and are acceptable to the Board. In no case may the applicant have less than one (1) year of supervised professional experience.

3. The LPC must be licensed as a licensed professional counselor and be in good standing with the Arkansas Board of Examiners in Counseling.
4. The LPC must meet all licensure requirements as set forth in Arkansas Code Annotated § 17-27-301 for licensed Professional Counselors (LPC).
5. The LPC must provide proof to the school district or ESC of two (2) years post-licensure experience treating children and adolescents with mental illness.
6. The LPC shall not provide services beyond those for which he or she has been trained and are within his or her scope of practice and licensure.

D. Licensed Associate Counselor (LAC)

1. The LAC must be licensed as a licensed associate counselor and in good standing with the Arkansas Board of Examiners in Counseling.
2. The LAC must meet all licensure requirements as held forth in Arkansas Code Annotated § 17-27-302.
3. The LAC may practice only under direct supervision of an LPC.
4. The plan for supervision of the LAC must be approved by the Board of Examiners in Counseling prior to any actual performance of counseling on the part of the LAC.
5. The LAC must provide proof to the school district or ESC of two (2) years post-licensure experience treating children and adolescents with mental illness.
6. The LAC shall not provide services beyond those for which he or she has been trained and are within his or her scope of practice and licensure.
7. The LAC shall provide to the school district or ESC a copy of his or her supervision plan including the name and license number of his or her supervising LPC before the LAC provides any service for which he or she is required to be under the supervision of a LPC.

E. Licensed Psychological Examiner (LPE)

1. The LPE must have two (2) academic years of graduate training in psychology, including a master's degree from an accredited educational institution recognized by the Arkansas Board of Examiners in Psychology as maintaining satisfactory standards or, in lieu thereof, such training and experience as the Board shall consider equivalent.
2. The LPE must be licensed as a licensed psychological examiner and be in good standing with the Arkansas Board of Examiners in Psychology.
3. The LPE shall provide to the school district or ESC the name and licensure number of his or her supervising psychologist before the LPE provides any service for which he or she is required to be under the supervision of a psychologist licensed by the Arkansas Board of Examiners in Psychology.
4. The LPE shall not provide services beyond those for which he or she has been trained and are within his or her scope of practice and licensure.

F. Psychologist

1. The psychologist must have at least two (2) years of experience in psychology of a type considered by the Board to be qualifying in nature with at least one (1) of those years being postdoctoral work.
2. The psychologist must be licensed as a psychologist by the Arkansas Board of Examiners in Psychology.

3. The psychologist shall not provide services beyond those for which he or she has been trained and are within his or her scope of practice and licensure.

211.000 Introduction 7-1-17

Medicaid (Arkansas Medical Assistance Program) is designed to assist eligible beneficiaries in obtaining medical care within the guidelines specified in Section I of the manual. Reimbursement will be made for allowed services rendered by a Medicaid-enrolled school-based provider within the Medicaid Program limitations as outlined in this manual.

211.300 Primary Care Physician (PCP) Referral PROPOSED 7-1-17

Each beneficiary who receives School-Based Mental Health Services can receive a limited amount of services. Once those limits are reached, a Primary Care Physician (PCP) referral or Patient-Centered Medical Home (PCMH) approval will be necessary to continue treatment. This referral or approval must be retained in the beneficiary's medical record.

A beneficiary can receive three (3) School-Based Mental Health Services before a PCP/PCMH referral is necessary. No services will be allowed to be provided without appropriate PCP/PCMH referral. The PCP/PCMH referral must be kept in the beneficiary's medical record.

The Patient-Centered Medical Home (PCMH) will be responsible for coordinating care with a beneficiary's PCP or physician for School-Based Mental Health Services. Medical responsibility for beneficiaries receiving School-Based Mental Health Services shall be vested in a physician licensed in Arkansas.

The PCP referral or PCMH authorization for School-Based Mental Health Services will serve as the prescription for those services.

See Section I of this manual for the PCP procedures. A PCP referral is generally obtained prior to providing service to Medicaid-eligible children. However, a PCP is given the option of providing a referral after a service is provided. If a PCP chooses to make a referral after a service has been provided, the referral must be received by the SBMH provider no later than 45 calendar days after the date of service. The PCP has no obligation to give a retroactive referral.

The SBMH provider may not file a claim and will not be reimbursed for any services provided that require a PCP referral unless the referral is received.

212.000 Scope 7-1-17

The School-Based Mental Health Services program consists of a range of mental health diagnostic, therapeutic, rehabilitative or palliative services provided by the employees and contractors described in Section 202.100 of this manual to Medicaid-eligible beneficiaries (including ARKids B) under age twenty-one (21) suffering from psychiatric conditions as described in the current allowable American Psychiatric Association Diagnostic and Statistical Manual (DSM).

Medicaid-covered school-based mental health services may be provided only when:

A. Referred, in writing or verbally, by a Medicaid-enrolled physician. See Section 212.100 for details.

B. Provided to Medicaid recipients under age 21.

C. Provided to outpatients.

D. Provided by School-Based Mental Health Services provider employees or contractors.

E. A comprehensive assessment indicates the need for services (see Section 212.200 for details).

F. Included in a treatment plan.

213.000 Exclusions 7-1-17

The following are non-covered School-Based Mental Health Services:

PROPOSED

A. Services provided in a supervised living or residential treatment facility.

B. Educational services.

C. Telephone contacts with the patient or telephone contacts with the collateral in regard to the beneficiary.

D. Services to individuals with developmental disabilities that are non-psychiatric in nature, except for testing purposes.

E. Inpatient Hospital Services.
"Inpatient" means a patient who has been admitted to a medical institution on recommendation of a physician or dentist and is receiving room, board and professional services in the institution on a continuous 24-hour-a-day basis, or who is expected by the institution to receive room, board and professional services for a 24-hour period or longer even though it later develops that the patient dies, is discharged or is transferred to another facility and does not actually stay in the institution for 24 hours.

F. Inpatient Psychiatric Services.
See E. above for definition of inpatient.

G. A School-Based Mental Health Services provider will not be reimbursed for the same procedure code for a service provided on the same date of service as services provided by a Counseling Level Outpatient Behavioral Health Services Provider or Outpatient Behavioral Health Services Provider certified by the Division of Behavioral Health Services.

214.000 Covered Services 7-1-17

Outpatient Services

Fifteen-minute units, unless otherwise stated.

Outpatient Behavioral Health Services must be billed on a per-unit basis, as reflected in a daily total, per beneficiary, per 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 Outpatient Behavioral Health service. Providers are not allowed to accumulatively bill for spanning dates of service.

All billing must reflect a daily total, per Outpatient Behavioral Health 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 number 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

PROPOSED

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.

Refer to Section 272.100 of this manual for descriptions of procedure codes that are reimbursable by Arkansas Medicaid for School-Based Mental Health providers.

219.000 Utilization Review 7-1-17

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

219.100 Record Reviews 7-1-17

The Division of Medical Services (DMS) of the Arkansas Department of Human Services (DHS) has contracted with an independent contractor to perform on-site inspections of care (IOC) and retrospective reviews of outpatient mental health services provided by Outpatient Behavioral Health Services providers. **View or print current contractor 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.

228.130 Retrospective Reviews 7-1-17

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

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

228.131 Purpose of a Review 7-1-17

The purpose of a review is to:

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

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

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

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

229.000 Medicaid Beneficiary Appeal Process 7-1-17

If an adverse decision is received, the beneficiary may request a fair hearing of the denial decision.

The appeal request must be in writing and received by the Appeals and Hearings Section of the Department of Human Services within thirty days of the date on the letter explaining the denial of services.

229.200 Recoupment Process 7-1-17

The Division of Medical Services (DMS), Utilization Review Section (UR) is required to initiate the recoupment process for all claims that the current contractor has denied because the records submitted do not support the claim of medical necessity.

Arkansas Medicaid will send the provider an Explanation of Recoupment Notice that will include the claim date of service, Medicaid beneficiary name and ID number, service provided, amount paid by Medicaid, amount to be recouped, and the reason the recoupment is initiated.

272.100 School-Based Mental Health Services Procedure Codes 7-1-17

The following is a list of covered services available in the School-Based Mental Health Services Program. Practitioners enrolled as school-based mental health services provider personnel may provide the services on this list according to their scope of practice as identified by the licensure requirements.

272.110 Mental Health Diagnosis 7-1-17

CPT®/HCPCS PROCEDURE CODE	PROCEDURE CODE DESCRIPTION
90791	Psychiatric diagnostic evaluation (with no medical services)
SERVICE DESCRIPTION	**MINIMUM DOCUMENTATION REQUIREMENTS**
Mental Health Diagnosis is a clinical service for the purpose of determining the existence, type, nature and appropriate treatment of a mental illness or related disorder as described in the current allowable DSM. This service may include time spent for obtaining necessary information for diagnostic purposes. The psychodiagnostic process may include, but is not limited to, a psychosocial and medical history, diagnostic findings, and recommendations. This service must include a face-to-face component and will serve as the basis for documentation of modality and issues to be addressed (Plan of Care). Services must be congruent with the age and abilities of the beneficiary, client-centered and strength-based, with emphasis on needs as identified by the beneficiary and provided with cultural competence.	• Date of service • Start and stop times of the face-to-face encounter with the beneficiary and the interpretation time for diagnostic formulation • Place of service • Identifying information • Referral reason • Presenting problem(s), history of presenting problem(s) including duration, intensity and response(s) to prior treatment • Culturally- and age-appropriate psychosocial history and assessment • Mental status/clinical observations and impressions • Current functioning plus strengths and needs in specified life domains

	• DSM diagnostic impressions to include all axes • Treatment recommendations • Goals and objectives to be placed in Plan of Care • Staff signature/credentials/date of signature

NOTES	UNIT	BENEFIT LIMITS
This service may be billed for face-to-face contact as well as for time spent obtaining necessary information for diagnostic purposes; however, this time may NOT be used for development or submission of required paperwork processes (i.e. treatment plans, etc.).	Encounter PROPOSED	DAILY MAXIMUM OF UNITS THAT MAY BE BILLED: 1 YEARLY MAXIMUM OF UNITS THAT MAY BE BILLED (extension of benefits can be requested): 1

APPLICABLE POPULATIONS	SPECIAL BILLING INSTRUCTIONS
Children and Youth	**Outpatient Behavioral Health Services Providers cannot bill 90791 on same date of service**
ALLOWED MODE(S) OF DELIVERY	**TIER**
Face-to-face	School-Based Mental Health
ALLOWABLE PERFORMING PROVIDER	**PLACE OF SERVICE**
• Licensed Certified Social Worker (LCSW) • Licensed Master Social Worker (LMSW) • Licensed Professional Counselor (LPC) • Licensed Associate Counselor (LAC) • Licensed Psychological Examiner (LPE) • Psychologist * School-Based Mental Health Services provider employees or contractors will provide services only in those areas in which they are licensed or credentialed.	03

272.120 Psychological Evaluation 7-1-17

CPT®/HCPCS PROCEDURE CODE	PROCEDURE CODE DESCRIPTION
96101	Psychological testing (includes psychodiagnostic assessment of emotionality, intellectual abilities, personality and psychopathology, e.g. MMPI, Rorschach®, WAIS®), per hour of the psychologist's or physician's time, both face-to-face time administering tests to the patient and time interpreting these test results and preparing the report.
SERVICE DESCRIPTION	**MINIMUM DOCUMENTATION REQUIREMENTS**

Psychological evaluation for personality assessment includes psychodiagnostic assessment of a beneficiary's emotional, personality, and psychopathology, e.g. MMPI, Rorschach®, and WAIS®. Psychological testing is billed per hour both face-time administering tests and time interpreting these tests and preparing the report. This service may reflect the mental abilities, aptitudes, interests, attitudes, motivation, emotional and personality characteristics of the beneficiary. Medical necessity for this service is met when: • the service is necessary to establish a differential diagnosis of behavioral or psychiatric conditions; • history and symptomatology are not readily attributable to a particular psychiatric diagnosis; or • questions to be answered by the evaluation could not be resolved by a psychiatric/diagnostic interview, observation in therapy or an assessment for level of care at a mental health facility.	• Date of service • Start and stop times of actual encounter with beneficiary • Start and stop times of scoring, interpretation and report preparation • Place of service • Identifying information • Rationale for referral • Presenting problem(s) • Culturally- and age-appropriate psychosocial history and assessment • Mental status/clinical observations and impressions • Psychological tests used, results, and interpretations, as indicated • DSM diagnostic impressions to include all axes • Treatment recommendations and findings related to rationale for service and guided by test results • Staff signature/credentials/date of signature(s)

PROPOSED

NOTES	UNIT	BENEFIT LIMITS
	60 minutes	DAILY MAXIMUM OF UNITS THAT MAY BE BILLED: 1 YEARLY MAXIMUM OF UNITS THAT MAY BE BILLED (extension of benefits can be requested): 8

APPLICABLE POPULATIONS	SPECIAL BILLING INSTRUCTIONS
Children and Youth	
ALLOWED MODE(S) OF DELIVERY	**TIER**
Face-to-face	School-Based Mental Health
ALLOWABLE PERFORMING PROVIDERS	**PLACE OF SERVICE**
• Licensed Psychological Examiner (LPE) • Psychologist	03

272.130 Interpretation of Diagnosis

7-1-17

CPT®/HCPCS PROCEDURE CODE	PROCEDURE CODE DESCRIPTION
90887	Interpretation or explanation of results of psychiatric or other medical examinations and procedures, or other accumulated data to family or other responsible persons, or advising them how to assist

	patient
SERVICE DESCRIPTION	**MINIMUM DOCUMENTATION REQUIREMENTS**
Interpretation of Diagnosis is a direct service provided for the purpose of interpreting the results of psychiatric or other medical exams, procedures or accumulated data. Services may include diagnostic activities and/or advising the beneficiary and his/ her family. Consent forms may be required for family or significant other involvement. Services must be congruent with the age and abilities of the beneficiary, client-centered and strength-based, with emphasis on needs as identified by the beneficiary and provided with cultural competence.	• Start and stop times of face to face encounter with beneficiary and/or parents or guardian • Date of service • Place of service • Participants present and relationship to beneficiary • Diagnosis • Rationale for and objective used that must coincide with the goals and objectives placed in Plan of Care • Participant(s) response and feedback • Staff signature/credentials/date of signature(s)

PROPOSED

NOTES	**UNIT**	**BENEFIT LIMITS**
For beneficiaries under the age of 18, the time may be spent face-to-face with the beneficiary, the beneficiary and the parent(s) or guardian(s) or alone with the parent(s) or guardian(s). For beneficiaries over the age of 18, the time may be spent face-to-face with the beneficiary and the spouse, legal guardian or significant other.	Encounter	DAILY MAXIMUM OF UNITS THAT MAY BE BILLED: 1 YEARLY MAXIMUM OF UNITS THAT MAY BE BILLED (extension of benefits can be requested): 1

APPLICABLE POPULATIONS	**SPECIAL BILLING INSTRUCTIONS**
Children and Youth	
ALLOWED MODE(S) OF DELIVERY	**TIER**
Face-to-face	School-Based Mental Health
ALLOWABLE PERFORMING PROVIDERS	**PLACE OF SERVICE**
• Licensed Certified Social Worker (LCSW) • Licensed Master Social Worker (LMSW) • Licensed Professional Counselor (LPC) • Licensed Associate Counselor (LAC) • Licensed Psychological Examiner (LPE) • Psychologist * School-Based Mental Health Services provider employees or contractors will provide services only in those areas in which they are licensed or credentialed.	03

272.140 Marital/Family Behavioral Health Counseling with Beneficiary Present 7-1-17

CPT®/HCPCS PROCEDURE CODE	**PROCEDURE CODE DESCRIPTION**

90847	Family psychotherapy with patient present (conjoint psychotherapy)
SERVICE DESCRIPTION	**MINIMUM DOCUMENTATION REQUIREMENTS**
Marital/Family Behavioral Health Counseling with Beneficiary Present is a face-to-face treatment provided to one or more family members in the presence of a beneficiary. Services must be congruent with the age and abilities of the beneficiary, client-centered and strength-based, with emphasis on needs as identified by the beneficiary and provided with cultural competence. Services are designed to enhance insight into family interactions, facilitate inter-family emotional or practical support and to develop alternative strategies to address familial issues, problems and needs. Services pertain to a beneficiary's (a) Mental Health and/or (b) Substance Abuse condition. Additionally, tobacco cessation counseling is a component of this service. PROPOSED	• Date of Service • Start and stop times of actual encounter with beneficiary and spouse/family • Place of service • Participants present and relationship to beneficiary • Diagnosis and pertinent interval history • Brief mental status of beneficiary and observations of beneficiary with spouse/family • Rationale for, and description of treatment used, that must coincide with the master treatment plan and improve the impact the beneficiary's condition has on the spouse/family and/or improve marital/family interactions between the beneficiary and the spouse/family. • Beneficiary and spouse/family's response to treatment that includes current progress or regression and prognosis • Any changes indicated for the master treatment plan, diagnosis, or medication(s) • Plan for next session, including any homework assignments and/or crisis plans • Staff signature/credentials/date of signature • HIPAA compliant release of Information, completed, signed and dated

NOTES	UNIT	BENEFIT LIMITS
Natural supports may be included in these sessions if justified in service documentation. Only one beneficiary per family per therapy session may be billed.	Encounter	DAILY MAXIMUM OF UNITS THAT MAY BE BILLED: 1 YEARLY MAXIMUM OF UNITS THAT MAY BE BILLED (extension of benefits can be requested): 12

APPLICABLE POPULATIONS	SPECIAL BILLING INSTRUCTIONS
Children and Youth	
ALLOWED MODE(S) OF DELIVERY	**TIER**
Face-to-face	School-Based Mental Health
ALLOWABLE PERFORMING PROVIDERS	**PLACE OF SERVICE**
• Licensed Certified Social Worker (LCSW) • Licensed Master Social Worker (LMSW) • Licensed Professional Counselor (LPC)	03

• Licensed Associate Counselor (LAC) • Licensed Psychological Examiner (LPE) • Psychologist * School-Based Mental Health Services provider employees or contractors will provide services only in those areas in which they are licensed or credentialed.	PROPOSED

272.150 Crisis Intervention 7-1-17

CPT®/HCPCS PROCEDURE CODE	PROCEDURE CODE DESCRIPTION	
H2011, HA	Crisis intervention service, per 15 minutes	
SERVICE DESCRIPTION	**MINIMUM DOCUMENTATION REQUIREMENTS**	
Crisis Intervention is unscheduled, immediate, short-term treatment activities provided to a Medicaid-eligible beneficiary who is experiencing a psychiatric or behavioral crisis. Services are to be congruent with the age, strengths, needed accommodation for any disability, and cultural framework of the beneficiary and his/her family. These services are designed to stabilize the person in crisis, prevent further deterioration and provide immediate indicated treatment in the least restrictive setting. (These activities include evaluating a Medicaid-eligible beneficiary to determine if the need for crisis services is present.)	• Date of service • Start and stop time of actual encounter with beneficiary and possible collateral contacts with caregivers or informed persons • Place of service • Specific persons providing pertinent information in relationship to beneficiary • Diagnosis and synopsis of events leading up to crisis situation • Brief mental status and observations • Utilization of previously established psychiatric advance directive or crisis plan as pertinent to current situation OR rationale for crisis intervention activities utilized • Beneficiary's response to the intervention that includes current progress or regression and prognosis • Clear resolution of the current crisis and/or plans for further services • Development of a clearly defined crisis plan or revision to existing plan • Staff signature/credentials/date of signature(s)	
NOTES	**UNIT**	**BENEFIT LIMITS**
A psychiatric or behavioral crisis is defined as an acute situation in which an individual is experiencing a serious mental illness or emotional disturbance to the point that the beneficiary or others are at risk for imminent harm or in which to prevent significant deterioration of the beneficiary's functioning. This service can be provided to beneficiaries that have not been previously assessed or have not previously received behavioral health services. The provider of this service MUST complete a	15 minutes	DAILY MAXIMUM OF UNITS THAT MAY BE BILLED: 12 YEARLY MAXIMUM OF UNITS THAT MAY BE BILLED (extension of benefits can be requested): 72

Mental Health Diagnosis (90791) within 7 days of provision of this service. If the beneficiary needs more time to be stabilized, this must be noted in the beneficiary's medical record and the Division of Medical Services Quality Improvement Organization (QIO) must be notified.		
APPLICABLE POPULATIONS	**SPECIAL BILLING INSTRUCTIONS**	
Children and Youth		
ALLOWED MODE(S) OF DELIVERY	**TIER**	
Face-to-face	School-Based Mental Health	
ALLOWABLE PERFORMING PROVIDERS	**PLACE OF SERVICE**	
• Licensed Certified Social Worker (LCSW) • Licensed Master Social Worker (LMSW) • Licensed Professional Counselor (LPC) • Licensed Associate Counselor (LAC) • Licensed Psychological Examiner (LPE) • Psychologist * School-Based Mental Health Services provider employees or contractors will provide services only in those areas in which they are licensed or credentialed.	03 PROPOSED	

TOC required

202.100 **Requirements for Certification of Provider Staff or Contracted Professionals Who Provide School-Based Mental Health Services** ~~10-13-037~~ 1-17

School-Based Mental Health Services provider employees and~~or~~ contractors will provide services only in those areas in which they are licensed or credentialed.

School-Based Mental Health Services provider employees and contractors will be under the supervision and jurisdiction of the school district and/or ESC and will provide services twelve months of each year.

School district and Educational Services Cooperative (ESC) mental health provider employee and contractor requirements are as follows:

A. Licensed Certified Social Worker (LCSW)

1. The LCSW must possess a master's degree in social work from a graduate school of social work accredited by the Council on Social Work Education (CSWE).
2. The LCSW must be state licensed and certified to practice as a licensed certified social worker in the State of Arkansas and in good standing with the Arkansas Social Work Licensing Board.
3. The LCSW must provide to the school district or ESC proof of two (2) years post-licensure experience treating children and adolescents with mental illness.
4. The LCSW shall not provide services beyond those for which he or she has been trained and are within his or her scope of practice and licensure.

NOTE: A licensed certified social worker employed or contracted with the school district or ESC may not be enrolled in the Targeted Case Management (TCM) Program. He or she must choose only one of these programs in which to participate.

B. Licensed Master Social Worker (LMSW)

1. The LMSW must have a master's degree from an accredited social work program in an accredited institution approved by the Council on Social Work Education (CSWE).
2. The LMSW must be state licensed and certified to practice as a licensed master social worker in the State of Arkansas and in good standing with the Arkansas Social Work Licensing Board.
3. The LMSW must work under the supervision of an LCSW.
4. The LMSW shall not provide services beyond those for which he or she has been trained and are within his or her scope of practice and licensure.

~~5. The LMSW shall not provide services beyond those for which he or she has been trained and are within his or her scope of practice and licensure.~~

NOTE: A licensed certified social worker employed or contracted with the school district or ESC may not be enrolled in the Targeted Case Management (TCM) Program. He or she must choose only one of these programs in which to participate.

C. Licensed Professional Counselor (LPC)

1. The LPC must have received a graduate (master's) degree that is primarily professional counseling in content from a regionally accredited institution of higher education. The LPC must have accumulated at least 48 graduate semester hours to meet the academic and training content standard established by the Arkansas Board of Examiners in Counseling.

2. The LPC has three (3) years of supervised full-time experience in professional counseling acceptable to the Arkansas Board of Examiners in Counseling. One (1) year of experience may be gained for each 30 graduate semester hours earned beyond the master's degree provided that the hours are clearly related to the field of counseling and are acceptable to the Board. In no case may the applicant have less than one (1) year of supervised professional experience.
3. The LPC must be licensed as a licensed professional counselor and be in good standing with the Arkansas Board of Examiners in Counseling.
4. The LPC must meet all licensure requirements as set forth in Arkansas Code Annotated § 17-27-301 for licensed Professional Counselors (LPC).
5. The LPC must provide proof to the school district or ESC of two (2) years post-licensure experience treating children and adolescents with mental illness.
6. The LPC shall not provide services beyond those for which he or she has been trained and are within his or her scope of practice and licensure.

D. Licensed Associate Counselor (LAC)

1. The LAC must be licensed as a licensed associate counselor and in good standing with the Arkansas Board of Examiners in Counseling.
2. The LAC must meet all licensure requirements as held forth in Arkansas Code Annotated § 17-27-302.
3. The LAC may practice only under direct supervision of an LPC.
4. The plan for supervision of the LAC must be approved by the Board of Examiners in Counseling prior to any actual performance of counseling on the part of the LAC.
5. The LAC must provide proof to the school district or ESC of two (2) years post-licensure experience treating children and adolescents with mental illness.
6. The LAC shall not provide services beyond those for which he or she has been trained and are within his or her scope of practice and licensure.
7. The LAC shall provide to the school district or ESC a copy of his or her supervision plan including the name and license number of his or her supervising LPC before the LAC provides any service for which he or she is required to be under the supervision of a LPC.

~~E. Licensed School Psychology Specialist (LSPS)~~

~~1. The LSPS must possess a minimum of 60 graduate semester hours sixth year/specialist program with an appropriate graduate degree from a North Central Accreditation for Teacher Education (NCATE) accredited institution of higher learning or one authorized by the Arkansas Department of Education.~~

~~2. The LSPS must hold a valid license from the Arkansas State Board of Education and be licensed as a school psychology specialist.~~

~~3. The LSPS must have completed an internship that consists of one academic year or its equivalent with a minimum of 1200 clock hours of supervised experience, at least 600 of which must be in a school setting.~~

~~4. The LSPS shall not provide services beyond those for which he or she has been trained and are within his or her scope of practice and licensure.~~

FE. Licensed Psychological Examiner (LPE)

1. The LPE must have two (2) academic years of graduate training in psychology, including a master's degree from an accredited educational institution recognized by the Arkansas Board of Examiners in Psychology as maintaining satisfactory

standards or, in lieu thereof, such training and experience as the Board shall consider equivalent.

2. The LPE must be licensed as a licensed psychological examiner and be in good standing with the Arkansas Board of Examiners in Psychology.
3. The LPE shall provide to the school district or ESC the name and licensure number of his or her supervising psychologist before the LPE provides any service for which he or she is required to be under the supervision of a psychologist licensed by the Arkansas Board of Examiners in Psychology.
4. The LPE shall not provide services beyond those for which he or she has been trained and are within his or her scope of practice and licensure.

~~G~~F. Psychologist

1. The psychologist must have at least two (2) years of experience in psychology of a type considered by the Board to be qualifying in nature with at least one (1) of those years being postdoctoral work.
2. The psychologist must be licensed as a psychologist by the Arkansas Board of Examiners in Psychology.
3. The psychologist shall not provide services beyond those for which he or she has been trained and are within his or her scope of practice and licensure.

211.000 Introduction ~~10-13-037~~-1-17

Medicaid (Arkansas Medical Assistance Program) is designed to assist eligible ~~recipients~~ beneficiaries in obtaining medical care within the guidelines specified in Section I of the manual. Reimbursement will be made for allowed services rendered by a Medicaid-enrolled school-based provider within the Medicaid Program limitations as outlined in this manual.

211.300 Primary Care Physician (PCP) Referral 7-1-0517

Each beneficiary who receives School-Based Mental Health Services can receive a limited amount of services. Once those limits are reached, a Primary Care Physician (PCP) referral or Patient-Centered Medical Home (PCMH) approval will be necessary to continue treatment. This referral or approval must be retained in the beneficiary's medical record.

A beneficiary can receive three (3) School-Based Mental Health Services before a PCP/PCMH referral is necessary. No services will be allowed to be provided without appropriate PCP/PCMH referral. The PCP/PCMH referral must be kept in the beneficiary's medical record.

The Patient-Centered Medical Home (PCMH) will be responsible for coordinating care with a beneficiary's PCP or physician for School-Based Mental Health Services. Medical responsibility for beneficiaries receiving School-Based Mental Health Services shall be vested in a physician licensed in Arkansas.

The PCP referral or PCMH authorization for School-Based Mental Health Services will serve as the prescription for those services.

See Section I of this manual for the PCP procedures. ~~A primary care physician (PCP) referral is required for each Medicaid recipient under age twenty-one for outpatient mental health services. See Section I of this manual for the PCP procedures.~~ A PCP referral is generally obtained prior to providing service to Medicaid-eligible children. However, a PCP is given the option of providing a referral after a service is provided. If a PCP chooses to make a referral after a

service has been provided, the referral must be received by the SBMH provider no later than 45 calendar days after the date of service. The PCP has no obligation to give a retroactive referral.

The SBMH provider may not file a claim and will not be reimbursed for any services provided that require a PCP referral unless the referral is received.

212.000 Scope

~~10-13-037~~-1-17

The School-Based Mental Health Services program consists of a range of mental health diagnostic, therapeutic, rehabilitative or palliative services provided by the employees and contractors described in Section 202.100 of this manual to Medicaid-eligible ~~recipients~~ beneficiaries (including ARKids B) under age twenty-one (21) suffering from psychiatric conditions as described in the current allowable American Psychiatric Association Diagnostic and Statistical Manual (DSM-~~IV~~) ~~and subsequent revisions~~.

Medicaid-covered school-based mental health services may be provided only when:

A. Referred, in writing or verbally, by a Medicaid-enrolled physician. See Section 212.100 for details.

B. Provided to Medicaid recipients under age 21.

C. Provided to outpatients.

D. Provided by School-Based Mental Health Services provider employees or contractors.

E. A comprehensive assessment indicates the need for services (see Section 212.200 for details).

F. Included in a treatment plan.

213.000 Exclusions

~~10-13-037~~-1-17

The following are non-covered School-Based Mental Health Services:

A. Services provided in a supervised living or residential treatment facility.

B. Educational services.

C. Telephone contacts with the patient or telephone contacts with the collateral in regard to the beneficiary~~recipient~~.

D. Services to individuals with developmental disabilities that are non-psychiatric in nature, except for testing purposes.

E. Inpatient Hospital Services.
"Inpatient" means a patient who has been admitted to a medical institution on recommendation of a physician or dentist and is receiving room, board and professional services in the institution on a continuous 24-hour-a-day basis, or who is expected by the institution to receive room, board and professional services for a 24-hour period or longer even though it later develops that the patient dies, is discharged or is transferred to another facility and does not actually stay in the institution for 24 hours.

F. Inpatient Psychiatric Services.
See E. above for definition of inpatient.

~~G. Medicaid-covered outpatient mental health services provided by school-based mental health services providers are not covered for ARKids First-B participants.~~

~~NOTE: ARKids First-B participants are those children previously known as ARKids First (aid category 01). Children in aid categories 61 (SOBRA children), 62 (Newborn to a Medicaid-eligible mother) and 63 (Newborn to a SOBRA eligible mother) are now called ARKids First-A. Exclusion number 6 does not apply to ARKids First-A recipients.~~

~~H~~G. A School-Based Mental Health Services provider will not be reimbursed for the same procedure code for a service provided on the same date of service as services provided by a Counseling Level Outpatient Behavioral Health Services Provider or Outpatient Behavioral Health Services Provider certified by the Division of Behavioral Health Services~~n independent licensed mental health practitioner or an RSPMI provider~~.

214.000 Covered Services **10-13-037-1-17**

Outpatient Services

Fifteen-minute units, unless otherwise stated.

Outpatient Behavioral Health Services must be billed on a per-unit basis, as reflected in a daily total, per beneficiary, per 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 Outpatient Behavioral Health service. Providers are not allowed to accumulatively bill for spanning dates of service.

All billing must reflect a daily total, per Outpatient Behavioral Health 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 number 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.

~~Services provided by School-Based Mental Health providers are billed on a per-unit basis. One unit equals 15 minutes. Services less than 15 minutes in duration are not reimbursable.~~

Refer to Section 272.100 of this manual for descriptions of procedure codes that are reimbursable by Arkansas Medicaid for School-Based Mental Health providers.

219.000 Utilization Review ~~10-13-037~~ 1-17

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

219.100 Record Reviews 7-1-17

The Division of Medical Services (DMS) of the Arkansas Department of Human Services (DHS) has contracted with an independent contractor to perform on-site inspections of care (IOC) and retrospective reviews of outpatient mental health services provided by Outpatient Behavioral Health Services providers. **View or print current contractor 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.

228.130 Retrospective Reviews 7-1-17

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

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

228.131 Purpose of a Review 7-1-17

The purpose of a review is to:

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

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

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

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

229.000 Medicaid Beneficiary Appeal Process 7-1-17

If an adverse decision is received, the beneficiary may request a fair hearing of the denial decision.

The appeal request must be in writing and received by the Appeals and Hearings Section of the Department of Human Services within thirty days of the date on the letter explaining the denial of services.

229.200 Recoupment Process 7-1-17

The Division of Medical Services (DMS), Utilization Review Section (UR) is required to initiate the recoupment process for all claims that the current contractor has denied because the records submitted do not support the claim of medical necessity.

Arkansas Medicaid will send the provider an Explanation of Recoupment Notice that will include the claim date of service, Medicaid beneficiary name and ID number, service provided, amount paid by Medicaid, amount to be recouped, and the reason the recoupment is initiated.

272.100 School-Based Mental Health Services Procedure Codes ~~9-1-13~~7-1-17

The following is a list of covered services available in the School-Based Mental Health Services Program. Practitioners enrolled as school-based mental health services provider personnel may provide the services on this list according to their scope of practice as identified by the licensure requirements.

272.110 Mental Health Diagnosis 7-1-17

CPT®/HCPCS PROCEDURE CODE	PROCEDURE CODE DESCRIPTION	
90791	Psychiatric diagnostic evaluation (with no medical services)	
SERVICE DESCRIPTION	**MINIMUM DOCUMENTATION REQUIREMENTS**	
Mental Health Diagnosis is a clinical service for the purpose of determining the existence, type, nature and appropriate treatment of a mental illness or related disorder as described in the current allowable DSM. This service may include time spent for obtaining necessary information for diagnostic purposes. The psychodiagnostic process may include, but is not limited to, a psychosocial and medical history, diagnostic findings, and recommendations. This service must include a face-to-face component and will serve as the basis for documentation of modality and issues to be addressed (Plan of Care). Services must be congruent with the age and abilities of the beneficiary, client-centered and strength-based, with emphasis on needs as identified by the beneficiary and provided with cultural competence.	• Date of service • Start and stop times of the face-to-face encounter with the beneficiary and the interpretation time for diagnostic formulation • Place of service • Identifying information • Referral reason • Presenting problem(s), history of presenting problem(s) including duration, intensity and response(s) to prior treatment • Culturally- and age-appropriate psychosocial history and assessment • Mental status/clinical observations and impressions • Current functioning plus strengths and needs in specified life domains • DSM diagnostic impressions to include all axes • Treatment recommendations • Goals and objectives to be placed in Plan of Care • Staff signature/credentials/date of signature	
NOTES	**UNIT**	**BENEFIT LIMITS**
This service may be billed for face-to-face contact as well as for time spent obtaining necessary information for diagnostic purposes; however, this time may NOT be used for development or submission of required paperwork processes (i.e. treatment plans, etc.).	Encounter	DAILY MAXIMUM OF UNITS THAT MAY BE BILLED 1 YEARLY MAXIMUM OF

		UNITS THAT MAY BE BILLED (extension of benefits can be requested) 1
APPLICABLE POPULATIONS	**SPECIAL BILLING INSTRUCTIONS**	
Children and Youth	**Outpatient Behavioral Health Services Providers cannot bill 90791 on same date of service**	
ALLOWED MODE(S) OF DELIVERY	**TIER**	
Face-to-face	School-Based Mental Health	
ALLOWABLE PERFORMING PROVIDER	**PLACE OF SERVICE**	
• Licensed Certified Social Worker (LCSW) • Licensed Master Social Worker (LMSW) • Licensed Professional Counselor (LPC) • Licensed Associate Counselor (LAC) • Licensed Psychological Examiner (LPE) • Psychologist * School-Based Mental Health Services provider employees or contractors will provide services only in those areas in which they are licensed or credentialed.	03	

272.120 Psychological Evaluation **7-1-17**

CPT®/HCPCS PROCEDURE CODE	**PROCEDURE CODE DESCRIPTION**
96101	Psychological testing (includes psychodiagnostic assessment of emotionality, intellectual abilities, personality and psychopathology, e.g. MMPI, Rorschach®, WAIS®), per hour of the psychologist's or physician's time, both face-to-face time administering tests to the patient and time interpreting these test results and preparing the report.
SERVICE DESCRIPTION	**MINIMUM DOCUMENTATION REQUIREMENTS**
Psychological evaluation for personality assessment includes psychodiagnostic assessment of a beneficiary's emotional, personality, and psychopathology, e.g. MMPI, Rorschach®, and WAIS®. Psychological testing is billed per hour both face-time administering tests and time interpreting these tests and preparing the report. This service may reflect the mental abilities, aptitudes, interests, attitudes, motivation, emotional and personality characteristics of the beneficiary. Medical necessity for this service is met when: • the service is necessary to establish a differential diagnosis of behavioral or psychiatric conditions;	• Date of service • Start and stop times of actual encounter with beneficiary • Start and stop times of scoring, interpretation and report preparation • Place of service • Identifying information • Rationale for referral • Presenting problem(s) • Culturally- and age-appropriate psychosocial history and assessment

• history and symptomatology are not readily attributable to a particular psychiatric diagnosis; or • questions to be answered by the evaluation could not be resolved by a psychiatric/diagnostic interview, observation in therapy or an assessment for level of care at a mental health facility.	• Mental status/clinical observations and impressions • Psychological tests used, results, and interpretations, as indicated • DSM diagnostic impressions to include all axes • Treatment recommendations and findings related to rationale for service and guided by test results • Staff signature/credentials/date of signature(s)

NOTES	UNIT	BENEFIT LIMITS
	60 minutes	DAILY MAXIMUM OF UNITS THAT MAY BE BILLED: 1 YEARLY MAXIMUM OF UNITS THAT MAY BE BILLED (extension of benefits can be requested): 8

APPLICABLE POPULATIONS	SPECIAL BILLING INSTRUCTIONS
Children and Youth	
ALLOWED MODE(S) OF DELIVERY	**TIER**
Face-to-face	School-Based Mental Health
ALLOWABLE PERFORMING PROVIDERS	**PLACE OF SERVICE**
• Licensed Psychological Examiner (LPE) • Psychologist	03

272.130 Interpretation of Diagnosis **7-1-17**

CPT®/HCPCS PROCEDURE CODE	PROCEDURE CODE DESCRIPTION
90887	Interpretation or explanation of results of psychiatric or other medical examinations and procedures, or other accumulated data to family or other responsible persons, or advising them how to assist patient
SERVICE DESCRIPTION	**MINIMUM DOCUMENTATION REQUIREMENTS**
Interpretation of Diagnosis is a direct service provided for the purpose of interpreting the results of psychiatric or other medical exams, procedures or accumulated data. Services may include diagnostic activities and/or advising the beneficiary and his/ her family. Consent forms may be required for family or significant other involvement. Services must be congruent with the age and abilities of the beneficiary, client-centered and strength-based, with emphasis on needs as identified by the beneficiary and provided with cultural competence.	• Start and stop times of face to face encounter with beneficiary and/or parents or guardian • Date of service • Place of service • Participants present and relationship to beneficiary • Diagnosis • Rationale for and objective used that must coincide with the goals and objectives placed in

	Plan of Care • Participant(s) response and feedback • Staff signature/credentials/date of signature(s)	
NOTES	**UNIT**	**BENEFIT LIMITS**
For beneficiaries under the age of 18, the time may be spent face-to-face with the beneficiary, the beneficiary and the parent(s) or guardian(s) or alone with the parent(s) or guardian(s). For beneficiaries over the age of 18, the time may be spent face-to-face with the beneficiary and the spouse, legal guardian or significant other.	Encounter	DAILY MAXIMUM OF UNITS THAT MAY BE BILLED: 1 YEARLY MAXIMUM OF UNITS THAT MAY BE BILLED (extension of benefits can be requested): 1
APPLICABLE POPULATIONS	**SPECIAL BILLING INSTRUCTIONS**	
Children and Youth		
ALLOWED MODE(S) OF DELIVERY	**TIER**	
Face-to-face	School-Based Mental Health	
ALLOWABLE PERFORMING PROVIDERS	**PLACE OF SERVICE**	
• Licensed Certified Social Worker (LCSW) • Licensed Master Social Worker (LMSW) • Licensed Professional Counselor (LPC) • Licensed Associate Counselor (LAC) • Licensed Psychological Examiner (LPE) • Psychologist * School-Based Mental Health Services provider employees or contractors will provide services only in those areas in which they are licensed or credentialed.	03	

272.140 Marital/Family Behavioral Health Counseling with Beneficiary Present 7-1-17

CPT®/HCPCS PROCEDURE CODE	**PROCEDURE CODE DESCRIPTION**
90847	Family psychotherapy with patient present (conjoint psychotherapy)
SERVICE DESCRIPTION	**MINIMUM DOCUMENTATION REQUIREMENTS**

Marital/Family Behavioral Health Counseling with Beneficiary Present is a face-to-face treatment provided to one or more family members in the presence of a beneficiary. Services must be congruent with the age and abilities of the beneficiary, client-centered and strength-based, with emphasis on needs as identified by the beneficiary and provided with cultural competence. Services are designed to enhance insight into family interactions, facilitate inter-family emotional or practical support and to develop alternative strategies to address familial issues, problems and needs. Services pertain to a beneficiary's (a) Mental Health and/or (b) Substance Abuse condition. Additionally, tobacco cessation counseling is a component of this service.	• Date of Service • Start and stop times of actual encounter with beneficiary and spouse/family • Place of service • Participants present and relationship to beneficiary • Diagnosis and pertinent interval history • Brief mental status of beneficiary and observations of beneficiary with spouse/family • Rationale for, and description of treatment used, that must coincide with the master treatment plan and improve the impact the beneficiary's condition has on the spouse/family and/or improve marital/family interactions between the beneficiary and the spouse/family. • Beneficiary and spouse/family's response to treatment that includes current progress or regression and prognosis • Any changes indicated for the master treatment plan, diagnosis, or medication(s) • Plan for next session, including any homework assignments and/or crisis plans • Staff signature/credentials/date of signature • HIPAA compliant release of Information, completed, signed and dated

NOTES	UNIT	BENEFIT LIMITS
Natural supports may be included in these sessions if justified in service documentation. Only one beneficiary per family per therapy session may be billed.	Encounter	DAILY MAXIMUM OF UNITS THAT MAY BE BILLED: 1 YEARLY MAXIMUM OF UNITS THAT MAY BE BILLED (extension of benefits can be requested): 12

APPLICABLE POPULATIONS	SPECIAL BILLING INSTRUCTIONS
Children and Youth	
ALLOWED MODE(S) OF DELIVERY	**TIER**
Face-to-face	School-Based Mental Health
ALLOWABLE PERFORMING PROVIDERS	**PLACE OF SERVICE**
• Licensed Certified Social Worker (LCSW) • Licensed Master Social Worker (LMSW) • Licensed Professional Counselor (LPC) • Licensed Associate Counselor (LAC) • Licensed Psychological Examiner (LPE) • Psychologist	03

* School-Based Mental Health Services provider employees or contractors will provide services only in those areas in which they are licensed or credentialed.	

272.150 Crisis Intervention 7-1-17

CPT©/HCPCS PROCEDURE CODE	PROCEDURE CODE DESCRIPTION
H2011, HA	Crisis intervention service, per 15 minutes

SERVICE DESCRIPTION	MINIMUM DOCUMENTATION REQUIREMENTS
Crisis Intervention is unscheduled, immediate, short-term treatment activities provided to a Medicaid-eligible beneficiary who is experiencing a psychiatric or behavioral crisis. Services are to be congruent with the age, strengths, needed accommodation for any disability, and cultural framework of the beneficiary and his/her family. These services are designed to stabilize the person in crisis, prevent further deterioration and provide immediate indicated treatment in the least restrictive setting. (These activities include evaluating a Medicaid-eligible beneficiary to determine if the need for crisis services is present.)	• Date of service • Start and stop time of actual encounter with beneficiary and possible collateral contacts with caregivers or informed persons • Place of service • Specific persons providing pertinent information in relationship to beneficiary • Diagnosis and synopsis of events leading up to crisis situation • Brief mental status and observations • Utilization of previously established psychiatric advance directive or crisis plan as pertinent to current situation OR rationale for crisis intervention activities utilized • Beneficiary's response to the intervention that includes current progress or regression and prognosis • Clear resolution of the current crisis and/or plans for further services • Development of a clearly defined crisis plan or revision to existing plan • Staff signature/credentials/date of signature(s)

NOTES	UNIT	BENEFIT LIMITS
A psychiatric or behavioral crisis is defined as an acute situation in which an individual is experiencing a serious mental illness or emotional disturbance to the point that the beneficiary or others are at risk for imminent harm or in which to prevent significant deterioration of the beneficiary's functioning. This service can be provided to beneficiaries that have not been previously assessed or have not previously received behavioral health services. The provider of this service MUST complete a Mental Health Diagnosis (90791) within 7 days of provision of this service. If the beneficiary needs more time to be stabilized, this must be noted in the beneficiary's medical record and the Division of Medical Services Quality Improvement	15 minutes	DAILY MAXIMUM OF UNITS THAT MAY BE BILLED: 12 YEARLY MAXIMUM OF UNITS THAT MAY BE BILLED (extension of benefits can be requested): 72

Organization (QIO) must be notified.	
APPLICABLE POPULATIONS	**SPECIAL BILLING INSTRUCTIONS**
Children and Youth	
ALLOWED MODE(S) OF DELIVERY	**TIER**
Face-to-face	School-Based Mental Health
ALLOWABLE PERFORMING PROVIDERS	**PLACE OF SERVICE**
• Licensed Certified Social Worker (LCSW) • Licensed Master Social Worker (LMSW) • Licensed Professional Counselor (LPC) • Licensed Associate Counselor (LAC) • Licensed Psychological Examiner (LPE) • Psychologist * School-Based Mental Health Services provider employees or contractors will provide services only in those areas in which they are licensed or credentialed.	03

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: 501-404-4619
TDD/TTY: 501-682-6789

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

EFFECTIVE DATE: July 1, 2017

SUBJECT: Provider Manual Update Transmittal INPPSYCH-3-16

PROPOSED

REMOVE		INSERT	
Section	**Effective Date**	**Section**	**Effective Date**
202.200	10-13-03	202.200	7-1-17
—	—	203.100	7-1-17
211.000	10-13-03	211.000	7-1-17
212.100	10-13-03	212.100	7-1-17
221.801	8-15-05	221.801	7-1-17
221.802	8-15-05	221.802	7-1-17
221.803	6-15-16	221.803	7-1-17
221.804	8-15-05	221.804	7-1-17
—	—	250.500	7-1-17
251.000	7-1-04	251.000	7-1-17
262.100	7-1-04	262.100	7-1-17

Explanation of Updates

Section 202.200 is updated to remove reference to the Division of Children and Family Services and only list the Arkansas Department of Human Services as the department licensing providers.

Section 203.100 is added to include information about the Facility-Based Community Reintegration Program.

Section 211.000 is updated with information regarding standardized independent assessment and re-assessment for Inpatient Psychiatric Services for Persons Under Age 21.

Section 212.100 is updated to add Facility-Based Community Reintegration Program as an Arkansas Medicaid covered location for inpatient psychiatric services.

Section 221.801 is updated to add Facility-Based Community Reintegration Program to entities that must attest.

Section 221.802 is updated to include Facility-Based Community Reintegration Programs as entities that are assigned a federal provider identification number.

Section 221.803 is updated to include Facility-Based Community Reintegration Programs' roles and responsibilities for reporting deaths, serious injuries and attempted suicides.

Section 221.804 is updated to add Facility-Based Community Reintegration Program to entities that must follow staffing and training requirements.

Section 250.500 is added to include reimbursement information for the Facility-Based Community Reintegration Program.

Section 251.000 is updated to include Facility-Based Community Reintegration Programs to entities that must submit an annual or partial period hospital cost report to Arkansas Medicaid.

Section 262.100 is updated to add the revenue code for Facility-Based Community Reintegration Program.

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 Hewlett Packard Enterprise 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.

PROPOSED

Dawn Stehle/TPH

Dawn Stehle
Director

TOC is required

202.200 Residential Treatment Facilities 7-1-17

To enroll as a freestanding residential treatment center or as a residential treatment unit within an inpatient psychiatric hospital, the inpatient psychiatric provider must meet both of the conditions listed below:

A. The provider must meet the child and adolescent standards of the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) and be accredited by JCAHO.

B. Any provider located within Arkansas must be licensed by the Arkansas Department of Human Services as a psychiatric residential treatment facility.

203.100 Facility-Based Community Reintegration Program PROPOSED 7-1-17

The Facility-Based Community Reintegration Program is designed to serve as an intermediate level of care between inpatient psychiatric facilities and outpatient services. To enroll as a freestanding Facility-Based Community Reintegration Program unit or as a Facility-Based Community Reintegration Program unit within an inpatient psychiatric hospital, the inpatient psychiatric provider must meet all of the conditions listed below:

A. The provider must meet the child and adolescent standards of the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) and be accredited by JCAHO.

B. Any provider located within Arkansas must be licensed by the Arkansas Department of Human Services as a Facility-Based Community Reintegration Program.

This manual, the Inpatient Psychiatric Services for Under Age 21 Provider Manual, shall govern all aspects of services provided as well as claim submissions for beneficiaries of the Facility-Based Community Reintegration Program.

211.000 Scope 7-1-17

Inpatient psychiatric services covered by the Arkansas Medicaid Program must be provided:

A. By an inpatient psychiatric provider enrolled in the Arkansas Medicaid Program;

B. By an enrolled inpatient psychiatric provider selected by the beneficiary;

C. To eligible Arkansas Medicaid beneficiaries only after receipt of a primary care physician (PCP) referral except in cases of emergency;

D. To eligible Arkansas Medicaid beneficiaries who have a certification of need issued by the facility-based and independent teams that the beneficiary meets the criteria for inpatient psychiatric services;

E. To eligible Arkansas Medicaid beneficiaries who have a prior authorization;

F. To eligible Arkansas Medicaid beneficiaries before the beneficiary reaches age 21 or, if the beneficiary was receiving inpatient psychiatric services at the time he or she reached age 21, services may continue until the beneficiary no longer requires the services or the beneficiary becomes 22 years of age, whichever comes first and

G. Under the direction of a physician (contracted physicians are acceptable).

A standardized independent assessment will determine eligibility for Inpatient Psychiatric Services for Persons Under Age 21. The standardized independent assessment must be performed by an independent entity.

The independent assessment will contain additional criteria and questions, which will be asked based upon results from the independent assessment to determine eligibility for Inpatient Psychiatric Services for Persons Under Age 21. Acute inpatient psychiatric care will not require an independent assessment.

The standardized independent assessment must be conducted at least every 12 months by an independent assessor in consultation with the beneficiary and anyone the beneficiary requests to participate in the standardized independent assessment. The standardized independent assessment will also take into consideration information obtained from behavioral health service providers that are providing services to the beneficiary.

A beneficiary must be referred to the independent assessment entity to evaluate whether the beneficiary meets the eligibility criteria for Inpatient Psychiatric Services for Persons Under Age 21. The following are allowable methods of referral to receive a standardized independent assessment for determination of eligibility for Inpatient Psychiatric Services for Persons Under Age 21:

A. Trigger from claims data/MMIS claims data

B. Referral from counseling level services provider

C. Referral from physician (including those in acute settings, mobile crisis units)

D. An individual determined to be medically fragile due to behavior health needs

E. Referral from the Division of Children and Family Services (DCFS)/the Division of Youth Services (DYS) when they are the legal guardian of the beneficiary

F. Referral/court order from the court system/justice system

G. Referral from care coordination entity

A re-assessment can be requested by the direct behavioral health service provider or the care coordination entity if the direct behavioral health service provider or care coordination entity determines the beneficiary's needs are not being met or the beneficiary is not benefitting from the Inpatient Psychiatric Services for Persons Under Age 21 being provided.

The independent assessor will contact the beneficiary to be assessed within 48 hours of referral and will complete the face-to-face assessment within 14 calendar days. For identified priority populations, the independent assessor will contact the beneficiary to be assessed within 24 hours of notification from the beneficiary's provider and will complete the assessment within 7 days of the notification. Examples of priority population include, but are not to be limited to:

A. Youth involved in the juvenile justice system

B. Individuals involved in the foster care system

C. Individuals discharged from acute hospital stays

D. Individuals discharged from crisis residential stays

E. Adults involved in the criminal justice system

F. Clients identified and referred by the Division of Behavioral Health Services (DBHS)

212.100 Covered Locations 7-1-17

Inpatient psychiatric services are covered by Arkansas Medicaid only when provided in:

A. An inpatient psychiatric hospital

B. A residential treatment unit within a psychiatric hospital

C. A residential treatment center (freestanding)

D. A Sexual Offender Program

E. A Facility-Based Community Reintegration Program

PROPOSED

221.801 Attestation of Facility Compliance 7-1-17

Each psychiatric residential treatment facility and Facility-Based Community Reintegration Program that provides inpatient psychiatric services to individuals under age 21 must attest, in writing, that the facility is in compliance with the Centers for Medicare and Medicaid Service (CMS) standards governing the use of restraint and seclusion. This attestation must be signed by the facility director.

A. Current Medicaid Providers

A facility with a current provider agreement with the Medicaid agency must provide a letter of attestation no later than July 21st of each year. Attestations must be sent to each state Medicaid agency (SMA) where the PRTF has established a provider agreement.

Exceptions:

1. If July 21st occurs on a weekend or holiday, the attestation is due on the first business day following the weekend or holiday and
2. If the letter of attestation is not received by the due date, the provider will be given 30 calendar days to submit it. If it is not received by the 30th day after the due date, the provider will be terminated from participation in the Arkansas Medicaid Program.

Attestation letters must be sent to the Medicaid Provider Enrollment Unit. **View or print the contact information for the Medicaid Provider Enrollment Unit.**

B. New Medicaid Provider Applicants

A facility enrolling as a Medicaid provider must meet this requirement at the time it executes a provider agreement with the Medicaid agency.

221.802 Federal Provider Identification Numbers 7-1-17

A federal provider identification number is assigned to each provider who meets the attestation requirement. The identification numbers for PRTFs and Facility-Based Community Reintegration Programs will have five digits and one letter. The first two digits identify the state in which the facility is located. This number is then followed by the letter L and then by three digits and is numbered according to the order in which a facility was identified.

A. Federal provider numbers are assigned by the State Medicaid agency (SMA).

B. A provider number is coded based on where the PRTF or Facility-Based Community Reintegration Program is physically located.

221.803 Roles and Responsibilities for the Reporting of Deaths, Serious Injuries and Attempted Suicides 7-1-17

The interim process for reporting deaths will follow a similar process as currently in place for the death reporting process for hospitals. The roles and responsibilities of the appropriate entities are outlined below.

A. PRTFs and Facility-Based Community Reintegration Programs

1. Report to the SMA, no later than close of business the next business day, all deaths, serious injuries, and attempted suicides via fax at (501) 682-6171.
2. Report to the CMS regional office (RO) all deaths no later than close of business the next business day after the resident's death. Death reporting information should be reported to CMS at (214) 767-4434.
3. Document in the resident's record that the death was reported to the CMS regional office.

PROPOSED

B. CMS Regional Office (RO)

1. The regional office should receive the report directly from the PRTF or Facility-Based Community Reintegration Program. Pursuant to 42 CFR 483.374(b)(1), the report must include the name of the resident, a description of the occurrence, and the name, street address and telephone number of the facility.
2. The CMS regional office should make sure the survey agency (SA) has received the report. The SA is responsible for carrying out the investigation in conjunction with instructions from the State Medicaid agency.
3. Since the PRTF or Facility-Based Community Reintegration Program is responsible for reporting to the agencies listed previously in addition to the CMS RO, the regional office should obtain the completed investigation from the SA.
4. The report should be received from the PRTF or Facility-Based Community Reintegration Program, according to 42 CFR 483.374(c)(1), no later than close of business the next business day after the resident's death.
5. The CMS regional office will send the death report to the CMS central office (CMS CO).

C. CMS Central Office (CO)

The CMS CO is responsible for maintaining a central log of the death information reported from the CMS RO.

221.804 PRTF and Facility-Based Community Reintegration Program Staff Education and Training 7-1-17

The facility must require staff to have ongoing education, training and demonstrated knowledge of:

A. Techniques to identify staff and resident behaviors, events and environmental factors that may trigger emergency safety situations;

B. The use of nonphysical intervention skills, such as de-escalation, mediation conflict resolution, active listening, and verbal and observational methods, to prevent emergency safety situations; and

C. The safe use of restraint and the safe use of seclusion, including the ability to recognize and respond to signs of physical distress in residents who are restrained or in seclusion.

1. Certification in the use of cardiopulmonary resuscitation, including periodic recertification, is required.
2. Individuals who are qualified by education, training and experience must provide staff training.
3. Staff training must include training exercises in which staff members successfully demonstrate in practice the techniques they have learned for managing emergency safety situations.

4. The staff must be trained and demonstrate competency before participating in an emergency safety intervention.
5. The staff must demonstrate their competencies as specified in paragraph A of this section on a semiannual basis and their competencies as specified in paragraph B of this section on an annual basis.
6. The facility must document in the staff personnel records that the training and demonstration of competency were successfully completed. Documentation must include the date training was completed and the name of persons certifying the completion of training.
7. All training programs and materials used by the facility must be available for review by CMS, the SMA and the State SA.

PROPOSED

250.500 Facility-Based Community Reintegration Program 7-1-17

The per diem rates for Facility-Based Community Reintegration Programs are established at the lesser of: 1) the center's budgeted cost per day which includes the professional component or 2) a $245 per day upper limit (cap). This is a prospective rate with no cost settlement.

The budgeted per diem cost is calculated from the annual budget, which all Facility-Based Community Reintegration Program providers are required to submit for the upcoming state fiscal year (July 1st through June 30th). Annual budgets are due by April 30th. Should April 30th fall on a Saturday, Sunday or state or federal holiday, the due date shall be the following business day. Failure to submit the budget by April 30th may result in the suspension of reimbursement until the budget is submitted. Rates are calculated annually and are effective for dates of service occurring during the state fiscal year for which the budgets have been prepared.

New providers are required to submit a full year's annual budget for the current state fiscal year (July 1st through June 30th) at the time of enrollment. This budget is used to set their rate at the lesser of the budgeted allowable cost per day or the upper limit (cap) of $245 per day.

251.000 Cost Report 7-1-17

Inpatient psychiatric hospitals, residential treatment units, Facility-Based Community Reintegration Programs and Sexual Offender Programs must submit an annual or partial period hospital cost report to the Arkansas Medicaid Program. Providers with less than a full 12-month reporting period are also required to submit a hospital cost report for the shorter period. Cost reports are due no later than five months following the close of the provider's fiscal year end. Extensions will not be allowed. Failure to file the cost report within the prescribed period may result in suspension of reimbursement until the cost report is filed.

Providers will submit all required hospital cost reports and budgets in accordance with Medicare Principles of Reasonable Cost Reimbursement identified in 42 CFR, Part 413. All cost settlements will be made using these principles.

262.100 Inpatient Psychiatric Revenue Codes 7-1-17

Revenue Code	Revenue Code Description
114	Inpatient Psychiatric Hospital only
124	Residential Treatment Center only
128	Sexual Offender Program only
129	Residential Treatment Unit only
TBD	Facility-Based Community Reintegration Program only

TOC is required

202.200 Residential Treatment Facilities ~~10-13-037~~-1-17

To enroll as a freestanding residential treatment center or as a residential treatment unit within an inpatient psychiatric hospital, the inpatient psychiatric provider must meet both of the conditions listed below:

A. The provider must meet the child and adolescent standards of the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) and be accredited by JCAHO.

B. Any provider located within Arkansas must be licensed by the Arkansas Department of Human Services~~, Division of Children and Family Services,~~ as a psychiatric residential treatment facility.

203.100 Facility-Based Community Reintegration Program 7-1-17

The Facility-Based Community Reintegration Program is designed to serve as an intermediate level of care between inpatient psychiatric facilities and outpatient services. To enroll as a freestanding Facility-Based Community Reintegration Program unit or as a Facility-Based Community Reintegration Program unit within an inpatient psychiatric hospital, the inpatient psychiatric provider must meet all of the conditions listed below:

A. The provider must meet the child and adolescent standards of the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) and be accredited by JCAHO.

B. Any provider located within Arkansas must be licensed by the Arkansas Department of Human Services as a Facility-Based Community Reintegration Program.

This manual, the Inpatient Psychiatric Services for Under Age 21 Provider Manual, shall govern all aspects of services provided as well as claim submissions for beneficiaries of the Facility-Based Community Reintegration Program.

211.000 Scope ~~10-13-037~~-1-17

Inpatient psychiatric services covered by the Arkansas Medicaid Program must be provided:

A. By an inpatient psychiatric provider enrolled in the Arkansas Medicaid Program;

B. By an enrolled inpatient psychiatric provider selected by the ~~recipient~~beneficiary;

C. To eligible Arkansas Medicaid ~~recipients~~ beneficiaries only after receipt of a primary care physician (PCP) referral except in cases of emergency;

D. To eligible Arkansas Medicaid ~~recipients~~beneficiaries who have a certification of need issued by the facility-based and independent teams that the beneficiary~~recipient~~ meets the criteria for inpatient psychiatric services;

E. To eligible Arkansas Medicaid ~~recipients~~beneficiaries who have a prior authorization;

F. To eligible Arkansas Medicaid ~~recipients~~beneficiaries before the beneficiary~~recipient~~ reaches age 21 or, if the ~~recipient~~beneficiary was receiving inpatient psychiatric services at the time he or she reached age 21, services may continue until the ~~recipient~~beneficiary no longer requires the services or the ~~recipient~~ beneficiary becomes 22 years of age, whichever comes first and

G. Under the direction of a physician (contracted physicians are acceptable).

A standardized independent assessment will determine eligibility for Inpatient Psychiatric Services for Persons Under Age 21. The standardized independent assessment must be performed by an independent entity.

The independent assessment will contain additional criteria and questions, which will be asked based upon results from the independent assessment to determine eligibility for Inpatient Psychiatric Services for Persons Under Age 21. Acute inpatient psychiatric care will not require an independent assessment.

The standardized independent assessment must be conducted at least every 12 months by an independent assessor in consultation with the beneficiary and anyone the beneficiary requests to participate in the standardized independent assessment. The standardized independent assessment will also take into consideration information obtained from behavioral health service providers that are providing services to the beneficiary.

A beneficiary must be referred to the independent assessment entity to evaluate whether the beneficiary meets the eligibility criteria for Inpatient Psychiatric Services for Persons Under Age 21. The following are allowable methods of referral to receive a standardized independent assessment for determination of eligibility for Inpatient Psychiatric Services for Persons Under Age 21:

A. Trigger from claims data/MMIS claims data

B. Referral from counseling level services provider

C. Referral from physician (including those in acute settings, mobile crisis units)

D. An individual determined to be medically fragile due to behavior health needs

E. Referral from the Division of Children and Family Services (DCFS)/the Division of Youth Services (DYS) when they are the legal guardian of the beneficiary

F. Referral/court order from the court system/justice system

G. Referral from care coordination entity

A re-assessment can be requested by the direct behavioral health service provider or the care coordination entity if the direct behavioral health service provider or care coordination entity determines the beneficiary's needs are not being met or the beneficiary is not benefitting from the Inpatient Psychiatric Services for Persons Under Age 21 being provided.

The independent assessor will contact the beneficiary to be assessed within 48 hours of referral and will complete the face-to-face assessment within 14 calendar days. For identified priority populations, the independent assessor will contact the beneficiary to be assessed within 24 hours of notification from the beneficiary's provider and will complete the assessment within 7 days of the notification. Examples of priority population include, but are not to be limited to:

A. Youth involved in the juvenile justice system

B. Individuals involved in the foster care system

C. Individuals discharged from acute hospital stays

D. Individuals discharged from crisis residential stays

E. Adults involved in the criminal justice system

F. Clients identified and referred by the Division of Behavioral Health Services (DBHS)

Inpatient psychiatric services are covered by Arkansas Medicaid only when provided in:

A. An inpatient psychiatric hospital;

B. A residential treatment unit within a psychiatric hospital;

C. A residential treatment center (freestanding) and

D. A Sexual Offender Program.

E. A Facility-Based Community Reintegration Program

221.801 Attestation of Facility Compliance 8-15-057-1-17

Each psychiatric residential treatment facility and Facility-Based Community Reintegration Program that provides inpatient psychiatric services to individuals under age 21 must attest, in writing, that the facility is in compliance with the Centers for Medicare and Medicaid Service (CMS) standards governing the use of restraint and seclusion. This attestation must be signed by the facility director.

A. Current Medicaid Providers

A facility with a current provider agreement with the Medicaid agency must provide a letter of attestation no later than July 21st of each year. Attestations must be sent to each state Medicaid agency (SMA) where the PRTF has established a provider agreement.

Exceptions:

1. If July 21st occurs on a weekend or holiday, the attestation is due on the first business day following the weekend or holiday and
2. If the letter of attestation is not received by the due date, the provider will be given 30 calendar days to submit it. If it is not received by the 30th day after the due date, the provider will be terminated from participation in the Arkansas Medicaid Program.

Attestation letters must be sent to the Medicaid Provider Enrollment Unit. **View or print the contact information for the Medicaid Provider Enrollment Unit.**

B. New Medicaid Provider Applicants

A facility enrolling as a Medicaid provider must meet this requirement at the time it executes a provider agreement with the Medicaid agency.

221.802 Federal Provider Identification Numbers) 8-15-057-1-17

A federal provider identification number is assigned to each provider who meets the attestation requirement. The identification numbers for PRTFs and Facility-Based Community Reintegration Programs will have five digits and one letter. The first two digits identify the state in which the facility is located. This number is then followed by the letter L and then by three digits and is numbered according to the order in which a facility was identified.

A. Federal provider numbers are assigned by the State Medicaid agency (SMA).

B. A provider number is coded based on where the PRTF or Facility-Based Community Reintegration Program is physically located.

221.803 Roles and Responsibilities for the Reporting of Deaths, Serious Injuries and Attempted Suicides 6-15-167-1-17

The interim process for reporting deaths will follow a similar process as currently in place for the death reporting process for hospitals. The roles and responsibilities of the appropriate entities are outlined below.

A. PRTFs and Facility-Based Community Reintegration Programs

1. Report to the SMA, no later than close of business the next business day, all deaths, serious injuries, and attempted suicides via fax at (501) 682-6171.
2. Report to the CMS regional office (RO) all deaths no later than close of business the next business day after the resident's death. Death reporting information should be reported to CMS at (214) 767-4434.
3. Document in the resident's record that the death was reported to the CMS regional office.

B. CMS Regional Office (RO)

1. The regional office should receive the report directly from the PRTF or Facility-Based Community Reintegration Program. Pursuant to 42 CFR 483.374(b)(1), the report must include the name of the resident, a description of the occurrence, and the name, street address and telephone number of the facility.
2. The CMS regional office should make sure the survey agency (SA) has received the report. The SA is responsible for carrying out the investigation in conjunction with instructions from the State Medicaid agency.
3. Since the PRTF or Facility-Based Community Reintegration Program is responsible for reporting to the agencies listed previously in addition to the CMS RO, the regional office should obtain the completed investigation from the SA.
4. The report should be received from the PRTF or Facility-Based Community Reintegration Program, according to 42 CFR 483.374(c)(1), no later than close of business the next business day after the resident's death.
5. The CMS regional office will send the death report to the CMS central office (CMS CO).

C. CMS Central Office (CO)

The CMS CO is responsible for maintaining a central log of the death information reported from the CMS RO.

221.804 PRTF and Facility-Based Community Reintegration Program Staff Education and Training ~~8-15-05~~7-1-17

The facility must require staff to have ongoing education, training and demonstrated knowledge of:

A. Techniques to identify staff and resident behaviors, events and environmental factors that may trigger emergency safety situations;

B. The use of nonphysical intervention skills, such as de-escalation, mediation conflict resolution, active listening, and verbal and observational methods, to prevent emergency safety situations; and

C. The safe use of restraint and the safe use of seclusion, including the ability to recognize and respond to signs of physical distress in residents who are restrained or in seclusion.

1. Certification in the use of cardiopulmonary resuscitation, including periodic recertification, is required.
2. Individuals who are qualified by education, training and experience must provide staff training.

3. Staff training must include training exercises in which staff members successfully demonstrate in practice the techniques they have learned for managing emergency safety situations.
4. The staff must be trained and demonstrate competency before participating in an emergency safety intervention.
5. The staff must demonstrate their competencies as specified in paragraph A of this section on a semiannual basis and their competencies as specified in paragraph B of this section on an annual basis.
6. The facility must document in the staff personnel records that the training and demonstration of competency were successfully completed. Documentation must include the date training was completed and the name of persons certifying the completion of training.
7. All training programs and materials used by the facility must be available for review by CMS, the SMA and the State SA.

250.500 Facility-Based Community Reintegration Program 7-1-17

The per diem rates for Facility-Based Community Reintegration Programs are established at the lesser of: 1) the center's budgeted cost per day which includes the professional component or 2) a $245 per day upper limit (cap). This is a prospective rate with no cost settlement.

The budgeted per diem cost is calculated from the annual budget, which all Facility-Based Community Reintegration Program providers are required to submit for the upcoming state fiscal year (July 1st through June 30th). Annual budgets are due by April 30th. Should April 30th fall on a Saturday, Sunday or state or federal holiday, the due date shall be the following business day. Failure to submit the budget by April 30th may result in the suspension of reimbursement until the budget is submitted. Rates are calculated annually and are effective for dates of service occurring during the state fiscal year for which the budgets have been prepared.

New providers are required to submit a full year's annual budget for the current state fiscal year (July 1st through June 30th) at the time of enrollment. This budget is used to set their rate at the lesser of the budgeted allowable cost per day or the upper limit (cap) of $245 per day.

251.000 Cost Report ~~7-1-04~~7-1-17

Inpatient psychiatric hospitals, residential treatment units, Facility-Based Community Reintegration Programs and Sexual Offender Programs must submit an annual or partial period hospital cost report to the Arkansas Medicaid Program. Providers with less than a full twelve12-month reporting period are also required to submit a hospital cost report for the shorter period. Cost reports are due no later than five months following the close of the provider's fiscal year end. Extensions will not be allowed. Failure to file the cost report within the prescribed period may result in suspension of reimbursement until the cost report is filed.

Providers will submit all required hospital cost reports and budgets in accordance with Medicare Principles of Reasonable Cost Reimbursement identified in 42 CFR, Part 413. All cost settlements will be made using these principles.

262.100 Inpatient Psychiatric Revenue Codes ~~7-1-04~~7-1-17

Revenue Code	Revenue Code Description
114	Inpatient Psychiatric Hospital only
124	Residential Treatment Center only

Revenue Code	Revenue Code Description
128	Sexual Offender Program only
129	Residential Treatment Unit only
TBD	Facility-Based Community Reintegration Program only

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: 501-404-4619
TDD/TTY: 501-682-6789

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

EFFECTIVE DATE: **July 1, 2017**

SUBJECT: **Provider Manual Update Transmittal RSPMI-4-16**

PROPOSED

REMOVE		INSERT	
Section	**Effective Date**	**Section**	**Effective Date**
201.000	10-5-09	201.000	7-1-17

Explanation of Updates

Section 201.000 has been updated with information regarding the transition of the Rehabilitative Services for Persons with Mental Illness (RSPMI) Program, Licensed Mental Health Practitioner (LMHP) Program and the Substance Abuse Treatment Services (SATS) Program to the Outpatient Behavioral Health Services Program.

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 Hewlett Packard Enterprise 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.

Dawn Stehle

Dawn Stehle
Director

TOC not required

201.000 Introduction 7-1-17

Medicaid (Medical Assistance) is designed to assist eligible Medicaid beneficiaries in obtaining medical care within the guidelines specified in Section I of this manual. Rehabilitative Services for Persons with Mental Illness (RSPMI) are covered by Medicaid when provided to eligible Medicaid beneficiaries by enrolled providers.

RSPMI may be provided to eligible Medicaid beneficiaries at all provider facility certified sites. Acceptable allowable places of service are found in the service definitions located in Section 252.110.

The transition process to eliminate the Rehabilitative Services for Persons with Mental Illness (RSPMI) Program, Licensed Mental Health Practitioner (LMHP) Program and the Substance Abuse Treatment Services (SATS) Program is contingent upon the approval of the implementation of the Outpatient Behavioral Health Services Program. Clients currently served by the RSPMI, LMHP and SATS programs will begin transitioning to the Outpatient Behavioral Health Program starting July 1, 2017. RSPMI, LMHP and SATS will cease to exist on June 30, 2018 and no Arkansas Medicaid payments will occur to any RSPMI, LMHP or SATS provider for services provided after June 30, 2018.

Mark up

TOC not required

201.000 Introduction 10-5-097-1-17

Medicaid (Medical Assistance) is designed to assist eligible Medicaid beneficiaries in obtaining medical care within the guidelines specified in Section I of this manual. Rehabilitative Services for Persons with Mental Illness (RSPMI) are covered by Medicaid when provided to eligible Medicaid beneficiaries by enrolled providers.

RSPMI may be provided to eligible Medicaid beneficiaries at all provider facility certified sites. Acceptable allowable places of service are found in the service definitions located in Section 252.110.

The transition process to eliminate the Rehabilitative Services for Persons with Mental Illness (RSPMI) Program, Licensed Mental Health Practitioner (LMHP) Program and the Substance Abuse Treatment Services (SATS) Program is contingent upon the approval of the implementation of the Outpatient Behavioral Health Services Program. Clients currently served by the RSPMI, LMHP and SATS programs will begin transitioning to the Outpatient Behavioral Health Program starting July 1, 2017. RSPMI, LMHP and SATS will cease to exist on June 30, 2018 and no Arkansas Medicaid payments will occur to any RSPMI, LMHP or SATS provider for services provided after June 30, 2018.

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: 501-404-4619
TDD/TTY: 501-682-6789

TO: **Arkansas Medicaid Health Care Providers – Licensed Mental Health Practitioners**

EFFECTIVE DATE: **July 1, 2017**

SUBJECT: **Provider Manual Update Transmittal LMHP-2-16**

PROPOSED

REMOVE		INSERT	
Section	**Effective Date**	**Section**	**Effective Date**
211.000	10-13-03	211.000	7-1-17

Explanation of Updates

Section 211.000 has been updated with information regarding the transition of the Rehabilitative Services for Persons with Mental Illness (RSPMI) Program, Licensed Mental Health Practitioner (LMHP) Program and the Substance Abuse Treatment Services (SATS) Program to the Outpatient Behavioral Health Services Program.

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 Hewlett Packard Enterprise 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.

Dawn Stehle/TPH

Dawn Stehle
Director

TOC not required

211.000 Introduction 7-1-17

Medicaid (Arkansas Medical Assistance Program) is designed to assist eligible Medicaid beneficiaries in obtaining medical care within the guidelines specified in Section I of this manual. Reimbursement will be made for allowed services rendered by a Medicaid enrolled provider within the Medicaid Program limitations as outlined in Section II of this manual.

The transition process to eliminate the Rehabilitative Services for Persons with Mental Illness (RSPMI) Program, Licensed Mental Health Practitioner (LMHP) Program and the Substance Abuse Treatment Services (SATS) Program is contingent upon the approval of the implementation of the Outpatient Behavioral Health Services Program. Clients currently served by the RSPMI, LMHP and SATS programs will begin transitioning to the Outpatient Behavioral Health Program starting July 1, 2017. RSPMI, LMHP and SATS will cease to exist on June 30, 2018 and no Arkansas Medicaid payments will occur to any RSPMI, LMHP or SATS provider for services provided after June 30, 2018.

TOC not required

211.000 Introduction

~~10-13-037~~-1-17

Medicaid (Arkansas Medical Assistance Program) is designed to assist eligible Medicaid beneficiaries in obtaining medical care within the guidelines specified in Section I of this manual. Reimbursement will be made for allowed services rendered by a Medicaid enrolled provider within the Medicaid Program limitations as outlined in Section II of this manual.

The transition process to eliminate the Rehabilitative Services for Persons with Mental Illness (RSPMI) Program, Licensed Mental Health Practitioner (LMHP) Program and the Substance Abuse Treatment Services (SATS) Program is contingent upon the approval of the implementation of the Outpatient Behavioral Health Services Program. Clients currently served by the RSPMI, LMHP and SATS programs will begin transitioning to the Outpatient Behavioral Health Program starting July 1, 2017. RSPMI, LMHP and SATS will cease to exist on June 30, 2018 and no Arkansas Medicaid payments will occur to any RSPMI, LMHP or SATS provider for services provided after June 30, 2018.

ARKANSAS DEPARTMENT OF HUMAN SERVICES

Division of Medical Services
Program Development & Quality Assurance

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

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

EFFECTIVE DATE: **July 1, 2017**

PROPOSED

SUBJECT: **Provider Manual Update Transmittal SATS-2-16**

REMOVE		INSERT	
Section	**Effective Date**	**Section**	**Effective Date**
201.000	7-1-11	201.000	7-1-17

Explanation of Updates

Section 201.000 has been updated with information regarding the transition of the Rehabilitative Services for Persons with Mental Illness (RSPMI) Program, Licensed Mental Health Practitioner (LMHP) Program and the Substance Abuse Treatment Services (SATS) Program to the Outpatient Behavioral Health Services Program.

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 Hewlett Packard Enterprise 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.

Dawn Stehle

Dawn Stehle
Director

TOC not required

201.000 Introduction 7-1-17

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.

The transition process to eliminate the Rehabilitative Services for Persons with Mental Illness (RSPMI) Program, Licensed Mental Health Practitioner (LMHP) Program and the Substance Abuse Treatment Services (SATS) Program is contingent upon the approval of the implementation of the Outpatient Behavioral Health Services Program. Clients currently served by the RSPMI, LMHP and SATS programs will begin transitioning to the Outpatient Behavioral Health Program starting July 1, 2017. RSPMI, LMHP and SATS will cease to exist on June 30, 2018 and no Arkansas Medicaid payments will occur to any RSPMI, LMHP or SATS provider for services provided after June 30, 2018.

TOC not required

201.000 Introduction ~~7-1-14~~7-1-17

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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: 501-404-4619
TDD/TTY: 501-682-6789

TO: **Arkansas Medicaid Health Care Providers – Outpatient Behavioral Health**

EFFECTIVE DATE: **July 1, 2017**

SUBJECT: **Provider Manual Update Transmittal OBH-New-16**

PROPOSED

REMOVE		INSERT	
Section	**Effective Date**	**Section**	**Effective Date**
____	____	ALL	7-1-17

Explanation of Updates

A new Outpatient Behavioral Health Services (OBHS) policy manual is available for all OBHS 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 Hewlett Packard Enterprise Provider Assistance Center at 1-800-457-4454 (Toll-Free) within Arkansas or locally and Out-of-State at (501) 376-2211.

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Director

SECTION – OUTPATIENT BEHAVIORAL HEALTH SERVICES

CONTENTS

200.000 OUTPATIENT BEHAVIORAL HEALTH SERVICES GENERAL INFORMATION

201.000 Introduction 7-1-17

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

Outpatient Behavioral Health Services may be provided to eligible Medicaid beneficiaries at all provider certified/enrolled sites. Allowable places of service are found in the service definitions located in Section 252, Section 253, Section 254 and Section 255 of this manual.

The transition process to eliminate the Rehabilitative Services for Persons with Mental Illness (RSPMI) Program, Licensed Mental Health Practitioner (LMHP) Program, and the Substance Abuse Treatment Services (SATS) Program is contingent upon the approval of the implementation of the Outpatient Behavioral Health Services Program. Clients currently served by the RSPMI, LMHP, and SATS programs will begin transitioning to the Outpatient Behavioral Health Program starting on July 1, 2017. RSPMI, LMHP and SATS will cease to exist on June 30, 2018; and no Arkansas Medicaid payments will occur to any RSPMI, LMHP, or SATS provider for a service provided after June 30, 2018.

The Inpatient Psychiatric Services for Persons Under Age 21 program and manual will also be amended to ensure that continuity of care is maintained for beneficiaries under the Age of 21 needing Inpatient Psychiatric Services. Eligibility for entry into a residential setting requires adherence to appropriate Medicaid rules regarding that setting, which will be amended to require an Intensive Level Services Independent Assessment. The Independent Assessment will contain additional criteria and questions which will be asked based upon results from the Independent Assessment to determine eligibility for Inpatient Level Services. Acute inpatient psychiatric care will not require an Independent Assessment.

202.000 Arkansas Medicaid Participation Requirements for Outpatient Behavioral Health Services 7-1-17

All behavioral health providers approved to receive Medicaid reimbursement for services to 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.

Behavioral Health 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:

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

B. A provider must be certified by the Division of Behavioral Health Services (DBHS). (See Section 202.100 for specific certification requirements.)

C. A copy of the current DBHS certification as a Behavioral Health provider must accompany the provider application and Medicaid contract.

D. The provider must give notification to the Office of the Medicaid Inspector General (OMIG) on or before the tenth day of each month of all covered health care practitioners who perform services on behalf of the provider. The notification must include the following information for each covered health care practitioner:

1. Name/Title
2. Enrolled site(s) where services are performed
3. Social Security Number
4. Date of Birth
5. Home Address
6. Start Date
7. End Date (if applicable)

Notification is not required when the list of covered health care practitioners remains unchanged from the previous notification.

DMS shall exclude providers for the reasons stated in 42 U.S.C. §1320a-7(a) and implementing regulations and may exclude providers for the reasons stated in 42 U.S.C. §1320a-7(b) and implementing regulations. The following factors shall be considered by DHS in determining whether sanction(s) should be imposed:

A. Seriousness of the offense(s)

B. Extent of violation(s)

C. History of prior violation(s)

D. Whether an indictment or information was filed against the provider or a related party as defined in DHS Policy 1088, titled DHS Participant Exclusion Rule.

202.100 Certification Requirements by the Division of Behavioral Health Services (DBHS) 7-1-17

In order to enroll into the Outpatient Behavioral Health Services Medicaid program as a Performing Provider or Group for Counseling Services or a Behavioral Health Agency for Rehabilitation Level Services, all performing providers, provider groups, and business entities participating in the Medicaid Outpatient Behavioral Health Services (OBH) Program must be certified by the Division of Behavioral Health Services (DBHS), unless expressly exempted from this requirement. The DBHS Certification Rules for Providers of Outpatient Behavioral Health Services is located at http://humanservices.arkansas.gov/dbhs/Pages/dbhs_docs.aspx.

Behavioral Health Agencies must have national accreditation that recognizes and includes all of the applicant's programs, services and service sites. Any outpatient behavioral health program service site associated with a hospital must have a free-standing behavioral health outpatient program national accreditation. Providers must meet all other DBHS certification requirements in addition to accreditation.

202.200 Providers with Multiple Sites 7-1-17

Behavioral Health Agencies with multiple service sites must apply for enrollment for each site. A cover letter must accompany the provider application for enrollment of each site that attests to their satellite status and the name, address and Arkansas Medicaid number of the parent organization.

A letter of attestation must be submitted to the Medicaid Enrollment Unit by the parent organization annually that lists the name, address and Arkansas Medicaid number of each site affiliated with the parent. The attestation letter must be received by Arkansas Medicaid no later than June 15 of each year.

Failure by the parent organization to submit a letter of attestation by June 15 each year may result in the loss of Medicaid enrollment. The Enrollment Unit will verify the receipt of all required

letters of attestation by July 1 of each year. A notice will be sent to any parent organization if a letter is not received advising of the impending loss of Medicaid enrollment.

210.000 PROGRAM COVERAGE

211.000 Coverage of Services 7-1-17

Outpatient Behavioral Health Services are limited to certified providers who offer core behavioral health services for the treatment and prevention of behavioral disorders. All performing providers, provider groups, and business entities participating in the Medicaid Outpatient Behavioral Health Services (OBH) Program must be certified by the Division of Behavioral Health Services (DBHS), unless expressly exempted from this requirement.

An Outpatient Behavioral Health Services provider must establish a site specific emergency response plan that complies with the DBHS Certification Rules for Providers of Outpatient Behavioral Health Services manual. Each agency site must have 24-hour emergency response capability to meet the emergency treatment needs of the Behavioral Health Services beneficiaries served by the site. The provider must implement and maintain a written policy reflecting the specific coverage plan to meet this requirement. An answering machine message to call 911 or report to the nearest emergency room in and of itself is not sufficient to meet the requirement.

Licensed performing providers as certified by DBHS must also maintain an Emergency Service Plan that complies with the DBHS Certification Rules for Providers of Outpatient Behavioral Health Services manual.

All Outpatient Behavioral Health Services providers must demonstrate the capacity to provide effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy and other communication needs.

211.100 Quality Assurance 7-1-17

Each Behavioral Health Agency must establish and maintain a quality assurance committee that will meet quarterly and examine the clinical records for completeness, adequacy and appropriateness of care, quality of care and efficient utilization of provider resources. The committee must also comply with the DBHS Certification Rules for Providers of Outpatient Behavioral Health Services manual. Documentation of quality assurance committee meetings and quality improvement programs must be filed separately from the clinical records.

211.200 Staff Requirements 7-1-17

Each Outpatient Behavioral Health Services provider must ensure that they employ staff which is able and available to provide appropriate and adequate services offered by the provider. Behavioral Health staff members must provide services only within the scope of their individual licensure. The following chart lists the terminology used in this provider manual and explains the licensure, certification and supervision that are required for each performing provider type.

PROVIDER TYPE	LICENSES	STATE CERTIFICATION REQUIRED	SUPERVISION
Certified Peer Support Specialist	N/A	Yes, to provide services within a certified behavioral health agency	Required
Certified Youth Support Specialist	N/A	Yes, to provide services within a certified behavioral health agency	Required
Certified Family Support Partner	N/A	Yes, to provide services within a certified behavioral health agency	Required
Qualified Behavioral Health Provider – non-degreed	N/A	Yes, to provide services within a certified behavioral health agency	Required
Qualified Behavioral Health Provider – Bachelors	N/A	Yes, to provide services within a certified behavioral health agency	Required
Independently Licensed Clinicians – Master's/Doctoral	Licensed Clinical Social Worker (LCSW) Licensed Marital and Family Therapist (LMFT) Licensed Psychologist (LP) Licensed Psychological Examiner – Independent (LPEI) Licensed Professional Counselor (LPC)	Yes, must be certified to provide services	Not Required
Independently Licensed Clinicians – Parent/Caregiver & Child (Dyadic treatment of Children age 0-47 months & Parent/Caregiver) Provider	Licensed Clinical Social Worker (LCSW) Licensed Marital and Family Therapist (LMFT) Licensed Psychologist (LP) Licensed Psychological Examiner – Independent (LPEI) Licensed Professional Counselor	Yes, must be certified to provide services	Not Required

PROVIDER TYPE	LICENSES	STATE CERTIFICATION REQUIRED	SUPERVISION
	(LPC)		
Non-independently Licensed Clinicians – Master's/Doctoral	Licensed Master Social Worker (LMSW) Licensed Associate Counselor (LAC) Licensed Psychological Examiner (LPE) Provisionally Licensed Psychologist (PLP)	Yes, must be supervised by appropriate Independently Licensed Clinician PROPOSED	Required
Non-independently Licensed Clinicians – Parent/Caregiver & Child (Dyadic treatment of Children age 0-47 months & Parent/Caregiver) Provider	Licensed Master Social Worker (LMSW) Licensed Associate Counselor (LAC) Licensed Psychological Examiner (LPE) Provisionally Licensed Psychologist (PLP)	Yes, must be supervised by appropriate Independently Licensed Clinician and must be certified to provide services	Required
Registered Nurse	Registered Nurse (RN)	No, must be a part of a certified agency	Required
Advanced Practice Nurse (APN)	Adult Psychiatric Mental Health Clinical Nurse Specialist Child Psychiatric Mental Health Clinical Nurse Specialist Adult Psychiatric Mental Health APN Family Psychiatric Mental Health APN	No, must be part of a certified agency or have a Collaborative Agreement with a Physician	Collaborative Agreement with Physician Required
Physician	Doctor of Medicine (MD) Doctor of Osteopathic Medicine (DO)	No, must provide proof of licensure	Not Required

The services of a medical records librarian are required. The medical records librarian (or person performing the duties of the medical records librarian) shall be responsible for ongoing quality controls, for continuity of patient care and patient traffic flow. The librarian shall assure that records are maintained, completed and preserved; that required indexes and registries are maintained and that statistical reports are prepared. This staff member will be personally responsible for ensuring that information on enrolled patients is immediately retrievable, establishing a central records index, and maintaining service records in such a manner as to enable a constant monitoring of continuity of care.

When an Outpatient Behavioral Health Services provider files a claim with Arkansas Medicaid, the staff member who actually performed the service must be identified on the claim as the performing provider. 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).

211.300 Certification of Performing Providers 7-1-17

As illustrated in the chart in § 211.200, certain Outpatient Behavioral Health performing providers are required to be certified by the Division of Behavioral Health Services (DBHS). The certification requirements for performing providers are located on the DBHS website at http://humanservices.arkansas.gov/dbhs/Pages/dbhs_docs.aspx.

211.400 Facility Requirements 7-1-17

The Outpatient Behavioral Health Services provider 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 and health. These standards apply to buildings in which care, treatment or services are provided. In situations where Outpatient Behavioral Health Services are not provided in buildings, a safe and appropriate setting must be provided.

211.500 Non-Refusal Requirement 7-1-17

The Outpatient Behavioral Health Services provider may not refuse services to a Medicaid-eligible beneficiary who meets the requirements for Outpatient Behavioral Health Services as outlined in this manual. If a provider does not possess the services or program to adequately treat the beneficiary's behavioral health needs, the provider must communicate this with the Care Coordination Entity for beneficiaries receiving Rehabilitation Services or the Patient-Centered Medical Home for beneficiaries receiving Counseling Services so that appropriate provisions can be made.

PROPOSED

212.000 Scope 7-1-17

The Outpatient Behavioral Health Services Program provides care, treatment and services which are provided by a certified Behavioral Health Services provider to Medicaid-eligible beneficiaries that have a Behavioral Health diagnosis as described in the American Psychiatric Association Diagnostic and Statistical Manual (DSM-IV and subsequent revisions).

Eligibility for services depends on the needs of the beneficiary. Counseling Level Services and Crisis Services can be provided to any beneficiary as long as the services are medically necessary. Beneficiaries will be deemed eligible for Rehabilitative Level Services and Intensive Level Services based upon the results of an Independent Assessment performed by an independent entity. The goal of the Independent Assessment is to determine the care, treatment, or services that will best meet the needs of the beneficiary initially and over time.

COUNSELING LEVEL SERVICES

Time-limited behavioral health services provided by qualified licensed practitioners in an outpatient-based setting for the purpose of assessing and treating mental health and/or substance abuse conditions. Counseling Services settings shall mean a behavioral health clinic/office, healthcare center, physician office, and/or school.

REHABILITATIVE LEVEL SERVICES

Home and community based behavioral health services with care coordination for the purpose of treating mental health and/or substance abuse conditions. Services shall be rendered and coordinated through a team based approach. A standardized Independent Assessment to determine eligibility and a Treatment Plan is required. Rehabilitative Level Services home and community based settings shall include services rendered in a beneficiary's home, community, behavioral health clinic/ office, healthcare center, physician office, and/ or school.

INTENSIVE LEVEL SERVICES

The most intensive behavioral health services for the purpose of treating mental health and/or substance abuse conditions. Services shall be rendered and coordinated through a team based approach. Eligibility for Intensive Level services will be determined by additional criteria and questions on the Independent Assessment based upon the results from the Independent Assessment to determine eligibility for Intensive Level Services. This level of care will be based upon a referral from a Behavioral Health Agency that is providing Rehabilitative Services to a beneficiary or the Independent Care Coordination entity. Residential treatment services are available—if deemed medically necessary and eligibility is determined by way of the additional criteria and questions on the standardized Independent Assessment.

213.000 Outpatient Behavioral Health Services Program Entry

PROPOSED

7-1-17

Prior to continuing provision of Counseling Level Services, the provider must provide documentation of the medical necessity of Outpatient Behavioral Health Counseling Services. This documentation must be made part of the beneficiary's medical record. The documentation of medical necessity is a written assessment that evaluates the beneficiary's mental condition and, based on the beneficiary's diagnosis, determines whether treatment in the Outpatient Behavioral Health Counseling Services program is appropriate. If a beneficiary is determined to be eligible for Rehabilitation Level Services or Intensive Level Services, the documentation of medical necessity of services will be met by the standardized Independent Assessment and the Psychiatric Diagnostic Assessment that will be required for beneficiaries in that level of care.

The documentation of medical necessity of Counseling Level Outpatient Behavioral Health Services must be completed by a mental health professional qualified by licensure and experienced in the diagnosis and treatment of behavioral health.

Each beneficiary that receives only Outpatient Behavioral Health Counseling Level Services can receive a limited amount of Counseling Level Services. Once those limits are reached, a Primary Care Physician (PCP) referral or PCMH approval will be necessary to continue treatment. This referral or approval must be retained in the beneficiary's medical record. The requirements for this are located in § 217.100 of this manual.

A standardized intake must be completed prior to provision of Counseling Level Services in the Outpatient Behavioral Health Services program. This standardized intake is a part of the Mental Health Diagnosis service (CPT® Code 90791) that is required for provision of Counseling Level Services. This standardized intake will assist providers in determining services needed and desired outcomes for the beneficiary. The standardized intake must be placed in the medical record of the beneficiary and must be signed by appropriately licensed providers.

213.100 Independent Assessment for Beneficiaries

7-1-17

A standardized Independent Assessment will determine eligibility for Rehabilitative Level Services and Intensive Level Services. The standardized Independent Assessment must be performed by an independent entity.

A standardized Independent Assessment of the beneficiary is required to determine eligibility and need for Rehabilitative Level Services. Any beneficiary may refuse to participate in the standardized Independent Assessment when contacted, and refusal will be noted. If the beneficiary chooses not to participate in the standardized Independent Assessment, he or she will not be eligible to access Rehabilitative Level Services.

Additional criteria and questions asked based upon results from the Independent Assessment will determine eligibility for Intensive Level Services. If the beneficiary chooses not to participate in the additional standardized Independent Assessment, he or she will not be eligible to access Intensive Level Services.

The standardized Independent Assessment must be conducted at least every 12 months by an Independent Assessor in consultation with the beneficiary and anyone the beneficiary requests to participate in the standardized Independent Assessment. The standardized Independent Assessment will also take into consideration information obtained from behavioral health service providers that are providing services to the beneficiary.

A beneficiary must be referred to the Independent Assessment entity to evaluate whether the beneficiary meets the eligibility criteria for Rehabilitative Level Services or Intensive Level Services. The following are allowable methods of referral to receive a standardized Independent Assessment for determination of eligibility for Rehabilitative Level Services or Intensive Level Services:

A. Trigger from claims data / MMIS claims data

B. Referral from Counseling Level Services provider

C. Referral from physician (including those in acute settings, mobile crisis units)

D. An individual determined to be Medically Fragile due to Behavioral Health needs

E. Referral from the Division of Children and Family Services (DCFS) / the Division of Youth Services (DYS) when they are the legal guardian of the beneficiary

F. Referral/Court Order from the Court System/Justice System

G. Referral from Care Coordination Entity

A re-assessment can be requested by the direct behavioral health service provider or the Care Coordination entity if the direct behavioral health service provider or Care Coordination entity determines the beneficiary's needs are not being met or the beneficiary is not benefitting from the Rehabilitative Level Services or Intensive Level Services being provided.

The Independent Assessor will contact the beneficiary to be assessed within 48 hours of referral and will complete the face-to-face assessment within 14 calendar days. For identified priority populations, the independent assessor will contact the beneficiary to be assessed within 24 hours of notification from the beneficiary's provider and will complete the assessment within 7 days of the notification. Examples of priority population include, but is not to be limited to:

A. Youth involved in the juvenile justice system

B. Individuals involved in the foster care system

C. Individuals discharged from acute hospital stays

D. Individuals discharged from crisis residential stays

E. Adults involved in the criminal justice system

F. Clients identified and referred by DBHS

213.200 Needs-based Eligibility Criteria for Rehabilitative Level Services 7-1-17

Eligibility for Rehabilitative Level Services is determined by a standardized Independent Assessment.

Based upon the standardized Independent Assessment, a Treatment Plan must be developed for all beneficiaries receiving Rehabilitative Level Services. The beneficiary will be supported in Treatment Plan development by a care coordinator and allowed the ability to choose who they want to participate in the development of the Treatment Plan. In the case of children Under Age18, the parents participation (or legal guardian, DCFS, DYS, caretaker) must be included in the development of the Treatment Plan.

If the beneficiary (or the person chosen by the beneficiary to participate in the Treatment Plan development) does not participate in the Treatment Plan development, they will not be eligible to receive Rehabilitative Level Services.

Individuals that do not qualify for Rehabilitative Level Services can continue to be provided Counseling Level Services.

213.210 Needs-based Eligibility Criteria for Intensive Level Services 7-1-17

Additional criteria and questions asked based upon results from the Independent Assessment will determine eligibility for Intensive Level Services.

Eligibility for entry into a residential setting requires adherence to appropriate Medicaid rules regarding that residential setting. Eligibility for Therapeutic Communities requires that an Individualized Treatment Plan be developed for the beneficiary. The beneficiary will be supported in Treatment Plan development by a care coordinator and allowed the ability to choose who they want to participate in the development of the Individualized Treatment Plan.

If the beneficiary (or the person chosen by the beneficiary to participate in the Treatment Plan development) does not participate in the Individualized Treatment Plan development, they will not be eligible to receive Intensive Level Services.

Individuals that do not qualify for Intensive Level Services can continue to be provided Counseling Level Services, and if they qualify based upon the standardized Independent Assessment, Rehabilitative Level Services.

213.300 Opt-Out Process 7-1-17

Any time while receiving services, the beneficiary may opt out of Rehabilitative Level Services or Intensive Level Services. When determined to be eligible to receive Rehabilitative Level Services or Intensive Level Services, the beneficiary will have the option to choose a provider of those services. The Independent Assessment entity will provide eligible beneficiaries a list of all current providers of Rehabilitative Level Services and Intensive Level Services.

214.000 Role of Providers of Counseling Level Services 7-1-17

Outpatient Behavioral Health Providers provide Counseling Level Services by qualified licensed practitioners in an outpatient based setting for the purpose of assessing and treating behavioral health conditions. Counseling Level Services outpatient based setting shall mean services rendered in a behavioral health clinic/ office, healthcare center, physician office, and/or school. The performing provider must provide services only within the scope of their individual licensure. Services available to be provided by Counseling Level Services providers are listed in Section 252.110 of the Outpatient Behavioral Health Services manual.

214.100 Parent/Caregiver & Child (Dyadic treatment of Children age 0-47 months & Parent/Caregiver) 7-1-17

Outpatient Behavioral Health Providers may provide dyadic treatment of beneficiary's age 0-47 months and the parent/caregiver of the eligible beneficiary. A prior authorization will be required for all dyadic treatment services (the Mental Health Diagnosis and Interpretation of Diagnosis DO NOT require a prior authorization). All performing providers of parent/caregiver and child Outpatient Behavioral Health Services MUST be certified by DBHS to provide those services.

Providers will diagnose children through the age of 47 months based on the DC: 0-3R. Providers will then crosswalk the DC: 0-3R diagnosis to a DMS diagnosis. Specified V codes will be allowable for this population.

216.000 Role of Providers of Rehabilitative Level Services 7-1-17

Certified Rehabilitative Level Services providers make available Rehabilitative Level Services to qualified beneficiaries based upon the standardized Independent Assessment. A Behavioral Health Agency is not required to offer all services in all levels of care.

216.100 Role of Providers of Intensive Level Services 7-1-17

Certified Intensive Level Services providers make available Intensive Level Services to qualified beneficiaries based upon the Intensive Level Services standardized Independent Assessment. A Behavioral Health Agency is not required to offer all services in all levels of care.

217.100 Primary Care Physician (PCP) Referral PROPOSED 7-1-17

Each beneficiary that receives only Counseling Level Services in the Outpatient Behavioral Health Services program can receive a limited amount of Counseling Level Services. Once those limits are reached, a Primary Care Physician (PCP) referral or PCMH approval will be necessary to continue treatment. This referral or approval must be retained in the beneficiary's medical record.

A beneficiary can receive three (3) Counseling Level services before a PCP/PCMH referral is necessary. No services will be allowed to be provided without appropriate PCP/PCMH referral. The PCP/PCMH must be kept in the beneficiary's medical record.

The Patient Centered Medical Home (PCMH) will be responsible for coordinating care with a beneficiary's PCP or physician for Counseling Level Services. Medical responsibility for beneficiaries receiving Counseling Level Services shall be vested in a physician licensed in Arkansas.

Beneficiaries receiving Rehabilitative Level Services or Intensive Level Services will have care coordination available through the Independent Assessment/Care Coordination Entity. Beneficiaries receiving Rehabilitative Level Services or Intensive Level Services will have their care managed by Independent Assessment/Care Coordination Entity.

The PCP referral or PCMH authorization for Counseling Level Services will serve as the prescription for those services.

Verbal referrals from PCPs or PCMHs are acceptable to Medicaid as long as they are documented in the beneficiary's chart as described in Section 171.410.

See Section I of this manual for an explanation of the process to obtain a PCP referral.

218.000 Treatment Plan 7-1-17

A Treatment Plan is required for beneficiaries who are determined to be qualified for Rehabilitative Level Services or Therapeutic Communities/Planned Respite in Intensive Level Services through the standardized Independent Assessment. The Treatment Plan should build upon the information from any Behavioral Health provider and information obtained during the standardized Independent Assessment. Beneficiaries receiving only Counseling Level Services do NOT require a Treatment Plan and providers will not be reimbursed for completion of a Treatment Plan for beneficiaries receiving only Counseling Level Services. However, the provider must provide documentation of the medical necessity of Counseling Level Services. This documentation must be made part of the beneficiary's medical record. The documentation of medical necessity is a written assessment that evaluates the beneficiary's mental condition and, based on the beneficiary's diagnosis, determines whether treatment in the Outpatient Behavioral Health Services Program is appropriate.

A Treatment Plan is required for beneficiaries who are determined to be qualified for Rehabilitative Level Services or Therapeutic Communities/Planned Respite in Intensive Level Services. The Treatment Plan must reflect services to address areas of need identified during the standardized Independent Assessment. The Treatment Plan must be included in the beneficiary's medical record and contain a written description of the treatment objectives for that beneficiary. It also must describe:

A. The treatment regimen—the specific medical and remedial services, therapies and activities that will be used to meet the treatment objectives

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

C. The type of personnel that will be furnishing the services

D. A projected schedule for completing reevaluations of the patient's condition and updating the Treatment Plan

The Treatment Plan for a beneficiary that is eligible for Rehabilitative Level Services or Therapeutic Communities/Planned Respite in Intensive Level Services must be completed by a mental health professional within 14 calendar days of the beneficiary entering care (first billable service) at a Rehabilitative Level Services or Therapeutic Communities certified Behavioral Health Agency. Subsequent revisions in the master treatment plan will be approved in writing (signed and dated) by the mental health professional and must occur at least every 90 days.

218.100 Participation of Families and Children in the Development of the Treatment Plan for Children Under Age 21 7-1-17

The Treatment Plan should be based on the beneficiary's (or the parents' or guardians' if the beneficiary is under the age of 18) articulation of the problems or needs to be addressed in treatment and the areas of need identified in the standardized Independent Assessment. Each problem or need must have one or more clearly defined behavioral goals or objectives that will allow the beneficiary, family members, provider and others to assess progress toward achievement of the goal or objective. For each goal or objective, the Treatment Plan must specify the treatment intervention(s) determined to be medically necessary to address the problem or need and to achieve the goal(s) or objective(s).

218.200 Periodic Treatment Plan Review 7-1-17

For all beneficiaries assessed to be qualified for and receiving Rehabilitative Level Services or Therapeutic Communities/Planned Respite in Intensive Level Services, the Treatment Plan must be periodically reviewed in order to determine the beneficiary's progress toward the treatment and care objectives, the need for the services provided and the enrolled beneficiary's continued participation. The reviews must be performed on a regular basis (at least every 90 calendar days), documented in detail in the enrolled beneficiary's medical record, kept on file and made available as requested for state and federal purposes. Without a change in eligibility for services based upon the standardized Independent Assessment, more frequent changes to a beneficiary's treatment plan will not be reimbursed by Arkansas Medicaid.

The standardized Independent Assessment must occur annually, which means that the information from the standardized Independent Assessment must be updated annually for all beneficiaries assessed to be qualified for and receiving Rehabilitative Level Services or Therapeutic Communities/Planned Respite in Intensive Level Services.

218.300 Participation of Families and Children in the Periodic Review of the Treatment Plan for Children Under Age 21 7-1-17

The review of the Treatment Plan must reflect the beneficiary's, or in the case of a beneficiary under the age of 18, the parent's or guardian's, assessment of progress toward meeting

treatment goals or objectives and their level of satisfaction with the treatment services provided. Problems, needs, goals, objectives, strengths and supports should be revised based on the progress made, barriers encountered, changes in clinical status and any other new information. The beneficiary, the parent or the guardian must be provided an opportunity to express comments about the Treatment Plan and a space on the treatment plan form to record these comments and their level of satisfaction with the services provided. The review of the Treatment Plan must also reflect addressing additional areas of need identified in the required annual standardized Independent Assessment.

PROPOSED

219.100 Covered Outpatient Services 7-1-17

Covered outpatient services include a broad range of services to Medicaid-eligible beneficiaries. Beneficiaries eligible for Rehabilitative Level Services and Therapeutic Communities/Planned Respite in Intensive Level Services shall be served with an array of treatment services outlined on their Treatment Plan in an amount and duration designed to meet their medical needs.

219.110 Daily Limit of Beneficiary Services 7-1-17

For services that are not reimbursed on a per diem or per encounter rate, Medicaid has established daily benefit limits for all services. Beneficiaries will be limited to a maximum of eight hours per 24 hour day of Outpatient Behavioral Health Services. Beneficiaries will be eligible for an extension of the daily maximum amount of services based on a medical necessity review by the contracted utilization management entity (See Section 231.000 for details regarding extension of benefits).

219.200 Telemedicine (Interactive Electronic Transactions) Services 7-1-17

Outpatient Behavioral Health telemedicine services are interactive electronic transactions performed "face-to-face" in real time, via two-way electronic video and audio data exchange.

Reimbursement for telemedicine services is only available when, at a minimum, the Arkansas Telehealth Network (ATN) recommended audio video standards for real-time, two-way interactive audiovisual transmissions are met. Those standards are:

A. Minimum bandwidth of fractional T1 (728 kilobytes);

B. Screen size of no less than 20 inch diagonal;

C. Transmitted picture frame rate capable of 30 frames per second at 384Kbps and the transmitted picture frame rate is suitable for the intended application; and

D. All applicable equipment is UL and FCC Class A approved.

Providers who provide telemedicine services for Medicaid-eligible beneficiaries **must be able to link or connect** to the Arkansas Telehealth Network to ensure HIPAA compliance. Sites providing reimbursable telemedicine services to Medicaid-eligible beneficiaries are required to demonstrate the ability to meet the ATN standards listed above. A site **must** be certified by ATN before telemedicine services can be conducted. ATN will conduct site visits at initial start-up to ensure that all standards are met and to certify each telemedicine site. ATN will view connectivity statistics in order to ensure that appropriate bandwidth is being utilized by sites and will conduct random site visits to ensure that providers continue to meet all recommended standards and guidelines.

The Arkansas licensed mental health professional may provide certain treatment services from a remote site to the Medicaid-eligible beneficiary who is located in a mental health clinic setting. There must be an employee of the clinic immediately available to the beneficiary when the beneficiary is receiving services provided via telemedicine. Refer to Section 256.200 for billing instructions.

The performing provider of telemedicine services practicing within the scope of their licensure MUST:

A. Possess a current license to practice in the state of Arkansas

B. Meet DMS telemedicine qualifications

PROPOSED

All providers participating in the provision of services via telemedicine must meet all applicable standards and rules enacted by the appropriate licensing authority. The above does not supersede any of the licensing board's authority.

The following services may be provided via telemedicine by an Arkansas licensed mental health professional to Medicaid-eligible beneficiaries under age 21 and Medicaid-eligible beneficiaries age 21 and over:

A. Individual Behavioral Health Counseling – (CPT Code 90832, 90834, 90837)

B. Psychoeducation – (HCPCS Code H2027)

C. Psychiatric Assessment – (CPT Code 90792)

D. Pharmacologic Management – (CPT Code 99212, 99213, 99214)

The following services may be provided via telemedicine by an Arkansas licensed mental health professional to Medicaid-eligible beneficiaries age 21 and over:

A. Mental Health Diagnosis – (CPT Code 90791)

B. Interpretation of Diagnosis – (CPT Code 90887)

219.300 Services Available to Residents of Long Term Care Facilities 7-1-17

The following services may be provided to residents of nursing homes and ICF/IID facilities who are Medicaid eligible when the services are prescribed according to policy guidelines detailed in this manual:

A. Mental Health Diagnosis – (CPT Code 90791)

B. Psychological Evaluation – (CPT Code 96101)

C. Pharmacologic Management by Physician - (CPT Code 99212, 99213, 99214)

D. Interpretation of Diagnosis – (CPT Code 90887)

E. Individual Behavioral Health Counseling – (CPT Code 90832, 90834, 90837)

Services provided to nursing home and ICF/IDD residents may be provided on- or off-site from the provider if allowable per the service definition. Some services may be provided in the Long-Term Care (LTC) facility, if necessary.

220.000 Inpatient Hospital Services 7-1-17

"Inpatient" means a patient who has been admitted to a medical institution on recommendation of a licensed practitioner authorized to admit patients; and who is receiving room, board and professional services in the institution on a continuous 24-hour-a-day basis; or who is expected by the institution to receive room, board and professional services for 24 hours or longer.

220.100 Hospital Visits 7-1-17

Inpatient hospital visits are Medicaid covered only for board certified or board eligible psychiatrists when the visit is necessary to evaluate, treat, or stabilize a psychiatric diagnosis

which is secondary to the actual hospital admission. Each attending physician is limited to billing one day of care for an inpatient hospital Medicaid covered day, regardless of the number of hospital visits made by the physician. Rehabilitative Level Services/Intensive Level Services are not allowed to be billed for a beneficiary in an inpatient setting.

A "Medicaid covered day" is defined as a day for which the patient is Medicaid eligible, the patient's inpatient benefit limit has not been exhausted, the patient's inpatient stay is medically necessary, the day is not part of a hospital stay for a non-payable procedure or non-authorized procedure and the claim is filed on time. (See Section III of this manual for information regarding "Timely Filing.")

PROPOSED

220.200 Inpatient Hospital Services Benefit Limit 7-1-17

There is no inpatient benefit limit for Medicaid-eligible individuals under age 21. The benefit limit for general and rehabilitative hospital inpatient services is 24 paid inpatient days per state fiscal year (July 1 through June 30) for Medicaid beneficiaries aged 21 and older. Effective October 1, 2014 inpatient days beyond 24 will be reimbursed at $400.00 per day. This is a prospective per diem rate and will not be included in the cost settlement.

221.000 Medicaid Utilization Management Program (MUMP) 7-1-17

The Medicaid Utilization Management Program (MUMP) determines covered lengths of stay in inpatient, general and rehabilitative hospitals, both in state and out of state. The MUMP does not apply to lengths of stay in psychiatric facilities.

Lengths-of-stay determinations are made by the Quality Improvement Organization (QIO) under contract with the Arkansas Medicaid Program.

221.100 MUMP Applicability 7-1-17

A. Medicaid covers up to four (4) days of inpatient service with no certification requirement, except in the case of a transfer (see subpart B, below). If a patient is not discharged before or during the fifth day of hospitalization, additional days are covered only if certified by the QIO under contract with the Arkansas Medicaid Program.

B. When a patient is transferred from one hospital to another, the stay in the receiving hospital must be certified from the first day.

221.110 MUMP Exemptions 7-1-17

A. Individuals in all Medicaid eligibility categories and all age groups, except beneficiaries under age one (1), are subject to this policy. Medicaid beneficiaries under age one (1) at the time of admission are exempt from the MUMP policy for dates of service before their first birthday.

B. MUMP policy does not apply to inpatient stays for bone marrow, liver, heart, lung, skin and pancreas/kidney transplant procedures.

221.200 MUMP Procedures 7-1-17

MUMP procedures are detailed in the following sections of this manual:

A. Direct (non-transfer) admissions – Section 221.210

B. Transfer admissions – Section 221.220

C. Certifications of inpatient stays involving retroactive eligibility – Section 221.230

D. Inpatients with third party or Medicare coverage – Section 221.240

E. Reconsideration reviews of denied extensions – Section 221.250

221.210 Direct Admissions 7-1-17

A. When the attending physician determines the patient should not be discharged by the fifth day of hospitalization, a hospital medical staff member may contact the QIO under contract with the Arkansas Medicaid Program and request an extension of inpatient days. View or print AFMC contact information. The following information is required:

1. Patient name and address (including ZIP code)
2. Patient birth date
3. Patient Medicaid number
4. Admission date
5. Hospital name
6. Hospital Medicaid provider number
7. Attending physician Medicaid provider number
8. Principal diagnosis and other diagnosis influencing this stay
9. Surgical procedures performed or planned
10. The number of days being requested for continued inpatient stay
11. All available medical information justifying or supporting the necessity of continued stay in the hospital

B. Calls for extension of days may be made at any time during the inpatient stay (except in the case of a transfer from another hospital–refer to Section 221.220).

1. Providers initiating their request after the fourth day must accept the financial liability should the stay not meet necessary medical criteria for inpatient services.
2. When the provider delays calling for extension verification and the services are denied based on medical necessity, the beneficiary may not be held liable.
3. If the fifth day of admission falls on a Saturday, Sunday or holiday, it is recommended that the hospital provider call for an extension prior to the fifth day, if the physician has recommended a continued stay.

C. When a Medicaid beneficiary reaches age one (1) during an inpatient stay, the days from the admission date through the day before the patient's birthday are exempt from the MUMP policy. MUMP policy becomes effective on the one-year birthday. The patient's birthday is the first day of the four days not requiring MUMP certification. If the stay continues beyond the fourth day following the patient's first birthday, hospital staff must apply for MUMP certification for the additional days.

D. The QIO under contract with the Arkansas Medicaid Program utilizes Medicaid guidelines and the medical judgment of its professional staff to determine the number of days to allow.

E. The QIO under contract with the Arkansas Medicaid Program assigns an authorization number to an approved extension request and sends written notification to the hospital.

F. Additional extensions may be requested as needed.

G. **The certification process under the MUMP is separate from prior authorization requirements.** Prior authorization for medical procedures thus restricted must be obtained by the appropriate providers. Hospital stays for restricted procedures may be disallowed if required prior authorizations are not obtained.

H. **Claims submitted without calling for an extension request will result in automatic denials of any days billed beyond the fourth day. There will be no exceptions granted except for claims reflecting third party liability.**

221.220 Transfer Admissions

PROPOSED

7-1-17

If a patient is transferred from one hospital to another, the receiving facility must contact the QIO under contract with the Arkansas Medicaid Program within 24 hours of admitting the patient to certify the inpatient stay. If admission falls on a weekend or holiday, the provider may contact the QIO under contract with the Arkansas Medicaid Program on the first working day following the weekend or holiday.

221.230 Retroactive Eligibility

7-1-17

A. If eligibility is determined while the patient is still an inpatient, the hospital may call to request post-certification of inpatient days beyond the first four (4) (or all days if the admission was by transfer) and a concurrent certification of additional days, if needed.

B. If eligibility is determined after discharge, the hospital may call the QIO under contract with the Arkansas Medicaid Program for post-certification of inpatient days beyond the first four (4) (or all days if the admission was by transfer). If certification sought is for a stay longer than 30 days, the provider must submit the entire medical record to the QIO under contract with the Arkansas Medicaid Program for review.

221.240 Third Party and Medicare Primary Claims

7-1-17

A. If a provider has not requested MUMP certification of inpatient days because there is apparent coverage by insurance or Medicare Part A, but the other payer has denied the claim for non-covered service, lost eligibility, benefits exhausted, etc., post-certification required by the MUMP may be obtained as follows:

1. Send a copy of the third party payer's denial notice to the QIO under contract with the Arkansas Medicaid Program, attention Pre-Certification Supervisor. **View or print AFMC contact information.**
2. Include a written request for post-certification.
3. Include complete provider contact information: full name and title, telephone number and extension.
4. A QIO under contract with the Arkansas Medicaid Program coordinator will call the provider contact for the certification information.

B. If a third party insurer pays the provider for an approved number of days, Medicaid will not grant an extension for days beyond the number of days approved by the private insurer.

221.250 Request for Reconsideration

7-1-17

Reconsideration reviews of denied extensions may be expedited by faxing the medical record to the QIO under contract with the Arkansas Medicaid Program. The QIO under contract with the Arkansas Medicaid Program will advise the hospital of its decision by the next working day. **View or print AFMC contact information.**

221.260 Post-Payment Review

7-1-17

A post payment review of a random sample is conducted on all admissions, including inpatient stays of four days or less, to ensure that medical necessity for the services is substantiated.

222.000 Approved Service Locations

7-1-17

Outpatient behavioral health services are covered by Medicaid only in the outpatient setting, except for inpatient hospital visits by board-certified psychiatrists.

The services and procedure codes available for billing are listed in Section 250.000 of this manual.

223.000 Exclusions 7-1-17

Services not covered under the Outpatient Behavioral Health Program include, but are not limited to:

A. Room and board residential costs

B. Educational services

C. Telephone contacts with patient

D. Transportation services, including time spent transporting a beneficiary for services **(reimbursement for other Outpatient Behavioral Health services is not allowed for the period of time the Medicaid beneficiary is in transport)**

E. Services to individuals with developmental disabilities that are non-psychiatric in nature, except for testing purposes

F. Services which are found not to be medically necessary

G. Services provided to nursing home and ICF/IDD residents other than those specified in Section 252.150

224.000 Physician's Role 7-1-17

Certified Behavioral Health Agencies which provide Rehabilitative Level Services and Therapeutic Communities/Planned Respite in Intensive Level Services are required to have relationships with a board certified or board eligible psychiatrist who provides appropriate supervision and oversight for all medical and treatment services for beneficiaries with behavioral health needs. A physician will supervise and coordinate all psychiatric and medical functions as indicated in the Treatment Plan that is required for beneficiaries receiving Rehabilitative Level Services or Intensive Level Services. Medical responsibility shall be vested in a physician licensed in Arkansas that signs the Treatment Plan of the beneficiary.

Certified Counseling Level Services providers must have relationships with a physician licensed in Arkansas in order to ensure psychiatric and medical conditions are monitored and addressed by appropriate physician oversight.

Medical supervision responsibility shall include, but is not limited to, the following:

A. A beneficiary can receive three (3) Counseling Level Services before a PCP/PCMH referral is necessary in the medical record (see Section 217.100). Medical responsibility will be vested in a physician licensed in Arkansas who signs the PCP referral or PCMH approval for Counseling Level Services of the Outpatient Behavioral Health Services program.

B. Beneficiaries receiving Rehabilitative Level Services or Therapeutic Communities/Planned Respite in Intensive Level Services will receive those services through a Behavioral Health Agency, which will be required to employ a Medical Director. A physician must review and approve the beneficiary's Treatment Plan, including any subsequent revisions. Medical responsibility will be vested in a physician licensed in Arkansas who signs the Treatment Plan of the beneficiary. If medical responsibility is not vested in a psychiatrist for a Behavioral Health Agency, then psychiatric consultation must be available, in accordance with Division of Behavioral Health Services (DBHS) certification requirements.

C. Approval of all updated or revised Treatment Plans must be documented by the physician's dated signature on the revised document. The new 90-day period begins on the date the revised Treatment Plan is completed.

224.100 Psychiatric Assessment 7-1-17

The Psychiatric Assessment is a face-to-face psychodiagnostic assessment conducted by a licensed physician, preferably one with specialized training and experience in psychiatry (child and adolescent psychiatry for beneficiaries under age 18). This service is provided to determine the existence, type, nature and most appropriate treatment of a behavioral health disorder. This service is not required for beneficiaries receiving only Counseling Level Services in the Outpatient Behavioral Health Services program. The Psychiatric Assessment is required for beneficiaries receiving Rehabilitative Level Services or Therapeutic Communities/Planned Respite in Intensive Level Services. This service can be provided to new patients and existing patients with differing requirements for each. This face-to-face psycho diagnostic assessment must be conducted by one of the following:

A. an Arkansas-licensed physician, preferably one with specialized training and experience in psychiatry (child and adolescent psychiatry for beneficiaries under age 18)

B. an Adult Psychiatric Mental Health Advanced Nurse Practitioner/Family Psychiatric Mental Health Advanced Nurse Practitioner (PMHNP-BC)

The PMHNP-BC must meet all of the following requirements:

A. Licensed by the Arkansas State Board of Nursing

B. Practicing with licensure through the American Nurses Credentialing Center

C. Practicing under the supervision of an Arkansas-licensed psychiatrist with whom the PMHNP-BC has a collaborative agreement. The findings of the Psychiatric Assessment conducted by the PMHNP-BC must be discussed with the supervising psychiatrist within 45 days of the beneficiary entering care. The collaborative agreement must comply with all Board of Nursing requirements and must spell out, in detail, what the nurse is authorized to do and what age group they may treat.

D. Practicing within the scope of practice as defined by the Arkansas Nurse Practice Act

E. Practicing within a PMHNP-BC's experience and competency level

A Psychiatric Assessment for a new patient must include:

A. An interview with the beneficiary, which covers the areas outlined below. The initial Psychiatric Assessment may build on information obtained through other assessments reviewed by the physician or the PMHNP-BC and verified through the physician's or the PMHNP-BC's interview. The interview should obtain or verify all of the following:

1. The beneficiary's understanding of the factors leading to the referral
2. The presenting problem (including symptoms and functional impairments)
3. Relevant life circumstances and psychological factors
4. History of problems
5. Treatment history
6. Response to prior treatment interventions
7. Medical history (and examination as indicated)

B. The Psychiatric Assessment must include:

1. A mental status evaluation (a developmental mental status evaluation for beneficiaries under age 18)
2. A complete diagnosis

C. For beneficiaries under the age of 18, the Psychiatric Assessment must also include an interview of a parent (preferably both), the guardian (including the responsible DCFS caseworker) and/or the primary caretaker (including foster parents) in order to:

1. Clarify the reason for referral
2. Clarify the nature of the current symptoms and functional impairments
3. To obtain a detailed medical, family and developmental history

A Psychiatric Assessment for an existing client must include:

A. An interview with the beneficiary, which covers the areas outlined below. The Psychiatric Assessment for existing clients may build on information obtained through other assessments reviewed by the physician or the PMHNP-BC and verified through the physician's or the PMHNP-BC's interview. The interview should obtain or verify all of the following:

1. Psychiatric assessment (including current symptoms and functional impairments)
2. Medications and responses
3. Response to current treatment interventions
4. Medical history (and examination, as indicated)

B. The Psychiatric Assessment must also include:

1. A mental status evaluation (a developmental mental status evaluation for beneficiaries under age 18)
2. A complete DSM diagnosis

C. For beneficiaries under the age of 18, the continuing care Psychiatric Assessment must include an interview of a parent (preferably both), the guardian (including the responsible DCFS caseworker) and/or the primary caretaker (including foster parents) in order to:

1. Clarify the nature of the current symptoms and functional impairments
2. Obtain a detailed, updated medical, family and developmental history

The Psychiatric Assessment must contain sufficient detailed information to substantiate all diagnoses specified in the Treatment Plan (Treatment Plan is required for beneficiaries receiving Rehabilitative Level Services and Therapeutic Communities/Planned Respite in Intensive Level Services) and all problems or needs to be addressed on the Treatment Plan. The Psychiatric Assessment for existing patients must be performed, at a minimum, every 12 months. Only one (1) Psychiatric Assessment is allowed per State Fiscal Year.

225.000 Diagnosis and Clinical Impression 7-1-17

Diagnosis and clinical impression is required in the terminology of ICD.

226.000 Documentation/Record Keeping Requirements

226.100 Documentation 7-1-17

All Outpatient Behavioral Health Services providers 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. Must be 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

C. Original signature, name and credentials of the person, who authorized the services

D. Original signature, name and credentials of the person, who provided the services, if different from authorizing professional

E. The setting in which the services were provided. For all settings other than the provider's enrolled sites, the name and physical address of the place of service must be included

F. The relationship of the services to the treatment regimen described in the Treatment Plan

G. Updates describing the patient's progress

H. 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 211.200.

All documentation must be available to representatives of the Division of Medical Services or Office of Medicaid Inspector General at the time of an audit. All documentation must be available at the provider's place of business. A provider will have 30 (thirty) days to submit additional documentation in response to a request from DMS or OMIG. Additional documentation will not be accepted after this 30 day period.

227.000 Prescription for Outpatient Behavioral Health Services 7-1-17

Each beneficiary that receives only Counseling Level Services can receive a limited amount of Counseling Level Services without a Primary Care Physician (PCP) referral or Patient-Centered Medical Home (PCMH) approval. Once those limits are reached, a PCP referral or PCMH approval will be necessary. This approval by the PCP or PCMH will serve as the prescription for Counseling Level Services in the Outpatient Behavioral Health Services program. Please see Section 217.100 for limits. Medicaid will not cover any service outside of the established limits without a current prescription signed by the PCP or PCMH.

Beneficiaries receiving Rehabilitative Level Services or Therapeutic Communities/Planned Respite in Intensive Level Services must have a signed prescription for services by a psychiatrist or physician. Medicaid will not cover any Rehabilitative Level Services or Therapeutic Communities/Planned Respite in Intensive Level Services without a current prescription signed by a psychiatrist or physician and eligibility determined by a standardized Independent Assessment or Intensive Level Services Independent Assessment. The signed Treatment Plan will serve as the prescription for beneficiaries that are eligible for Rehabilitative Level Services and Therapeutic Communities/Planned Respite in Intensive Level Services.

Prescriptions shall be based on consideration of an evaluation of the enrolled beneficiary, the Independent Assessment, and goals and objectives of the Treatment Plan. The prescription of the services and subsequent renewals must be documented in the beneficiary's medical record.

228.000 Provider Reviews 7-1-17

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

228.100 Record Reviews 7-1-17

The Division of Medical Services of the Arkansas Department of Human Services (DHS) has contracted with a third-party vendor to perform on-site Inspections of Care (IOC) and retrospective reviews of outpatient mental health services provided by Outpatient Behavioral Health Services providers. **View or print current contractor 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.

228.110 On-Site Inspections of Care (IOC)

PROPOSED

228.111 Purpose of the Review 7-1-17

The on-site inspections of care of Outpatient Behavioral Health Services providers are intended to:

A. Promote Outpatient Behavioral Health 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

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.

228.112 Provider Notification of IOC 7-1-17

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 patient care areas and the medical records.

228.113 Information Available Upon Arrival of the IOC Team 7-1-17

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

228.114 Cases Chosen for Review 7-1-17

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:

A. All required assessments, including SED/SMI Certifications where applicable

B. Master treatment plan and periodic reviews of master treatment plan

C. Progress notes, including physician notes

D. Physician orders and lab results

D. Copies of records. The reviewer shall retain a copy of any record reviewed.

228.115 Program Activity Observation 7-1-17

The reviewer will observe at least one program activity.

228.116 Beneficiary/Family Interviews 7-1-17

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.

228.117 Exit Conference 7-1-17

The Inspection of Care Team will conduct an exit conference summarizing their findings and recommendations. Providers are free to involve staff in the exit conference.

228.118 Written Reports and Follow-Up Procedures 7-1-17

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.

228.120 DMS/DBHS Work Group Reports and Recommendations 7-1-17

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.

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).

228.121 Corrective Action Plans 7-1-17

PROPOSED

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.

228.122 Actions 7-1-17

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

A. Decertification of any beneficiary determined as not meeting 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

M. Any sanction identified in Section 152.000

PROPOSED

228.130 Retrospective Reviews 7-1-17

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

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

228.131 Purpose of the Review 7-1-17

The purpose of the review is to:

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

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

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

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

228.132 Review Sample and the Record Request 7-1-17

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

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

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

PROPOSED

228.133 Review Process 7-1-17

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

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

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

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

229.000 Medicaid Beneficiary Appeal Process 7-1-17

When an adverse decision is received, the beneficiary may request a fair hearing of the denial decision.

The appeal request must be in writing and received by the Appeals and Hearings Section of the Department of Human Services within thirty days of the date on the letter explaining the denial of services.

229.100 Electronic Signatures 7-1-17

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

229.200 Recoupment Process 7-1-17

The Division of Medical Services (DMS), Utilization Review Section (UR) is required to initiate the recoupment process for all claims that the current contractor has denied because the records submitted do not support the claim of medical necessity.

Arkansas Medicaid will send the provider an Explanation of Recoupment Notice that will include the claim date of service, Medicaid beneficiary name and ID number, service provided, amount paid by Medicaid, amount to be recouped, and the reason the recoupment is initiated.

230.000 PRIOR AUTHORIZATION (PA) AND EXTENSION OF BENEFITS

231.000 Introduction to Extension of Benefits 7-1-17

The Division of Medical Services contracts with third-party vendor to complete the prior authorization and extension of benefit processes.

231.100 Prior Authorization PROPOSED 7-1-17

Prior Authorization is required for certain Outpatient Behavioral Health Services provided to Medicaid-eligible beneficiaries.

Prior Authorization requests must be sent to the DMS contracted entity to perform prior authorizations for beneficiaries under the age of 21 and for beneficiaries age 21 and over for services that require a Prior Authorization. **View or print current contractor contact information.** Information related to clinical management guidelines and authorization request processes is available at **current contractor's website**.

Procedure codes requiring prior authorization:

National Codes	Required Modifier	Service Title
90832	UK	Individual Behavioral Health Counseling – Age 3
90834	UK	Individual Behavioral Health Counseling – Age 3
90837	UK	Individual Behavioral Health Counseling – Age 3
90847	UK	Marital/Family Behavioral Health Counseling with Beneficiary Present – Dyadic Treatment
H2027	UK	Psychoeducation – Dyadic Treatment
H0015	—	Intensive Outpatient Substance Abuse Treatment
H2023	—	Supportive Employment
H0043	—	Supportive Housing

231.200 Extension of Benefits 7-1-17

Extension of benefits 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. Extension of Benefits is also required whenever a beneficiary exceeds eight hours of outpatient services in one 24-hour day, with the exception of any service that is paid on a per diem basis.

Extension of benefit requests must be sent to the DMS contracted entity to perform extensions of benefits for beneficiaries. **View or print current contractor contact information.** Information related to clinical management guidelines and authorization request processes is available at **current contractor's website**.

240.000 REIMBURSEMENT

240.100 Reimbursement 7-1-17

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

PROPOSED

Fifteen-Minute Units, unless otherwise stated

Outpatient Behavioral Health Services must be billed on a per unit basis, as reflected in a daily total, per beneficiary, per 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 Outpatient Behavioral Health service. Providers are not allowed to accumulatively bill for spanning dates of service.

All billing must reflect a daily total, per Outpatient Behavioral Health 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 Qualified Behavioral Health Provider (QBHP), the accumulated time for the Outpatient Behavioral Health service, per date of service, is one total, regardless of the number of QBHPs seeing the beneficiary on that day. For example, two (2) QBHPs see the same beneficiary on the same date of service and provide Behavioral Assistance (CPT Code 2019). The first QBHP spends a total of 10 minutes. Later in the day, another QBHP provides Behavioral Assistance (CPT Code 2019) to the same beneficiary and spends a total of 15 minutes. A total of 25 minutes of Behavioral Assistance (CPT Code 2019) was provided, which equals (two) 2 allowable units of service. Only one QBHP may be shown on the claim as the performing provider.

B. Inpatient Services

PROPOSED

The length of time and number of units that may be billed for inpatient hospital visits are determined by the description of the service in *Current Procedural Terminology (CPT).*

241.00 Fee Schedule **7-1-17**

Arkansas Medicaid provides fee schedules on the Arkansas Medicaid website. The fee schedule link is located at **https://www.medicaid.state.ar.us** under the provider manual section. The fees represent the fee-for-service reimbursement methodology.

Fee schedules do not address coverage limitations or special instructions applied by Arkansas Medicaid before final payment is determined.

Procedure codes and/or fee schedules do not guarantee payment, coverage or amount allowed. Information may be changed or updated at any time to correct a discrepancy and/or error. Arkansas Medicaid always reimburses the lesser of the amount billed or the Medicaid maximum.

242.000 Rate Appeal Process **7-1-17**

A provider may request reconsideration of a Program decision by writing to the Assistant Director, Division of Medical Services. This request must be received within 20 calendar days following the application of policy and/or procedure or the notification of the provider of its rate. Upon receipt of the request for review, the Assistant Director will determine the need for a Program/Provider conference and will contact the provider to arrange a conference if needed. Regardless of the Program decision, the provider will be afforded the opportunity for a conference, if he or she so wishes, for a full explanation of the factors involved and the Program decision. Following review of the matter, the Assistant Director will notify the provider of the action to be taken by the Division within 20 calendar days of receipt of the request for review or the date of the Program/Provider conference.

If the decision of the Assistant Director, Division of Medical Services is unsatisfactory, the provider may then appeal the question to a standing Rate Review Panel, established by the Director of the Division of Medical Services, which will include one member of the Division of Medical Services, a representative of the provider association and a member of the Department of Human Services (DHS) Management Staff, who will serve as chairman.

The request for review by the Rate Review Panel must be postmarked within 15 calendar days following the notification of the initial decision by the Assistant Director, Division of Medical Services. The Rate Review Panel will meet to consider the question(s) within 15 calendar days after receipt of a request for such appeal. The question(s) will be heard by the panel and a recommendation will be submitted to the Director of the Division of Medical Services.

250.000 BILLING PROCEDURES

251.000 Introduction to Billing 7-1-17

Outpatient Behavioral Health Services providers use the CMS-1500 form to bill the Arkansas Medicaid Program on paper for services provided to eligible Medicaid beneficiaries. 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

PROPOSED

252.100 Procedure Codes for Types of Covered Services 7-1-17

Covered Behavioral Health Services are outpatient services. Specific Behavioral Health Services are available to inpatient hospital patients (as outlined in Sections 240.000 and 220.100), through telemedicine, and to nursing home and ICF/IDD residents. Outpatient Behavioral Health Services are billed on a per unit basis as listed. All services must be provided by at least the minimum staff within the licensed or certified scope of practice to provide the service.

Benefits are separated by Level of Service. A beneficiary can receive three (3) Counseling Level Services before a PCP/PCMH referral is necessary in the medical record.

Prior to reimbursement for Rehabilitative Level Services, a standardized Independent Assessment will determine eligibility and need for Rehabilitative Level Services. The standardized Independent Assessment must be performed by an independent entity.

Prior to reimbursement for Therapeutic Communities/Planned Respite in Intensive Level Services, a beneficiary must be eligible for Rehabilitative Level Services as determined by the standardized Independent Assessment. The beneficiary must then also be determined by an Intensive Level Services Independent Assessment to be eligible for Therapeutic Communities.

ANY beneficiary that is to be placed into an inpatient psychiatric setting covered by the Arkansas Medicaid Inpatient Psychiatric Services for Under Age 21 program (excluding crisis or emergency admissions) must also follow the above process. The beneficiary must be eligible for Rehabilitative Level Services as determined by the standardized Independent Assessment. The beneficiary must then also be determined by an Intensive Level Services Independent Assessment to be eligible for Inpatient Psychiatric Care or Inpatient Residential Care.

The allowable services differ by the age of the beneficiary and are addressed in the Applicable Populations section of the service definitions in this manual.

252.110 Counseling Level Services

252.111 Individual Behavioral Health Counseling 7-1-17

CPT®/HCPCS PROCEDURE CODE	PROCEDURE CODE DESCRIPTION
90832	90832: psychotherapy, 30 min
90834	90834: psychotherapy, 45 min
90837	90837: psychotherapy, 60 min
90832, U7 - Telemedicine	
90834, U7 – Telemedicine	

90837, U7 – Telemedicine 90832, HF – Substance Abuse 90834, HF – Substance Abuse 90837, HF – Substance Abuse 90832, UK – Under Age 4 90834, UK – Under Age 4 90837, UK – Under Age 4	PROPOSED
SERVICE DESCRIPTION	**MINIMUM DOCUMENTATION REQUIREMENTS**
Individual Behavioral Health Counseling is a face-to-face treatment provided to an individual in an outpatient setting for the purpose of treatment and remediation of a condition as described in the current allowable DSM. Services must be congruent with the age and abilities of the beneficiary, client-centered and strength-based; with emphasis on needs as identified by the beneficiary and provided with cultural competence. The treatment service must reduce or alleviate identified symptoms related to either (a) Mental Health or (b) Substance Abuse, and maintain or improve level of functioning, and/or prevent deterioration. Additionally, tobacco cessation counseling is a component of this service.	• Date of Service • Start and stop times of face to face encounter with beneficiary • Place of service • Diagnosis and pertinent interval history • Brief mental status and observations • Rationale and description of the treatment used that must coincide with objectives on the master treatment plan • Beneficiary's response to treatment that includes current progress or regression and prognosis • Any revisions indicated for the master treatment plan, diagnosis, or medication(s) • Plan for next individual therapy session, including any homework assignments and/or advanced psychiatric directive • Staff signature/credentials/date of signature

NOTES	UNIT	BENEFIT LIMITS
Services provided must be congruent with the objectives and interventions articulated on the most recent treatment plan. Services must be consistent with established behavioral healthcare standards. Individual Psychotherapy is not permitted with beneficiaries who do not have the cognitive ability to benefit from the service. This service is not for beneficiaries under the age of 4 except in documented exceptional cases. This service will require a Prior Authorization for beneficiaries under the age of 4.	90832: 30 minutes 90834: 45 minutes 90837: 60 minutes	DAILY MAXIMUM OF UNITS THAT MAY BE BILLED: 90832: 1 90834: 1 90837: 1 YEARLY MAXIMUM OF UNITS THAT MAY BE BILLED (extension of benefits can be requested): <u>Counseling Level Beneficiary</u>: 12 units between all 3 codes

		Rehabilitative/Intensive Level Beneficiary: 26 units between all 3 codes
APPLICABLE POPULATIONS	**SPECIAL BILLING INSTRUCTIONS**	
Children, Youth, and Adults PROPOSED	A provider may only bill one Individual Counseling / Psychotherapy Code per day per beneficiary. A provider cannot bill any other Individual Counseling / Psychotherapy Code on the same date of service for the same beneficiary. For Counseling Level Beneficiaries, there are 12 total individual counseling visits allowed per year regardless of code billed for Individual Behavioral Health Counseling unless an extension of benefits is allow by the Quality Improvement Organization contracted with Arkansas Medicaid. For Rehabilitative/Intensive Level Beneficiaries, there are 12 total individual counseling visits allowed per year regardless of code billed for Individual Behavioral Health Counseling unless an extension of benefits is allow by the Quality Improvement Organization contracted with Arkansas Medicaid.	
ALLOWED MODE(S) OF DELIVERY	**TIER**	
Face-to-face Telemedicine (Adults and Children)	Counseling	
ALLOWABLE PERFORMING PROVIDERS	**PLACE OF SERVICE (POS)**	
• Independently Licensed Clinicians – Master's/Doctoral • Non-independently Licensed Clinicians – Master's/Doctoral • Advanced Practice Nurse • Physician • Providers of services for beneficiaries under age 4 must be trained and certified in specific evidence based practices to be reimbursed for those services o Independently Licensed Clinicians - Parent/Caregiver & Child (Dyadic treatment of Children age 0-47 months & Parent/Caregiver) Provider o Non-independently Licensed Clinicians - Parent/Caregiver & Child (Dyadic treatment of Children age 0-47 months & Parent/Caregiver) Provider	03, 11, 49, 50, 53, 57, 71, 72	

252.112 Group Behavioral Health Counseling 7-1-17

CPT®/HCPCS PROCEDURE CODE	PROCEDURE CODE DESCRIPTION

90853 90853, HF – Substance Abuse	Group psychotherapy (other than of a multiple-family group)
SERVICE DESCRIPTION	**MINIMUM DOCUMENTATION REQUIREMENTS**
Group Behavioral Health Counseling is a face-to-face treatment provided to a group of beneficiaries. Services leverage the emotional interactions of the group's members to assist in each beneficiary's treatment process, support his/her rehabilitation effort, and to minimize relapse. Services must be congruent with the age and abilities of the beneficiary, client-centered and strength-based; with emphasis on needs as identified by the beneficiary and provided with cultural competence. Services pertain to a beneficiary's (a) Mental Health and/or (b) Substance Abuse condition. Additionally, tobacco cessation counseling is a component of this service.	• Date of Service • Start and stop times of actual group encounter that includes identified beneficiary • Place of service • Number of participants • Diagnosis • Focus of group • Brief mental status and observations • Rationale for group counseling must coincide with master treatment plan • Beneficiary's response to the group counseling that includes current progress or regression and prognosis • Any changes indicated for the master treatment plan, diagnosis, or medication(s) • Plan for next group session, including any homework assignments • Staff signature/credentials/date of signature

NOTES	**UNIT**	**BENEFIT LIMITS**
This does NOT include psychosocial groups. Beneficiaries eligible for Group Outpatient – Group Psychotherapy must demonstrate the ability to benefit from experiences shared by others, the ability to participate in a group dynamic process while respecting the others' rights to confidentiality, and must be able to integrate feedback received from other group members. For groups of beneficiaries aged 18 and over, the minimum number that must be served in a specified group is 2. The maximum that may be served in a specified group is 12. For groups of beneficiaries under 18 years of age, the minimum number that must be served in a specified group is 2. The maximum that may be served in a specified group is 10. A beneficiary must be 4 years of age to receive group therapy. Group treatment must be age and developmentally appropriate, (i.e.: 16 year olds and 4 year olds must not be treated in the same group). Providers may bill for services only at times during which beneficiaries participate in group activities,	Encounter	DAILY MAXIMUM OF UNITS THAT MAY BE BILLED: 1 YEARLY MAXIMUM OF UNITS THAT MAY BE BILLED (extension of benefits can be requested): <u>Counseling Level Beneficiary</u>: 12 units <u>Rehabilitative/Intensive Level Beneficiary</u>: 104 units

APPLICABLE POPULATIONS	**SPECIAL BILLING INSTRUCTIONS**
Children, Youth, and Adults	A provider can only bill one Group Behavioral

	Health Counseling / Community Group Psychotherapy encounter per day. For Counseling Level Beneficiaries, there are 12 total group behavioral health counseling visits allowed per year unless an extension of benefits is allow by the Quality Improvement Organization contracted with Arkansas Medicaid. For Rehabilitative/Intensive Level Beneficiaries, there are 104 total group behavioral health counseling visits allowed per year unless an extension of benefits is allow by the Quality Improvement Organization contracted with Arkansas Medicaid.
ALLOWED MODE(S) OF DELIVERY	**TIER**
Face-to-face	Counseling
ALLOWABLE PERFORMING PROVIDERS	**PLACE OF SERVICE**
• Independently Licensed Clinicians - Master's/Doctoral • Non-independently Licensed Clinicians – Master's/Doctoral • Advanced Practice Nurse • Physician	03, 11, 49, 50, 53, 57, 71, 72 PROPOSED

252.113 Marital/Family Behavioral Health Counseling with Beneficiary Present **7-1-17**

CPT®/HCPCS PROCEDURE CODE	PROCEDURE CODE DESCRIPTION
90847 90847, HF – Substance Abuse 90847, UK – Dyadic Treatment *	Family psychotherapy (conjoint psychotherapy) (with patient present)
SERVICE DESCRIPTION	**MINIMUM DOCUMENTATION REQUIREMENTS**
Marital/Family Behavioral Health Counseling with Beneficiary Present is a face-to-face treatment provided to one or more family members in the presence of a beneficiary. Services must be congruent with the age and abilities of the beneficiary, client-centered and strength-based; with emphasis on needs as identified by the beneficiary and provided with cultural competence. Services are designed to enhance insight into family interactions, facilitate inter-family emotional or practical support and to develop alternative strategies to address familial issues, problems and needs. Services pertain to a beneficiary's (a) Mental Health and/or (b) Substance Abuse condition. Additionally, tobacco cessation counseling is a component of this service. ***Dyadic treatment is available for**	• Date of Service • Start and stop times of actual encounter with beneficiary and spouse/family • Place of service • Participants present and relationship to beneficiary • Diagnosis and pertinent interval history • Brief mental status of beneficiary and observations of beneficiary with spouse/family • Rationale for, and description of treatment used that must coincide with the master treatment plan and improve the impact the beneficiary's condition has on the spouse/family and/or improve marital/family interactions between the beneficiary and the spouse/family.

parent/caregiver & child for dyadic treatment of children age 0 through 47 months & parent/caregiver. Dyadic treatment must be prior authorized and is only available for beneficiaries in Tier 1. Dyadic Infant/Caregiver Psychotherapy is a behaviorally based therapy that involves improving the parent-child relationship by transforming the interaction between the two parties. The primary goal of Dyadic Infant/Parent Psychotherapy is to strengthen the relationship between a child and his or her parent (or caregiver) as a vehicle for restoring the child's sense of safety, attachment, and appropriate affect and improving the child's cognitive, behavioral, and social functioning. This service uses child directed interaction to promote interaction between the parent and the child in a playful manner. Providers must utilize a national recognized evidence based practice. Practices include, but are not limited to, Child-Parent Psychotherapy (CPP) and Parent Child Interaction Therapy (PCIT).	• Beneficiary and spouse/family's response to treatment that includes current progress or regression and prognosis • Any changes indicated for the master treatment plan, diagnosis, or medication(s) • Plan for next session, including any homework assignments and/or crisis plans • Staff signature/credentials/date of signature • HIPAA compliant release of Information, completed, signed and dated

NOTES	UNIT	BENEFIT LIMITS
Natural supports may be included in these sessions if justified in service documentation and if supported in the master treatment plan. Only one beneficiary per family per therapy session may be billed.	Encounter	DAILY MAXIMUM OF UNITS THAT MAY BE BILLED: 1 YEARLY MAXIMUM OF UNITS THAT MAY BE BILLED (extension of benefits can be requested): Counseling Level Beneficiaries: 12 units Rehabilitative/Intensive Level Beneficiaries: 30 units between any use of procedure code 90847 and 90846

APPLICABLE POPULATIONS	SPECIAL BILLING INSTRUCTIONS
Children, Youth, and Adults	A provider can only bill one Marital / Family Behavioral Health Counseling with (or without) Patient Present / Home and Community Marital / Family Psychotherapy with (or without) Patient Present encounter per day. There are 12 total Marital/Family Behavioral Health Counseling with

	Beneficiary Present visits allowed per year unless an extension of benefits is allow by the Quality Improvement Organization contracted with Arkansas Medicaid. **The following codes cannot be billed on the Same Date of Service:** 90849 - Multi-Family Behavioral Health Counseling
ALLOWED MODE(S) OF DELIVERY	**TIER**
Face-to-face	Counseling
ALLOWABLE PERFORMING PROVIDERS	**PLACE OF SERVICE**
• Independently Licensed Clinicians - Master's/Doctoral • Non-independently Licensed Clinicians – Master's/Doctoral • Advanced Practice Nurse • Physician • Providers of dyadic services must be trained and certified in specific evidence based practices to be reimbursed for those services o Independently Licensed Clinicians - Parent/Caregiver & Child (Dyadic treatment of Children age 0-47 months & Parent/Caregiver) Provider o Non-independently Licensed Clinicians - Parent/Caregiver & Child (Dyadic treatment of Children age 0-47 months & Parent/Caregiver) Provider	03, 11, 49, 50, 53, 57, 71, 72 PROPOSED

252.114 Marital/Family Behavioral Health Counseling without Beneficiary Present 7-1-17

CPT®/HCPCS PROCEDURE CODE	PROCEDURE CODE DESCRIPTION
90846 90846, HF – Substance Abuse	Family psychotherapy (without the patient present)
SERVICE DESCRIPTION	**MINIMUM DOCUMENTATION REQUIREMENTS**
Marital/Family Behavioral Health Counseling without Beneficiary Present is a face-to-face treatment provided to one or more family members outside the presence of a beneficiary. Services must be congruent with the age and abilities of the beneficiary or family member(s), client-centered and strength-based; with	• Date of Service • Start and stop times of actual encounter with beneficiary and spouse/family • Place of service • Participants present and relationship to

emphasis on needs as identified by the beneficiary and family and provided with cultural competence. Services are designed to enhance insight into family interactions, facilitate inter-family emotional or practical support and to develop alternative strategies to address familial issues, problems and needs. Services pertain to a beneficiary's (a) Mental Health and/or (b) Substance Abuse condition. Additionally, tobacco cessation counseling is a component of this service. PROPOSED	beneficiary • Diagnosis and pertinent interval history • Brief mental status of beneficiary and observations of beneficiary with spouse/family • Rationale for, and description of treatment used that must coincide with the master treatment plan and improve the impact the beneficiary's condition has on the spouse/family and/or improve marital/family interactions between the beneficiary and the spouse/family. • Beneficiary and spouse/family's response to treatment that includes current progress or regression and prognosis • Any changes indicated for the master treatment plan, diagnosis, or medication(s) • Plan for next session, including any homework assignments and/or crisis plans • Staff signature/credentials/date of signature • HIPAA compliant release of Information, completed, signed and dated

NOTES	UNIT	BENEFIT LIMITS
Natural supports may be included in these sessions if justified in service documentation and if supported in the master treatment plan. Only one beneficiary per family per therapy session may be billed.	Encounter	DAILY MAXIMUM OF UNITS THAT MAY BE BILLED: 1 YEARLY MAXIMUM OF UNITS THAT MAY BE BILLED (extension of benefits can be requested): Counseling Level Beneficiaries: 12 units Rehabilitative/Intensive Level Beneficiaries: 30 units between any use of procedure code 90847 and 90846

APPLICABLE POPULATIONS	SPECIAL BILLING INSTRUCTIONS
Children, Youth, and Adults	A provider can only bill one Marital / Family Behavioral Health Counseling with (or without) Beneficiary Present / Home and Community Marital / Family Psychotherapy with (or without) Beneficiary Present encounter per day.

	The following codes cannot be billed on the Same Date of Service: 90849 - Multi-Family Behavioral Health Counseling
ALLOWED MODE(S) OF DELIVERY	**TIER**
Face-to-face	Counseling
ALLOWABLE PERFORMING PROVIDERS	**PLACE OF SERVICE**
• Independently Licensed Clinicians - Master's/Doctoral • Non-independently Licensed Clinicians – Master's/Doctoral • Advanced Practice Nurse • Physician	03, 11, 49, 50, 53, 57, 71, 72 PROPOSED

252.115 Psychoeducation **7-1-17**

CPT®/HCPCS PROCEDURE CODE	PROCEDURE CODE DESCRIPTION
H2027 H2027, U7 – Telemedicine H2027, UK – Dyadic Treatment*	Psychoeducational service; per 15 minutes
SERVICE DESCRIPTION	**MINIMUM DOCUMENTATION REQUIREMENTS**
Psychoeducation provides beneficiaries and their families with pertinent information regarding mental illness, substance abuse, and tobacco cessation, and teaches problem-solving, communication, and coping skills to support recovery. Psychoeducation can be implemented in two formats: multifamily group and/or single family group. Due to the group format, beneficiaries and their families are also able to benefit from support of peers and mutual aid. Services must be congruent with the age and abilities of the beneficiary, client-centered, and strength-based; with emphasis on needs as identified by the beneficiary and provided with cultural competence. ***Dyadic treatment is available for parent/caregiver & child for dyadic treatment of children age 0 through 47 months & parent/caregiver. Dyadic treatment must be prior authorized. Providers must utilize a national recognized evidence based practice. Practices include, but are not limited to, Nurturing Parents and Incredible Years.**	• Date of Service • Start and stop times of actual encounter with spouse/family • Place of service • Participants present • Nature of relationship with beneficiary • Rationale for excluding the identified beneficiary • Diagnosis and pertinent interval history • Rationale for and objective used that must coincide with the master treatment plan and improve the impact the beneficiary's condition has on the spouse/family and/or improve marital/family interactions between the beneficiary and the spouse/family. • Spouse/Family response to treatment that includes current progress or regression and prognosis • Any changes indicated for the master treatment plan, diagnosis, or medication(s) • Plan for next session, including any

	homework assignments and/or crisis plans • HIPAA compliant Release of information forms, completed, signed and dated • Staff signature/credentials/date of signature	
NOTES	**UNIT**	**BENEFIT LIMITS**
Information to support the appropriateness of excluding the identified beneficiary must be documented in the service note and medical record. Natural supports may be included in these sessions when the nature of the relationship with the beneficiary and that support's expected role in attaining treatment goals is documented. Only one beneficiary per family per therapy session may be billed.	15 minutes	DAILY MAXIMUM OF UNITS THAT MAY BE BILLED: 4 YEARLY MAXIMUM OF UNITS THAT MAY BE BILLED (extension of benefits can be requested): 48
APPLICABLE POPULATIONS	**SPECIAL BILLING INSTRUCTIONS**	
Children, Youth, and Adults PROPOSED	A provider can only bill a total of 48 units of Psychoeducation / Home and Community Family Psychoeducation per SFY combined, regardless of code billed. **The following codes cannot be billed on the Same Date of Service:** 90847 – Marital/Family Behavioral Health Counseling with Beneficiary Present 90847 – Home and Community Marital/Family Psychotherapy with Beneficiary Present 90846 – Marital/Family Behavioral Health Counseling without Beneficiary Present 90846 – Home and Community Marital/Family Psychotherapy without Beneficiary Present	
ALLOWED MODE(S) OF DELIVERY	**TIER**	
Face-to-face Telemedicine (Adults and Children)	Counseling	
ALLOWABLE PERFORMING PROVIDERS	**PLACE OF SERVICE**	
• Independently Licensed Clinicians - Master's/Doctoral • Non-independently Licensed Clinicians – Master's/Doctoral • Advanced Practice Nurse • Physician • Providers of dyadic services must be trained and certified in specific evidence based practices to be reimbursed for those services	03, 11, 49, 50, 53, 57, 71, 72	

o Independently Licensed Clinicians - Parent/Caregiver & Child (Dyadic treatment of Children age 0-47 months & Parent/Caregiver) Provider o Non-independently Licensed Clinicians - Parent/Caregiver & Child (Dyadic treatment of Children age 0-47 months & Parent/Caregiver) Provider	PROPOSED

252.116 Multi-Family Behavioral Health Counseling **7-1-17**

CPT®/HCPCS PROCEDURE CODE	PROCEDURE CODE DESCRIPTION
90849 90849, HF – Substance Abuse	Multiple-family group psychotherapy
SERVICE DESCRIPTION	**MINIMUM DOCUMENTATION REQUIREMENTS**
Multi-Family Behavioral Health Counseling 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. Services are a more cost-effective alternative to Family Behavioral Health Counseling, 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. Services may pertain to a beneficiary's (a) Mental Health or (b) Substance Abuse condition. Services must be congruent with the age and abilities of the beneficiary, client-centered and strength-based; with emphasis on needs as identified by the beneficiary and family and provided with cultural competence. Additionally, tobacco cessation counseling is a component of this service.	• Date of Service • Start and stop times of actual encounter with spouse/family • Place of service • Participants present • Nature of relationship with beneficiary • Rationale for excluding the identified beneficiary • Diagnosis and pertinent interval history • Rationale for and objective used to improve the impact the beneficiary's condition has on the spouse/family and/or improve marital/family interactions between the beneficiary and the spouse/family. • Spouse/Family response to treatment that includes current progress or regression and prognosis • Any changes indicated for the master treatment plan, diagnosis, or medication(s) • Plan for next session, including any homework assignments and/or crisis plans • HIPAA compliant Release of information forms, completed, signed and dated • Staff signature/credentials/date of signature

NOTES	UNIT	BENEFIT LIMITS
May be provided independently if patient is being treated for substance abuse diagnosis only. Comorbid substance abuse should be	Encounter	DAILY MAXIMUM OF UNITS THAT MAY BE

provided as integrated treatment utilizing Family Psychotherapy.		BILLED: 1 YEARLY MAXIMUM OF UNITS THAT MAY BE BILLED (extension of benefits can be requested): 12
APPLICABLE POPULATIONS	**SPECIAL BILLING INSTRUCTIONS**	
Children, Youth, and Adults PROPOSED	There are 12 total Multi-Family Behavioral Health Counseling visits allowed per year. **The following codes cannot be billed on the Same Date of Service:** 90887 – Interpretation of Diagnosis 90887 – Interpretation of Diagnosis, Telemedicine	
ALLOWED MODE(S) OF DELIVERY	**TIER**	
Face-to-face	Counseling	
ALLOWABLE PERFORMING PROVIDERS	**PLACE OF SERVICE**	
• Independently Licensed Clinicians - Master's/Doctoral • Non-independently Licensed Clinicians – Master's/Doctoral • Advanced Practice Nurse • Physician	03, 11, 49, 50, 53, 57, 71, 72	

252.117 Mental Health Diagnosis 7-1-17

CPT®/HCPCS PROCEDURE CODE	PROCEDURE CODE DESCRIPTION
90791 90791, U7 – Telemedicine 90791, UK – Dyadic Treatment *	Psychiatric diagnostic evaluation (with no medical services)
SERVICE DESCRIPTION	**MINIMUM DOCUMENTATION REQUIREMENTS**
Mental Health Diagnosis is a clinical service for the purpose of determining the existence, type, nature, and appropriate treatment of a mental illness or related disorder as described in the current allowable DSM. This service may include time spent for obtaining necessary information for diagnostic purposes. The psychodiagnostic process may include, but is not limited to: a psychosocial and medical history, diagnostic findings, and recommendations. This service must include a face-to-face component and will serve as the basis for documentation of modality and issues to be addressed (plan of care). Services must be congruent with the age and abilities of the beneficiary, client-centered and strength-based; with emphasis on needs as identified by the beneficiary and provided with cultural competence. PROPOSED	• Date of Service • Start and stop times of the face to face encounter with the beneficiary and the interpretation time for diagnostic formulation • Place of service • Identifying information • Referral reason • Presenting problem (s), history of presenting problem(s), including duration, intensity, and response(s) to prior treatment • Culturally- and age-appropriate psychosocial history and assessment • Mental status/Clinical observations and impressions • Current functioning plus strengths and needs in specified life domains • DSM diagnostic impressions to include all axes • Treatment recommendations • Goals and objectives to be placed in Plan of Care • Staff signature/credentials/date of signature

NOTES	UNIT	BENEFIT LIMITS
This service may be billed for face-to-face contact as well as for time spent obtaining necessary information for diagnostic purposes; however, this time may NOT be used for development or submission of required paperwork processes (i.e. treatment plans, etc.). This service can be provided via telemedicine to beneficiaries only ages 21 and above. ***Dyadic treatment is available for parent/caregiver & child for dyadic treatment of children age 0 through 47 months & parent/caregiver. A Mental**	Encounter	DAILY MAXIMUM OF UNITS THAT MAY BE BILLED: 1 YEARLY MAXIMUM OF UNITS THAT MAY BE BILLED (extension of benefits can be requested): 1

Health Diagnosis will be required for all children through 47 months to receive services. This service includes up to four encounters for children through the age of 47 months and can be provided without a prior authorization. This service must include an assessment of: o **Presenting symptoms and behaviors;** o **Developmental and medical history;** o **Family psychosocial and medical history;** o **Family functioning, cultural and communication patterns, and current environmental conditions and stressors;** o **Clinical interview with the primary caregiver and observation of the caregiver-infant relationship and interactive patterns;** o **Child's affective, language, cognitive, motor, sensory, self-care, and social functioning.**	PROPOSED
APPLICABLE POPULATIONS	**SPECIAL BILLING INSTRUCTIONS**
Children, Youth, and Adults	**The following codes cannot be billed on the Same Date of Service:** 90792 – Psychiatric Assessment H0001 – Substance Abuse Assessment
ALLOWED MODE(S) OF DELIVERY	**TIER**
Face-to-face Telemedicine (Adults Only)	Counseling
ALLOWABLE PERFORMING PROVIDER	**PLACE OF SERVICE**
• Independently Licensed Clinicians – Master's/Doctoral • Non-independently Licensed Clinicians – Master's/Doctoral • Advanced Practice Nurse • Physician • Providers of dyadic services must be trained and certified in specific evidence based practices to be reimbursed for those services o Independently Licensed Clinicians – Parent/Caregiver & Child (Dyadic treatment of Children age 0-47 months & Parent/Caregiver) Provider	03, 11, 49, 50, 53, 57, 71, 72

o Non-independently Licensed Clinicians – Parent/Caregiver & Child (Dyadic treatment of Children age 0-47 months & Parent/Caregiver) Provider	PROPOSED

252.118 Interpretation of Diagnosis **7-1-17**

CPT®/HCPCS PROCEDURE CODE	PROCEDURE CODE DESCRIPTION
90887 90887, U7 – Telemedicine 90887, UK – Dyadic Treatment	Interpretation or explanation of results of psychiatric, other medical examinations and procedures, or other accumulated data to family or other responsible persons, or advising them how to assist patient

SERVICE DESCRIPTION	MINIMUM DOCUMENTATION REQUIREMENTS
Interpretation of Diagnosis is a direct service provided for the purpose of interpreting the results of psychiatric or other medical exams, procedures, or accumulated data. Services may include diagnostic activities and/or advising the beneficiary and his/ her family. Consent forms may be required for family or significant other involvement. Services must be congruent with the age and abilities of the beneficiary, client-centered and strength-based; with emphasis on needs as identified by the beneficiary and provided with cultural competence.	• Start and stop times of face to face encounter with beneficiary and/or parents or guardian • Date of service • Place of service • Participants present and relationship to beneficiary • Diagnosis • Rationale for and objective used that must coincide with the master treatment plan or proposed master treatment plan or recommendations. • Participant(s) response and feedback • Staff signature/credentials/date of signature(s)

NOTES	UNIT	BENEFIT LIMITS
For beneficiaries under the age of 18, the time may be spent face-to-face with the beneficiary; the beneficiary and the parent(s) or guardian(s); or alone with the parent(s) or guardian(s). For beneficiaries over the age of 18, the time may be spent face-to-face with the beneficiary and the spouse, legal guardian or significant other. This service can be provided via telemedicine to beneficiaries only ages 21 and above. ***Dyadic treatment is available for parent/caregiver & child for dyadic treatment of children age 0 through 47 months& parent/caregiver. Interpretation of Diagnosis will be required for all children through 47 months to receive services. This service**	Encounter	DAILY MAXIMUM OF UNITS THAT MAY BE BILLED: 1 YEARLY MAXIMUM OF UNITS THAT MAY BE BILLED (extension of benefits can be requested): Counseling Level Beneficiary: 1 Rehabilitative/Intensive Level Beneficiary: 2

includes up to four encounters for children through the age of 47 months and can be provided without a prior authorization. The Interpretation of Diagnosis is a direct service that includes an interpretation from a broader perspective the history and information collected through the Mental Health Diagnosis. This interpretation identifies and prioritizes the infant's needs, establishes a diagnosis, and helps to determine the care and services to be provided.		

APPLICABLE POPULATIONS	SPECIAL BILLING INSTRUCTIONS
Children, Youth, and Adults	**The following codes cannot be billed on the Same Date of Service:** H2027 – Psychoeducation 90792 – Psychiatric Assessment H0001 – Substance Abuse Assessment
ALLOWED MODE(S) OF DELIVERY	**TIER**
Face-to-face Telemedicine (Adults Only)	Counseling
ALLOWABLE PERFORMING PROVIDERS	**PLACE OF SERVICE**
• Independently Licensed Clinicians – Master's/Doctoral • Non-independently Licensed Clinicians – Master's/Doctoral • Advanced Practice Nurse • Physician • Providers of dyadic services must be trained and certified in specific evidence based practices to be reimbursed for those services o Independently Licensed Clinicians – Parent/Caregiver & Child (Dyadic treatment of Children age 0-47 months & Parent/Caregiver) Provider o Non-independently Licensed Clinicians – Parent/Caregiver & Child (Dyadic treatment of Children age 0-47 months & Parent/Caregiver) Provider	03, 11, 49, 50, 53, 57, 71, 72 PROPOSED

252.119 Substance Abuse Assessment 7-1-17

CPT®/HCPCS PROCEDURE CODE	PROCEDURE CODE DESCRIPTION	
H0001	Alcohol and / or drug assessment	
SERVICE DESCRIPTION	**MINIMUM DOCUMENTATION REQUIREMENTS**	
Substance Abuse Assessment is a service that identifies and evaluates the nature and extent of a beneficiary's substance abuse condition using the Addiction Severity Index (ASI) or an assessment instrument approved by DBHS and DMS. The assessment must screen for and identify any existing co-morbid conditions. The assessment should assign a diagnostic impression to the beneficiary, resulting in a treatment recommendation and referral appropriate to effectively treat the condition(s) identified. PROPOSED	• Date of Service • Start and stop times of the face to face encounter with the beneficiary and the interpretation time for diagnostic formulation • Place of service • Identifying information • Referral reason • Presenting problem (s), history of presenting problem(s), including duration, intensity, and response(s) to prior treatment • Culturally- and age-appropriate psychosocial history and assessment • Mental status/Clinical observations and impressions • Current functioning and strengths in specified life domains • DSM diagnostic impressions to include all axes • Treatment recommendations • Staff signature/credentials/date of signature	
NOTES	**UNIT**	**BENEFIT LIMITS**
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	Encounter	DAILY MAXIMUM OF UNITS THAT MAY BE BILLED: 1 YEARLY MAXIMUM OF UNITS THAT MAY BE BILLED (extension of benefits can be requested): 1
APPLICABLE POPULATIONS	**SPECIAL BILLING INSTRUCTIONS**	
Children, Youth, and Adults	**The following codes cannot be billed on the Same Date of Service:** 90792 – Psychiatric Assessment 90887 – Interpretation of Diagnosis 90791 – Mental Health Diagnosis	

ALLOWED MODE(S) OF DELIVERY	TIER
Face-to-face	Counseling
ALLOWABLE PERFORMING PROVIDERS	**PLACE OF SERVICE**
• Independently Licensed Clinicians - Master's/Doctoral • Non-independently Licensed Clinicians – Master's/Doctoral • Advanced Practice Nurse • Physician	03, 11, 49, 50, 53, 57, 71, 72 PROPOSED

252.120 Psychological Evaluation 7-1-17

CPT®/HCPCS PROCEDURE CODE	PROCEDURE CODE DESCRIPTION
96101	Psychological testing (includes psychodiagnostic assessment of emotionality, intellectual abilities, personality and psychopathology, e.g. MMPI, Rorschach®, WAIS®), per hour of the psychologist's or physician's time, both face-to-face time administering tests to the patient and time interpreting these test results and preparing the report.
SERVICE DESCRIPTION	**MINIMUM DOCUMENTATION REQUIREMENTS**
Psychological Evaluation for personality assessment includes psychodiagnostic assessment of a beneficiary's emotional, personality, and psychopathology, eg. MMPI, Rorschach®, and WAIS®. Psychological testing is billed per hour both face-time administering tests and time interpreting these tests and preparing the report. This service may reflect the mental abilities, aptitudes, interests, attitudes, motivation, emotional and personality characteristics of the beneficiary. Medical necessity for this service is met when: • the service is necessary to establish a differential diagnosis of behavioral or psychiatric conditions • history and symptomatology are not readily attributable to a particular psychiatric diagnosis • questions to be answered by the evaluation could not be resolved by a psychiatric/diagnostic interview, observation in therapy, or an assessment for level of care at a mental health facility	• Date of Service • Start and stop times of actual encounter with beneficiary • Start and stop times of scoring, interpretation and report preparation • Place of service • Identifying information • Rationale for referral • Presenting problem(s) • Culturally- and age-appropriate psychosocial history and assessment • Mental status/Clinical observations and impressions • Psychological tests used, results, and interpretations, as indicated • DSM diagnostic impressions to include all axes • Treatment recommendations and findings related to rationale for service and guided by test results

	• Staff signature/credentials/date of signature(s)	
NOTES	**UNIT**	**BENEFIT LIMITS**
	60 minutes PROPOSED	DAILY MAXIMUM OF UNITS THAT MAY BE BILLED: 1 YEARLY MAXIMUM OF UNITS THAT MAY BE BILLED (extension of benefits can be requested): 8
APPLICABLE POPULATIONS	**SPECIAL BILLING INSTRUCTIONS**	
Children, Youth, and Adults		
ALLOWED MODE(S) OF DELIVERY	**TIER**	
Face-to-face	Counseling	
ALLOWABLE PERFORMING PROVIDERS	**PLACE OF SERVICE**	
• Licensed Psychologist (LP) • Licensed Psychological Examiner (LPE) • Licensed Psychological Examiner – Independent (LPEI)	03, 11, 49, 50, 53, 57, 71, 72	

252.121 Pharmacologic Management **7-1-17**

CPT®/HCPCS PROCEDURE CODE	PROCEDURE CODE DESCRIPTION
99212, UB – Physician 99213, UB – Physician 99214, UB – Physician 99212, U7, UB – Physician, Telemedicine 99213 U7, UB – Physician, Telemedicine 99214 U7, UB – Physician, Telemedicine 99212, SA – APN 99213, SA – APN 99214, SA – APN 99212, U7, SA – APN, Telemedicine 99213, U7, SA – APN, Telemedicine 99214, U7, SA – APN, Telemedicine	99212: Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A problem focused history; A problem focused examination; Straightforward medical decision making 99213: Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: An expanded problem focused history; An expanded problem focused examination; Medical decision making of low complexity. 99214: Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A detailed history, A detailed examination; Medical decision making of moderate complexity

SERVICE DESCRIPTION	MINIMUM DOCUMENTATION REQUIREMENTS
Pharmacologic Management is a service tailored to reduce, stabilize or eliminate psychiatric symptoms. This service includes evaluation of the medication prescription, administration, monitoring, and supervision and informing beneficiaries regarding medication(s) and its potential effects and side effects in order to make informed decisions regarding the prescribed medications. Services must be congruent with the age, strengths, and accommodations necessary for disability and cultural framework. PROPOSED	• Date of Service • Start and stop times of actual encounter with beneficiary • Place of service (When 99 is used for telemedicine, specific locations of the beneficiary and the physician must be included) • Diagnosis and pertinent interval history • Brief mental status and observations • Rationale for and treatment used that must coincide with the master treatment plan • Beneficiary's response to treatment that includes current progress or regression and prognosis • Revisions indicated for the master treatment plan, diagnosis, or medication(s) • Plan for follow-up services, including any crisis plans • If provided by physician that is not a psychiatrist, then any off label uses of medications should include documented consult with the overseeing psychiatrist within 24 hours of the prescription being written • Staff signature/credentials/date of signature

NOTES	UNIT	BENEFIT LIMITS
Applies only to medications prescribed to address targeted symptoms as identified in the treatment plan.	Encounter	DAILY MAXIMUM OF UNITS THAT MAY BE BILLED: 1 YEARLY MAXIMUM OF UNITS THAT MAY BE BILLED (extension of benefits can be requested): 12

APPLICABLE POPULATIONS	SPECIAL BILLING INSTRUCTIONS
Children, Youth, and Adults	

ALLOWED MODE(S) OF DELIVERY	TIER
Face-to-face Telemedicine (Adults and Children)	Counseling

ALLOWABLE PERFORMING PROVIDERS	PLACE OF SERVICE
• Advanced Practice Nurse	03, 11, 49, 50, 53, 57, 71, 72

• Physician	

252.122 Psychiatric Assessment **7-1-17**

CPT®/HCPCS PROCEDURE CODE	PROCEDURE CODE DESCRIPTION
90792 90792, U7 - Telemedicine	Psychiatric diagnostic evaluation with medical services

SERVICE DESCRIPTION	MINIMUM DOCUMENTATION REQUIREMENTS
Psychiatric Assessment is a face-to-face psychodiagnostic assessment conducted by a licensed physician or Advanced Practice Nurse (APN), preferably one with specialized training and experience in psychiatry (child and adolescent psychiatry for beneficiaries under age 18). This service is provided to determine the existence, type, nature, and most appropriate treatment of a behavioral health disorder. This service is not required for beneficiaries to receive Counseling Level Services. PROPOSED	• Date of Service • Start and stop times of the face to face encounter with the beneficiary and the interpretation time for diagnostic formulation • Place of service • Identifying information • Referral reason • Presenting problem (s), history of presenting problem(s), including duration, intensity, and response(s) to prior treatment • Culturally- and age-appropriate psychosocial history and assessment • Mental status/Clinical observations and impressions • Current functioning and strengths in specified life domains • DSM diagnostic impressions to include all axes • Treatment recommendations • Staff signature/credentials/date of signature

NOTES	UNIT	BENEFIT LIMITS
This service may be billed for face-to-face contact as well as for time spent obtaining necessary information for diagnostic purposes; however, this time may NOT be used for development or submission of required paperwork processes (i.e. treatment plans, etc.). This service is not required for beneficiaries receiving only Counseling Level Services in the Outpatient Behavioral Health Services program. The Psychiatric Assessment is required for beneficiaries receiving Rehabilitative Level Services or Therapeutic Communities in	Encounter	DAILY MAXIMUM OF UNITS THAT MAY BE BILLED: 1 YEARLY MAXIMUM OF UNITS THAT MAY BE BILLED (extension of benefits can be requested): 1

Intensive Level Services.		
APPLICABLE POPULATIONS	**SPECIAL BILLING INSTRUCTIONS**	
Children, Youth, and Adults Telemedicine (Adults and Children)	**The following codes cannot be billed on the Same Date of Service:** H0001 – Substance Abuse Assessment 90791 – Mental Health Diagnosis	
ALLOWED MODE(S) OF DELIVERY	**TIER**	
Face-to-face	Counseling	
ALLOWABLE PERFORMING PROVIDERS	**PLACE OF SERVICE**	
• Advanced Practice Nurse • Physician	03, 11, 49, 50, 53, 57, 71, 72	

PROPOSED

253.000 Rehabilitative Level Services

253.001 Treatment Plan **7-1-17**

CPT®/HCPCS PROCEDURE CODE	PROCEDURE CODE DESCRIPTION
S0220 	S0220: Medical conference by a physician with interdisciplinary team of health professionals representative of community agencies to coordinate activities of patient care (patient is present)
SERVICE DESCRIPTION	**MINIMUM DOCUMENTATION REQUIREMENTS**
Treatment Plan is a plan developed in cooperation with the beneficiary (or parent or guardian if under 18) to deliver specific mental health services to restore, improve, or stabilize the beneficiary's mental health condition. The Plan must be based on individualized service needs as identified in the completed Mental Health Diagnosis, independent assessment, and independent care plan. The Plan must include goals for the medically necessary treatment of identified problems, symptoms and mental health conditions. The Plan must identify individuals or treatment teams responsible for treatment, specific treatment modalities prescribed for the beneficiary, and time limitations for services. The plan must be congruent with the age and abilities of the beneficiary, client-centered and strength-based; with emphasis on needs as identified by the beneficiary and demonstrate cultural competence.	• Date of Service (date plan is developed) • Start and stop times for development of plan • Place of service • Diagnosis • Beneficiary's strengths and needs • Treatment goal(s) developed in cooperation with and as stated by beneficiary that are related specifically to the beneficiary's strengths and needs • Measurable objectives • Treatment modalities — The specific services that will be used to meet the measurable objectives • Projected schedule for service delivery, including amount, scope, and duration • Credentials of staff who will be providing the services • Discharge criteria • Signature/credentials of staff drafting the document and primary staff who will be delivering or supervising the delivery of the specific services/ date of signature(s) • Beneficiary's signature (or signature of parent, guardian, or custodian of beneficiaries under the age of 18)/ date of signature • Physician's signature indicating medical necessity /date of signature

NOTES	UNIT	BENEFIT LIMITS
This service may be billed when the beneficiary enters care and must be reviewed every ninety (90) calendar days or more frequently if there is documentation of significant acuity changes in clinical status requiring an update/change in the beneficiary's master treatment plan. It is the responsibility of the primary mental health professional to insure that all individuals working with the client have a clear understanding and work toward the goals and objectives stated on the treatment plan.	30 minutes	DAILY MAXIMUM OF UNITS THAT MAY BE BILLED: 2 YEARLY MAXIMUM OF UNITS THAT MAY BE BILLED (extension of benefits can be requested): 8
APPLICABLE POPULATIONS	**SPECIAL BILLING INSTRUCTIONS**	
Children, Youth, and Adults	Must be reviewed every ninety (90) calendar days	
ALLOWED MODE(S) OF DELIVERY	**TIER**	
Face-to-face	Rehabilitative	
ALLOWABLE PERFORMING PROVIDERS	**PLACE OF SERVICE**	
• Independently Licensed Clinicians - Master's/Doctoral • Non-independently Licensed Clinicians – Master's/Doctoral • Advanced Practice Nurse • Physician	03, 04, 11, 12, 14, 33, 49, 50, 53, 57, 71, 72 PROPOSED	

253.002 Crisis Stabilization Intervention 7-1-17

CPT®/HCPCS PROCEDURE CODE	PROCEDURE CODE DESCRIPTION
H2011, HA, U6 – Mental Health Professional H2011 – HA, U5 - QBHP	Crisis intervention service, per 15 minutes
SERVICE DESCRIPTION	**MINIMUM DOCUMENTATION REQUIREMENTS**
Crisis Stabilization Intervention is a scheduled face-to-face treatment activities provided to a beneficiary who has recently experienced a psychiatric or behavioral crisis that are expected to further stabilize, prevent deterioration and serve as an alternative to 24-hour inpatient care. Services are to be congruent with the age, strengths, needed accommodation for any disability and cultural framework of the beneficiary and his/her family.	• Date of service • Start and stop time of actual encounter with beneficiary and possible collateral contacts with caregivers or informed persons • Place of service (When 99 is used, specific location and rationale for location must be included) • Specific persons providing pertinent information in relationship to beneficiary • Diagnosis and synopsis of events leading up to crisis situation • Brief mental status and observations • Utilization of previously established

	psychiatric advance directive or crisis plan as pertinent to current situation OR rationale for crisis intervention activities utilized • Beneficiary's response to the intervention that includes current progress or regression and prognosis • Clear resolution of the current crisis and/or plans for further services • Development of a clearly defined crisis plan or revision to existing plan • Staff signature/credentials/date of signature(s)

NOTES	UNIT	BENEFIT LIMITS
A psychiatric or behavioral crisis is defined as an acute situation in which an individual is experiencing a serious mental illness or emotional disturbance to the point that the beneficiary or others are at risk for imminent harm or in which to prevent significant deterioration of the beneficiary's functioning. This service is a planned intervention that MUST be on the beneficiary's treatment plan to serve as an alternative to 24-hour inpatient care.	15 Minutes PROPOSED	DAILY MAXIMUM OF UNITS THAT MAY BE BILLED: 12 YEARLY MAXIMUM OF UNITS THAT MAY BE BILLED (extension of benefits can be requested): 72

APPLICABLE POPULATIONS	SPECIAL BILLING INSTRUCTIONS
Children, Youth, and Adults	

ALLOWED MODE(S) OF DELIVERY	TIER
Face-to-face	Rehabilitative

ALLOWABLE PERFORMING PROVIDERS	PLACE OF SERVICE
• Independently Licensed Clinicians - Master's/Doctoral • Non-independently Licensed Clinicians – Master's/Doctoral • Advanced Practice Nurse • Physician • Qualified Behavioral Health Provider – Bachelors • Qualified Behavioral Health Provider – Non-Degreed • Registered Nurse	03, 04, 11, 12, 14, 33, 49, 50, 53, 57, 71, 72, 99

253.003 Partial Hospitalization 7-1-17

CPT®/HCPCS PROCEDURE CODE	PROCEDURE CODE DESCRIPTION
H0035	Mental health partial hospitalization treatment, less than 24 hours

SERVICE DESCRIPTION	MINIMUM DOCUMENTATION REQUIREMENTS
Partial Hospitalization is an intensive nonresidential, therapeutic treatment program. It can be used as an alternative to and/or a step-down service from inpatient residential treatment or to stabilize a deteriorating condition and avert hospitalization. The program provides clinical treatment services in a stable environment on a level equal to an inpatient program, but on a less than 24-hour basis. The environment at this level of treatment is highly structured and should maintain a staff-to-patient ratio of 1:5 to ensure necessary therapeutic services and professional monitoring, control, and protection. This service shall include at a minimum intake, individual therapy, group therapy, and psychoeducation. Partial Hospitalization shall be at a minimum (5) five hours per day, of which 90 minutes must be a documented service provided by a Mental Health Professional. If a beneficiary receives other services during the week but also receives Partial Hospitalization, the beneficiary must receive, at a minimum, 20 documented hours of services on no less than (4) four days in that week.	• Start and stop times of actual program participation by beneficiary • Place of service • Diagnosis and pertinent interval history • Brief mental status and observations • Rationale for and treatment used that must coincide with the master treatment plan • Beneficiary's response to the treatment must include current progress or lack of progress toward symptom reduction and attainment of goals • Rationale for continued acute day service, including necessary changes to diagnosis, master treatment plan or medication(s) and plans to transition to less restrictive services • All services provided must be clearly documented in the medical record • Staff signature/credentials PROPOSED

NOTES	UNIT	BENEFIT LIMITS
Partial hospitalization may include drug testing, medical care other than detoxification and other appropriate services depending on the needs of the individual. The medical record must indicate the services provided during Partial Hospitalization.	Per Diem	DAILY MAXIMUM OF UNITS THAT MAY BE BILLED: 1 YEARLY MAXIMUM OF UNITS THAT MAY BE BILLED (extension of benefits can be requested): 40

APPLICABLE POPULATIONS	SPECIAL BILLING INSTRUCTIONS
Children, Youth, and Adults	A provider may not bill for any other services on the same date of service.
ALLOWED MODE(S) OF DELIVERY	**TIER**
Face-to-face	Rehabilitative
ALLOWABLE PERFORMING PROVIDERS	**PLACE OF SERVICE**

Partial Hospitalization must be provided in a facility that is certified by the Division of Behavioral Health Services as a Partial Hospitalization provider	11 , 22, 49, 52, 53

EXAMPLE ACTIVITIES
Care provided to a client who is not ill enough to need admission to facility but who has need of more intensive care in the therapeutic setting than can be provided in the community. This service shall include at a minimum intake, individual and group therapy, and psychosocial education. Partial hospitalization may include drug testing, medical care other than detoxification and other appropriate services depending on the needs of the individual.

253.004 **Behavioral Assistance** PROPOSED **7-1-17**

CPT®/HCPCS PROCEDURE CODE	PROCEDURE CODE DESCRIPTION
H2019, HK, HN – QBHP Bachelors or RN H2019, HK, HM – QBHP Non-Degreed	H2019: Therapeutic behavioral services, per 15 minutes

SERVICE DESCRIPTION	MINIMUM DOCUMENTATION REQUIREMENTS
Behavioral Assistance is a specific outcome oriented intervention provided individually or in a group setting with the child/youth and/or his/her caregiver(s) that will provide the necessary support to attain the goals of the treatment plan. Services involve applying positive behavioral interventions and supports within the community to foster behaviors that are rehabilitative and restorative in nature. The intervention should result in sustainable positive behavioral changes that improve functioning, enhance the quality of life and strengthen skills in a variety of life domains.	• Date of Service • Names and relationship to the beneficiary of all persons involved • Start and stop times of actual encounter with collateral contact • Place of Service (When 99 is used, specific location and rationale for location must be included) • Client diagnosis necessitating treatment • Document how treatment used address goals and objectives from the master treatment plan • Information gained from contact and how it relates to master treatment plan objectives • Impact of information received/given on the beneficiary's treatment • Any changes indicated for the master treatment plan which must be documented and communicated to the supervising MHP for consideration • Plan for next contact, if any • Staff signature/credentials/Date of signature

NOTES	UNIT	BENEFIT LIMITS
	15 minutes	YEARLY MAXIMUM OF UNITS THAT MAY BE BILLED (extension of benefits can be

		requested): 292
APPLICABLE POPULATIONS	**SPECIAL BILLING INSTRUCTIONS**	
Children and Youth	A provider can only bill 292 units of H2019, HK, HN or H2019, HK, HM combined per SFY.	
ALLOWED MODE(S) OF DELIVERY	**TIER**	
Face-to-face	Rehabilitative	
ALLOWABLE PERFORMING PROVIDERS	**PLACE OF SERVICE**	
• Qualified Behavioral Health Provider – Bachelors • Qualified Behavioral Health Provider – Non-Degreed • Registered Nurse (Use Code H2019 with HK, HN modifiers)	03, 04, 11, 12, 13, 14, 15, 16 , 22, 23, 31, 32, 33, 34, 49, 50, 52, 53, 57, 71, 72, 99 PROPOSED	
EXAMPLE ACTIVITIES		
Behavioral Assistance is designed to support youth and their families in meeting behavioral goals identified goals in various community settings. The service is targeted for children and adolescents who are at risk of out-of-home placement or who have returned home from residential placement and need flexible wrap-around supports to ensure safety and support community integration. The service is tied to specific treatment goals and is developed in coordination with the youth and their family. Behavioral Assistance aids the family in implementing safety plans and behavioral management plans when youth are at risk for offending behaviors, aggressions, and oppositional defiance. Staff provides supports to youth and their families during periods when behaviors have been typically problematic - such as during morning preparation for school, at bedtime, after school, or other times when there is evidence of a pattern of an escalation of problem difficult behaviors. The service may be provided in school classrooms or on school busses for short periods of time to help a youth's transition from hospitals or residential settings but is not intended as a permanent solution to problem difficult behaviors at school.		

253.005 Adult Rehabilitative Day Service **7-1-17**

CPT®/HCPCS PROCEDURE CODE	**PROCEDURE CODE DESCRIPTION**
H2017, HK, HN – QBHP Bachelors or RN H2017, HK, HM – QBHP Non-Degreed	Psychosocial rehabilitation services
SERVICE DESCRIPTION	**MINIMUM DOCUMENTATION REQUIREMENTS**
A continuum of care provided to recovering individuals living in the community based on their level of need. This service includes educating and assisting the individual with accessing supports and services needed. The service assists the recovering individual to direct their resources and support systems. Activities include training to assist the person to learn, retain, or improve specific job skills, and to successfully adapt and adjust to a particular work environment. This service includes	• Date of Service • Names and relationship to the beneficiary of all persons involved • Start and stop times of actual encounter • Place of Service (When 99 is used, specific location and rationale for location must be included) • Client diagnosis necessitating service

training and assistance to live in and maintain a household of their choosing in the community. In addition, transitional services to assist individuals adjust after receiving a higher level of care. The goal of this service is to promote and maintain community integration. An array of face-to-face rehabilitative day activities providing a preplanned and structured group program for identified beneficiaries that aimed at long-term recovery and maximization of self-sufficiency, as distinguished from the symptom stabilization function of acute day treatment. These rehabilitative day activities are person- and family-centered, recovery-based, culturally competent, provide needed accommodation for any disability and must have measurable outcomes. These activities assist the beneficiary with compensating for or eliminating functional deficits and interpersonal and/or environmental barriers associated with their chronic mental illness. The intent of these services is to restore the fullest possible integration of the beneficiary as an active and productive member of his/her family, social and work community and/or culture with the least amount of ongoing professional intervention. Skills addressed may include: emotional skills, such as coping with stress, anxiety or anger; behavioral skills, such as proper use of medications, appropriate social interactions and managing overt expression of symptoms like delusions or hallucinations; daily living and self-care skills, such as personal care and hygiene, money management and daily structure/use of time; cognitive skills, such as problem solving, understanding illness and symptoms and reframing; community integration skills and any similar skills required to implement a beneficiary's master treatment plan.	• Document how treatment used address goals and objectives from the master treatment plan • Information gained from contact and how it relates to master treatment plan objectives • Impact of information received/given on the beneficiary's treatment • Any changes indicated for the master treatment plan which must be documented and communicated to the supervising MHP for consideration • Plan for next contact, if any • Staff signature/credentials/Date of signature PROPOSED	
NOTES	**UNIT**	**BENEFIT LIMITS**
	60 minutes	DAILY MAXIMUM OF UNITS THAT MAY BE BILLED (extension of benefits can be requested: 6 units QUARTERLY MAXIMUM OF UNITS THAT MAY BE BILLED (extension of benefits can be requested):

		90 units
APPLICABLE POPULATIONS	**SPECIAL BILLING INSTRUCTIONS**	
Adult	**The following codes cannot be billed on the Same Date of Service:** H2015 – Individual Recovery Support, Bachelors H2015 – Individual Recovery Support, Non-Degreed H2015 – Group Recovery Support, Bachelors H2015 – Group Recovery Support, Non-Degreed	
ALLOWED MODE(S) OF DELIVERY	**TIER**	
Face-to-face	Rehabilitative	
ALLOWABLE PERFORMING PROVIDERS	**PLACE OF SERVICE**	
• Qualified Behavioral Health Provider – Bachelors • Qualified Behavioral Health Provider – Non-Degreed • Registered Nurse (Use Code H2019 with HK, HN modifiers)	04, 11, 12, 13, 14, 22, 23, 31, 32, 33, 49, 50, 52, 53, 57, 71, 72, 99 PROPOSED	

253.006 Peer Support **7-1-17**

CPT®/HCPCS PROCEDURE CODE	**PROCEDURE CODE DESCRIPTION**
H0038 H0038, U8 - Telephonic	Self-help/peer services, per 15 minutes
SERVICE DESCRIPTION	**MINIMUM DOCUMENTATION REQUIREMENTS**
Peer Support is a consumer centered service provided by individuals (ages 18 and older) who self-identify as someone who has received or is receiving behavioral health services and thus is able to provide expertise not replicated by professional training. Peer providers are trained and certified peer specialists who self-identify as being in recovery from behavioral health issues. Peer support is a service to work with beneficiaries to provide education, hope, healing, advocacy, self-responsibility, a meaningful role in life, and empowerment to reach fullest potential. Specialists will assist with navigation of multiple systems (housing, supportive employment, supplemental benefits, building/rebuilding natural supports, etc.) which impact beneficiaries' functional ability. Services	• Date of Service • Names and relationship to the beneficiary of all persons involved • Start and stop times of actual contact • Place of Service (When 99 is used, specific location and rationale for location must be included) • Client diagnosis necessitating service • Document how treatment used address goals and objectives from the master treatment plan • Information gained from contact and how it relates to master treatment plan objectives • Impact of information received/given on the

are provided on an individual or group basis, and in either the beneficiary's home or community environment.	beneficiary's treatment • Any changes indicated for the master treatment plan which must be documented and communicated to the supervising MHP for consideration • Plan for next contact, if any • Staff signature/credentials/Date of signature

NOTES	UNIT	BENEFIT LIMITS
	15 minutes	YEARLY MAXIMUM OF UNITS THAT MAY BE BILLED (extension of benefits can be requested): 120

APPLICABLE POPULATIONS	SPECIAL BILLING INSTRUCTIONS
Youth and Adults	Provider can only bill for 120 units (combined between H0038 and H0038, U8) per SFY
ALLOWED MODE(S) OF DELIVERY	**TIER**
Face-to-face	Rehabilitative
ALLOWABLE PERFORMING PROVIDERS	**PLACE OF SERVICE**
• Certified Peer Support Specialist • Certified Youth Support Specialist	03, 04, 11, 12, 13, 14, 15, 16 , 22, 23, 31, 32, 33, 34, 49, 50, 52, 53, 57, 71, 72, 99

EXAMPLE ACTIVITIES

Peer support may include assisting their peers in articulating their goals for recovery, learning and practicing new skills, helping them monitor their progress, assisting them in their treatment, modeling effective coping techniques and self-help strategies based on the specialist's own recovery experience, and supporting them in advocating for themselves to obtain effective services.

253.007 Family Support Partners **7-1-17**

CPT®/HCPCS PROCEDURE CODE	PROCEDURE CODE DESCRIPTION
H2014 H2014, U8 - Telephonic	Skills training and development, per 15 minutes
SERVICE DESCRIPTION	**MINIMUM DOCUMENTATION REQUIREMENTS**
Family Support Partners is a service provided by peer counselors, or Family Support Partners (FSP), who model recovery and resiliency for caregivers of children or youth with behavioral health care needs. Family Support Partners come from legacy families and use their lived experience, training, and skills to help caregivers and their families identify goals and actions that promote recovery and resiliency. A	• Date of Service • Names and relationship to the beneficiary of all persons involved • Start and stop times of actual encounter • Place of Service (When 99 is used, specific location and rationale for location must be included)

FSP may assist, teach, and model appropriate child-rearing strategies, techniques, and household management skills. This service provides information on child development, age-appropriate behavior, parental expectations, and childcare activities. It may also assist the family in securing community resources and developing natural supports. PROPOSED	• Client diagnosis necessitating service • Document how services used address goals and objectives from the master treatment plan • Information gained from contact and how it relates to master treatment plan objectives • Impact of information received/given on the beneficiary's treatment • Any changes indicated for the master treatment plan which must be documented and communicated to the supervising MHP for consideration • Plan for next contact, if any • Staff signature/credentials/Date of signature

NOTES	UNIT	BENEFIT LIMITS
	15 minutes	YEARLY MAXIMUM OF UNITS THAT MAY BE BILLED (extension of benefits can be requested): 120

APPLICABLE POPULATIONS	SPECIAL BILLING INSTRUCTIONS
Children and Youth	Provider can only bill for 120 units (combined between H2014 and H2014, U8) per SFY
ALLOWED MODE(S) OF DELIVERY	**TIER**
Face-to-face	Rehabilitative
ALLOWABLE PERFORMING PROVIDERS	**PLACE OF SERVICE**
Certified Family Support Partner	03, 04, 11, 12, 13, 14, 15, 16 , 22, 23, 31, 32, 33, 34, 49, 50, 52, 53, 57, 71, 72, 99

EXAMPLE ACTIVITIES

Family Support Partners serve as a resource for families with a child, youth, or adolescent receiving behavioral health services. Family Support Partners help families identify natural supports and community resources, provide leadership and guidance for support groups, and work with families on: individual and family advocacy, social support for assigned families, educational support, systems advocacy, lagging skills development, problem solving technics and self-help skills.

253.008 Individual Pharmacologic Counseling by RN **7-1-17**

CPT®/HCPCS PROCEDURE CODE	PROCEDURE CODE DESCRIPTION
H0034, TD	Medication training and support
SERVICE DESCRIPTION	**MINIMUM DOCUMENTATION REQUIREMENTS**
A specific, time limited one-to-one intervention by a nurse with a beneficiary and/or caregivers,	• Date of Service

related to their psychopharmological treatment. Individual Pharmaceutical counseling involves providing medication information orally or in written form to the beneficiary and/or caregivers. The service should encompass all the parameters to make the beneficiary and/or family understand the diagnosis prompting the need for the medication and any life style modification required. 	• Start and stop times of actual encounter with beneficiary • Place of service • Diagnosis and pertinent interval history • Brief mental status and observations • Rationale for and treatment used that must coincide with the master treatment plan • Beneficiary's response to treatment that includes current progress or regression and prognosis • Revisions indicated for the master treatment plan, diagnosis, or medication(s) • Plan for follow-up services, including any crisis plans • Staff signature/credentials/date of signature

NOTES	UNIT	BENEFIT LIMITS
	Encounter	YEARLY MAXIMUM OF UNITS THAT MAY BE BILLED (extension of benefits can be requested): 12

APPLICABLE POPULATIONS	SPECIAL BILLING INSTRUCTIONS
Children and Youth	Provider can only bill for 12 units (combined between H0034, TD and H0034, HQ, TD) per SFY
ALLOWED MODE(S) OF DELIVERY	**TIER**
Face-to-face	Rehabilitative
ALLOWABLE PERFORMING PROVIDERS	**PLACE OF SERVICE**
Registered Nurse	03, 04, 11, 12, 13, 14, 15, 16 , 22, 23, 31, 32, 33, 34, 49, 50, 52, 53, 57, 71, 72, 99

253.009 Group Pharmacologic Counseling by RN 7-1-17

CPT®/HCPCS PROCEDURE CODE	PROCEDURE CODE DESCRIPTION
H0034, HQ, TD	Medication training and support
SERVICE DESCRIPTION	**MINIMUM DOCUMENTATION REQUIREMENTS**
A specific, time limited intervention provided to a group of beneficiaries and/or caregivers by a nurse, related to their psychopharmological treatment. Group Pharmaceutical counseling involves providing medication information orally	• Date of Service • Start and stop times of actual encounter with beneficiary • Place of service

or in written form to the beneficiary and/or caregivers. The service should encompass all the parameters to make the beneficiary and/or family understand the diagnosis prompting the need for the medication and any life style modification required. PROPOSED	• Diagnosis and pertinent interval history • Brief mental status and observations • Rationale for and treatment used that must coincide with the master treatment plan • Beneficiary's response to treatment that includes current progress or regression and prognosis • Revisions indicated for the master treatment plan, diagnosis, or medication(s) • Plan for follow-up services, including any crisis plans • Staff signature/credentials/date of signature

NOTES	UNIT	BENEFIT LIMITS
	Encounter	YEARLY MAXIMUM OF UNITS THAT MAY BE BILLED (extension of benefits can be requested): 12

APPLICABLE POPULATIONS	SPECIAL BILLING INSTRUCTIONS
Children and Youth	Provider can only bill for 12 units (combined between H0034, TD and H0034, HQ, TD) per SFY
ALLOWED MODE(S) OF DELIVERY	**TIER**
Face-to-face	Rehabilitative
ALLOWABLE PERFORMING PROVIDERS	**PLACE OF SERVICE**
Registered Nurse	03, 04, 11, 12, 13, 14, 15, 16 , 22, 23, 31, 32, 33, 34, 49, 50, 52, 53, 57, 71, 72, 99

253.010 Intensive Outpatient Substance Abuse Treatment **7-1-17**

CPT®/HCPCS PROCEDURE CODE	PROCEDURE CODE DESCRIPTION
H0015	Alcohol and/or drug services; intensive outpatient (treatment program that operates at least 3 hours/day and at least 3 days/week and is based upon an individualized treatment plan), including assessment, counseling, crisis intervention, activity therapies or education
SERVICE DESCRIPTION	**MINIMUM DOCUMENTATION REQUIREMENTS**
Intensive Outpatient services provide group based, non-residential, intensive, structured interventions consisting primarily of counseling and education to improve symptoms that may significantly interfere with functioning in at least	• Date of Service • Start and stop times of the face to face encounter with the beneficiary and the interpretation time for diagnostic formulation

one life domain (e.g., familial, social, occupational, educational, etc.). Services are goal oriented interactions with the individual or in group/family settings. This community based service allows the individual to apply skills in "real world" environments. Such treatment may be offered during the day, before or after work or school, in the evening or on a weekend. The services follow a defined set of policies and procedures or clinical protocols. The service also provides a coordinated set of individualized treatment services to persons who are able to function in a school, work, and home environment but are in need of treatment services beyond traditional outpatient programs. Treatment may appropriately be used to transition persons from higher levels of care or may be provided for persons at risk of being admitted to higher levels of care. Intensive outpatient programs provide 9 or more hours per week of skilled treatment, 3 – 5 times per week in groups of no fewer than three and no more than 12 clients. This service is available to beneficiaries in all Tiers.	• Place of service • Identifying information • Referral reason • Presenting problem (s), history of presenting problem(s), including duration, intensity, and response(s) to prior treatment • Rationale for service and service used that must coincide with master treatment plan • Beneficiary's response to service that includes current progress or regression and prognosis • Any changes indicated for the master treatment plan, diagnosis, or medication(s) • Mental status/Clinical observations and impressions • Current functioning and strengths in specified life domains • DSM diagnostic impressions to include all axes • Treatment recommendations • Staff signature/credentials/date of signature

NOTES	UNIT	BENEFIT LIMITS
A prior authorization is required for this service. PROPOSED	Per diem	Beneficiary can receive no more than 19 hours of Intensive Outpatient Substance Abuse Treatment Services per week YEARLY MAXIMUM OF UNITS THAT MAY BE BILLED (extension of benefits can be requested): 24

APPLICABLE POPULATIONS	SPECIAL BILLING INSTRUCTIONS
Youth, and Adults	A provider cannot bill any other services on the same date of service.
ALLOWED MODE(S) OF DELIVERY	**TIER**
Face-to-face	Rehabilitative
ALLOWABLE PERFORMING PROVIDERS	**PLACE OF SERVICE**
Intensive Outpatient Substance Abuse Treatment must be provided in a facility that is certified by the Division of Behavioral Health Services as an Intensive Outpatient Substance	11, 14, ,22, 49, 50, 53, 57, 71

Abuse Treatment provider.	

253.011 Individual Life Skills Development 7-1-17

CPT®/HCPCS PROCEDURE CODE	PROCEDURE CODE DESCRIPTION
H2017, HA, HN – QBHP Bachelors or RN H2017, HA, HM – QBHP Non-Degreed	Psychosocial rehabilitation services, per 15 minutes

SERVICE DESCRIPTION	MINIMUM DOCUMENTATION REQUIREMENTS
Individual Life Skills Development is a service that provides support and training for transitional aged youth (ages 16 to 21) on a one-on-one basis. This service should be a strength-based, culturally appropriate process that integrates the youth into their community as they develop their recovery plan. This service is designed to assist youth in acquiring the skills needed to support an independent lifestyle and promote a strong sense of self-worth. In addition, it aims to assist youth in setting and achieving goals, learning independent life skills, demonstrating accountability, and making goal-oriented decisions related to independent living. Topics may include: educational or vocational training, employment, resource and medication management, self-care, household maintenance, health, wellness, and nutrition. PROPOSED	• Date of Service • Names and relationship to the beneficiary of all persons involved • Start and stop times of actual encounter • Place of Service (When 99 is used, specific location and rationale for location must be included) • Client diagnosis necessitating service • Document how services address goals and objectives from the master treatment plan • Information gained from contact and how it relates to master treatment plan objectives • Impact of information received/given on the beneficiary's treatment • Any changes indicated for the master treatment plan which must be documented and communicated to the supervising MHP for consideration • Plan for next contact, if any • Staff signature/credentials/Date of signature

NOTES	UNIT	BENEFIT LIMITS
	15 minutes	DAILY MAXIMUM OF UNITS THAT MAY BE BILLED: 8 YEARLY MAXIMUM OF UNITS THAT MAY BE BILLED (extension of benefits can be requested): 292

APPLICABLE POPULATIONS	SPECIAL BILLING INSTRUCTIONS
Youth (Age 16-20)	A provider cannot bill any other H2017 code (regardless of service) on the same date of service.

ALLOWED MODE(S) OF DELIVERY	TIER
Face-to-face	Rehabilitative
ALLOWABLE PERFORMING PROVIDERS	**PLACE OF SERVICE**
• Qualified Behavioral Health Provider – Bachelors • Qualified Behavioral Health Provider – Non-Degreed • Registered Nurse (Use Code H2017 with HA, HN modifiers)	03, 04, 11, 12, 14, 16, 22 , 49, 50, 53, 57, 71, 72 PROPOSED
EXAMPLE ACTIVITIES	
General skills training, family and relationship supports and skill development, parenting support, anger management, basic life skill training, self-help, drug and alcohol management, lifestyle programs, filling out job applications, developing positive interview skills, assisting with passing permit test and obtaining a license and/or learning the mass transit transportation system.	

253.014 Group Life Skills Development **7-1-17**

CPT®/HCPCS PROCEDURE CODE	PROCEDURE CODE DESCRIPTION
H2017, HQ, HN – QBHP Bachelors or RN H2017, HQ, HM – QBHP Non-Degreed	Psychosocial rehabilitation services, per 15 minutes
SERVICE DESCRIPTION	**MINIMUM DOCUMENTATION REQUIREMENTS**
Group Life Skills Development is a service that provides support and training for transitional aged youth (ages 16 to 21) in a group setting of up to six (6) beneficiaries with one staff member or up to ten (10) beneficiaries with two staff members. This service should be a strength-based, culturally appropriate process that integrates the youth into their community as they develop their recovery plan. This service is designed to assist youth in acquiring the skills needed to support an independent lifestyle and promote a strong sense of self-worth. In addition, it aims to assist youth in setting and achieving goals, learning independent life skills, demonstrating accountability, and making goal-oriented decisions related to independent living. Topics may include: educational or vocational training, employment, resource and medication management, self-care, household maintenance, health, wellness, and nutrition.	• Date of Service • Names and relationship to the beneficiary of all persons involved • Start and stop times of actual encounter with contact • Place of Service (If 99 is used, specific location and rationale for location must be included) • Client diagnosis necessitating service • Document how services address goals and objectives from the master treatment plan • Information gained from contact and how it relates to master treatment plan objectives • Impact of information received/given on the beneficiary's treatment • Any changes indicated for the master treatment plan which must be documented and communicated to the supervising MHP for consideration • Plan for next contact, if any

	• Staff signature/credentials/Date of signature	
NOTES	**UNIT**	**BENEFIT LIMITS**
PROPOSED	15 minutes	YEARLY MAXIMUM OF UNITS THAT MAY BE BILLED (extension of benefits can be requested): 292
APPLICABLE POPULATIONS	**SPECIAL BILLING INSTRUCTIONS**	
Youth (Age 16-20)	A provider cannot bill any other H2017 code (regardless of service) on the same date of service.	
ALLOWED MODE(S) OF DELIVERY	**TIER**	
Face-to-face	Rehabilitative	
ALLOWABLE PERFORMING PROVIDERS	**PLACE OF SERVICE**	
• Qualified Behavioral Health Provider – Bachelors • Qualified Behavioral Health Provider – Non-Degreed • Registered Nurse (Use Code H2017 with HA, HN modifiers)	03, 04, 11, 14, 16, 22 , 49, 50, 53, 57, 71, 72	
EXAMPLE ACTIVITIES		
General skills training, family and relationship supports and skill development, parenting support, parenting classes, anger management, basic life skill training, self-help, drug and alcohol management, lifestyle programs,. filling out job applications, developing positive interview skills, assisting with passing permit test and obtaining a driver's license and/or learning the mass transit transportation system . Referrals to Vocational Rehabilitation Services, supportive housing or supportive employment.		

253.014 Child and Youth Support Services **7-1-17**

CPT®/HCPCS PROCEDURE CODE	**PROCEDURE CODE DESCRIPTION**
H2015, HA, HN – QBHP Bachelors or RN H2015, HA, HM – QBHP Non-Degreed	Comprehensive community support services
SERVICE DESCRIPTION	**MINIMUM DOCUMENTATION REQUIREMENTS**
Child and Youth Support Services are clinical, time-limited services for principal caregivers designed to increase a child's positive behaviors and encourage compliance with parents at home; working with teachers/schools to modify classroom environment to increase positive behaviors in the classroom; and increase a child's social skills, including	• Date of Service • Names and relationship to the beneficiary of all persons involved • Start and stop times of actual encounter with collateral contact • Place of Service (If 99 is used, specific location and rationale for location must be

understanding of feelings, conflict management, academic engagement, school readiness, and cooperation with teachers and other school staff. This service is intended to increase parental skill development in managing their child's symptoms of their illness and training the parents in effective interventions and techniques for working with the schools. Services might include an In-Home Case Aide. An In-Home Case Aide is an intensive, time-limited therapy for youth in the beneficiary's home or, in rare instances, a community based setting. Youth served may be in imminent risk of out-of-home placement or have been recently reintegrated from an out of-home placement. Services may deal with family issues related to the promotion of healthy family interactions, behavior training, and feedback to the family.	included) • Client diagnosis necessitating intervention • Document how interventions used address goals and objectives from the master treatment plan • Information gained from collateral contact and how it relates to master treatment plan objectives • Impact of information received/given on the beneficiary's treatment • Any changes indicated for the master treatment plan which must be documented and communicated to the supervising MHP for consideration • Plan for next contact, if any • Staff signature/credentials/Date of signature

NOTES	UNIT	BENEFIT LIMITS
PROPOSED	60 Minutes	**QUARTERLY** MAXIMUM OF UNITS THAT MAY BE BILLED (extension of benefits can be requested): 60

APPLICABLE POPULATIONS	SPECIAL BILLING INSTRUCTIONS
Children and Youth	A provider can bill up to 60 units per quarter (Quarters are defined as January-March, April-June, July-September, October-December) prior to an extension of benefits. A provider cannot bill any other H2015 code on the same date of service.

ALLOWED MODE(S) OF DELIVERY	TIER
Face-to-face	Rehabilitative

ALLOWABLE PERFORMING PROVIDERS	PLACE OF SERVICE
• Qualified Behavioral Health Provider – Bachelors • Qualified Behavioral Health Provider – Non-Degreed • Registered Nurse (Use Code H2015 with HA, HN modifiers)	03, 04, 12, 16

254.015 Supportive Employment PROPOSED 7-1-17

CPT®/HCPCS PROCEDURE CODE	PROCEDURE CODE DESCRIPTION
H2023	Supportive Employment
SERVICE DESCRIPTION	**MINIMUM DOCUMENTATION REQUIREMENTS**
Supportive Employment is designed to help beneficiaries acquire and keep meaningful jobs in a competitive job market. The service actively facilitates job acquisition by sending staff to accompany beneficiaries on interviews and providing ongoing support and/or on-the-job training once the beneficiary is employed. This service replaces traditional vocational approaches that provide intermediate work experiences (prevocational work units, transitional employment, or sheltered workshops), which tend to isolate beneficiaries from mainstream society. Service settings may vary depending on individual need and level of community integration, and may include the beneficiary's home. Services delivered in the home are intended to foster independence in the community setting and may include training in menu planning, food preparation, housekeeping and laundry, money management, budgeting, following a medication regimen, and interacting with the criminal justice system.	• Date of Service • Names and relationship to the beneficiary of all persons involved • Start and stop times of actual encounter with collateral contact • Place of Service (If 99 is used, specific location and rationale for location must be included) • Client diagnosis necessitating intervention • Document how interventions used address goals and objectives from the master treatment plan • Information gained from collateral contact and how it relates to master treatment plan objectives • Impact of information received/given on the beneficiary's treatment • Any changes indicated for the master treatment plan which must be documented and communicated to the supervising MHP for consideration • Plan for next contact, if any • Staff signature/credentials/Date of signature

NOTES	UNIT	BENEFIT LIMITS
A prior authorization is required for this service.	60 Minutes	QUARTERLY MAXIMUM OF UNITS THAT MAY BE BILLED (extension of benefits can be requested): 60

APPLICABLE POPULATIONS	SPECIAL BILLING INSTRUCTIONS
Adults	A provider can bill up to 60 units per quarter (Quarters are defined as January-March, April-June, July-September, October-December) prior to an extension of benefits. A provider cannot bill any H2017, H2015 code on the same date of service.

ALLOWED MODE(S) OF DELIVERY	TIER
Face-to-face	Rehabilitative
ALLOWABLE PERFORMING PROVIDERS	**PLACE OF SERVICE**
• Qualified Behavioral Health Provider – Bachelors • Qualified Behavioral Health Provider – Non-Degreed • Registered Nurse	04, 11, 12 , 16, 49, 53, 57, 99 PROPOSED

254.016 Supportive Housing **7-1-17**

CPT®/HCPCS PROCEDURE CODE	PROCEDURE CODE DESCRIPTION
H0043	Supportive Housing
SERVICE DESCRIPTION	**MINIMUM DOCUMENTATION REQUIREMENTS**
Supportive Housing is designed to ensure that beneficiaries have a choice of permanent, safe, and affordable housing. An emphasis is placed on the development and strengthening of natural supports in the community. This service assists beneficiaries in locating, selecting, and sustaining housing, including transitional housing and chemical free living; provides opportunities for involvement in community life; and facilitates the individual's recovery journey. Service settings may vary depending on individual need and level of community integration, and may include the beneficiary's home. Services delivered in the home are intended to foster independence in the community setting and may include training in menu planning, food preparation, housekeeping and laundry, money management, budgeting, following a medication regimen, and interacting with the criminal justice system.	• Date of Service • Names and relationship to the beneficiary of all persons involved • Start and stop times of actual encounter with collateral contact • Place of Service (If 99 is used, specific location and rationale for location must be included) • Client diagnosis necessitating intervention • Document how interventions used address goals and objectives from the master treatment plan • Information gained from collateral contact and how it relates to master treatment plan objectives • Impact of information received/given on the beneficiary's treatment • Any changes indicated for the master treatment plan which must be documented and communicated to the supervising MHP for consideration • Plan for next contact, if any • Staff signature/credentials/Date of signature

NOTES	UNIT	BENEFIT LIMITS
A prior authorization is required for this service.	60 Minutes	QUARTERLY MAXIMUM OF UNITS THAT MAY BE BILLED (extension of benefits can be requested): 60

APPLICABLE POPULATIONS	SPECIAL BILLING INSTRUCTIONS
Adults	A provider can bill up to 60 units per quarter (Quarters are defined as January-March, April-June, July-September, October-December) prior to an extension of benefits. A provider cannot bill any H2017, H2015 code on the same date of service.
ALLOWED MODE(S) OF DELIVERY	**TIER**
Face-to-face	Rehabilitative
ALLOWABLE PERFORMING PROVIDERS	**PLACE OF SERVICE**
• Qualified Behavioral Health Provider – Bachelors • Qualified Behavioral Health Provider – Non-Degreed • Registered Nurse (Use Code H2015 with HK, HN modifiers)	04, 11, 12 , 16, 49, 53, 57, 99 PROPOSED

254.017 Adult Life Skills Development **7-1-17**

CPT®/HCPCS PROCEDURE CODE	PROCEDURE CODE DESCRIPTION
H2017, HN – QBHP Bachelors or RN H2017, HM– QBHP Non-degreed	Comprehensive community support services
SERVICE DESCRIPTION	**MINIMUM DOCUMENTATION REQUIREMENTS**
Life Skills Development services are designed to assist beneficiaries in acquiring the skills needed to support an independent lifestyle and promote an improved sense of self-worth. Life skills training is designed to assist in setting and achieving goals, learning independent living skills, demonstrate accountability, and making goal-directed decisions related to independent living (i.e., educational/vocational training, employment, resource and medication management, self-care, household maintenance, health, wellness and nutrition). Service settings may vary depending on individual need and level of community integration, and may include the beneficiary's home. Services delivered in the home are intended to foster independence in the community setting and may include training in menu planning, food preparation, housekeeping and laundry, money management, budgeting, following a medication regimen, and interacting	• Date of Service • Names and relationship to the beneficiary of all persons involved • Start and stop times of actual encounter with collateral contact • Place of Service (If 99 is used, specific location and rationale for location must be included) • Client diagnosis necessitating intervention • Document how interventions used address goals and objectives from the master treatment plan • Information gained from collateral contact and how it relates to master treatment plan objectives • Impact of information received/given on the beneficiary's treatment • Any changes indicated for the master

with the criminal justice system.	treatment plan which must be documented and communicated to the supervising MHP for consideration • Plan for next contact, if any • Staff signature/credentials/Date of signature	
NOTES	**UNIT**	**BENEFIT LIMITS**
PROPOSED	15 Minutes	DAILY MAXIMUM OF UNITS THAT MAY BE BILLED: 8 YEARLY MAXIMUM OF UNITS THAT MAY BE BILLED (extension of benefits can be requested): 292
APPLICABLE POPULATIONS	**SPECIAL BILLING INSTRUCTIONS**	
Adults		
ALLOWED MODE(S) OF DELIVERY	**TIER**	
Face-to-face	Rehabilitative	
ALLOWABLE PERFORMING PROVIDERS	**PLACE OF SERVICE**	
• Qualified Behavioral Health Provider – Bachelors • Qualified Behavioral Health Provider – Non-Degreed • Registered Nurse (Use Code H2015 with HK, HN modifiers)	04, 11, 12 , 16, 49, 53, 57, 99	

254.000 Intensive Level Services **7-1-17**

Eligibility for Intensive Level Services is determined by the Intensive Level Services standardized Independent Assessment.

Prior to reimbursement for Therapeutic Communities or Planned Respite in Intensive Level Services, a beneficiary must be eligible for Rehabilitative Level Services as determined by the standardized Independent Assessment. The beneficiary must then also be determined by an Intensive Level Services Independent Assessment to be eligible for Therapeutic Communities.

Eligibility for entry into a residential setting requires adherence to appropriate Medicaid rules regarding that residential setting. Eligibility for Therapeutic Communities requires that an Individualized Treatment Plan be developed for the beneficiary. The beneficiary will be supported in Treatment Plan development by a care coordinator and allowed the ability to choose who they want to participate in the development of the Individualized Treatment Plan.

254.001 Therapeutic Communities PROPOSED 7-1-17

CPT®/HCPCS PROCEDURE CODE	PROCEDURE CODE DESCRIPTION
H0019, HQ – Level 1 H0019, HQ, HK – Level 2	Behavioral health; long-term residential (nonmedical, non-acute care in a residential treatment program where stay is typically longer than 30 days), without room and board, per diem.

SERVICE DESCRIPTION	MINIMUM DOCUMENTATION REQUIREMENTS
Therapeutic Communities are highly structured residential environments or continuums of care in which the primary goals are the treatment of behavioral health needs and the fostering of personal growth leading to personal accountability. Services address the broad range of needs identified by the person served. Therapeutic Communities employs community-imposed consequences and earned privileges as part of the recovery and growth process. In addition to daily seminars, group counseling, and individual activities, the persons served are assigned responsibilities within the therapeutic community setting. Participants and staff members act as facilitators, emphasizing personal responsibility for one's own life and self-improvement. The service emphasizes the integration of an individual within his or her community, and progress is measured within the context of that community's expectation.	• Date of Service • Names and relationship to the beneficiary of all persons involved • Place of Service • Document how interventions used address goals and objectives from the master treatment plan • Information gained from contact and how it relates to master treatment plan objectives • Impact of information received/given on the beneficiary's treatment • Staff signature/credentials/Date of signature

NOTES	UNIT	BENEFIT LIMITS
Therapeutic Communities Level will be determined by the following: • Functionality based upon the Independent Assessment Score • Outpatient Treatment History and Response • Medication • Compliance with Medication/Treatment Eligibility for this service is determined by the Intensive Level Services standardized Independent Assessment. Prior to reimbursement for Therapeutic Communities in Intensive Level Services, a beneficiary must be eligible for Rehabilitative Level Services as determined by the standardized Independent Assessment. The beneficiary must then also be determined by an Intensive Level Services Independent Assessment to be eligible for Therapeutic Communities.	Per Diem	DAILY MAXIMUM OF UNITS THAT MAY BE BILLED: 1 YEARLY MAXIMUM OF UNITS THAT MAY BE BILLED (extension of benefits can be requested): H0019, HQ – 180 H0019, HQ, HK - 185

APPLICABLE POPULATIONS	SPECIAL BILLING INSTRUCTIONS
Adults	A provider cannot bill any other services on the same date of service.
	PROGRAM SERVICE CATEGORY
	Intensive
ALLOWED MODE(S) OF DELIVERY	**TIER**
Face-to-face	N/A
ALLOWABLE PERFORMING PROVIDERS	**PLACE OF SERVICE**
Therapeutic Communities must be provided in a facility that is certified by the Division of Behavioral Health Services as a Therapeutic Communities provider	14, 21, 51, 55 PROPOSED

254.002 Planned Respite **7-1-17**

CPT®/HCPCS PROCEDURE CODE	PROCEDURE CODE DESCRIPTION
H0045	Respite care services, per diem
SERVICE DESCRIPTION	**MINIMUM DOCUMENTATION REQUIREMENTS**
Planned Respite provides temporary direct care and supervision for a beneficiary in the beneficiary's community that is not facility-based. The primary purpose is relief to the principal caregiver of an individual with a behavioral health need. Respite services de-escalate stressful situations and provide a therapeutic outlet. Services should be scheduled and reflected in the wraparound or treatment plan. Planned Respite can only be provided by a provider who is certified by the Division of Behavioral Health Services as a Planned Respite provider.	
NOTES	**EXAMPLE ACTIVITIES**
Eligibility for this service is determined by the Intensive Level Services standardized Independent Assessment. Prior to reimbursement for Planned Respite in Intensive Level Services, a beneficiary must be eligible for Rehabilitative Level Services as determined by the standardized Independent Assessment. The beneficiary must then also be determined by an Intensive Level Services Independent Assessment to be eligible for Planned Respite.	

APPLICABLE POPULATIONS	UNIT	BENEFIT LIMITS
Children and Youth	Per Diem	DAILY MAXIMUM OF UNITS THAT MAY BE BILLED: 1 YEARLY MAXIMUM OF UNITS THAT MAY BE BILLED (extension of benefits can be requested): 8
	PROGRAM SERVICE CATEGORY	
	Intensive	
ALLOWED MODE(S) OF DELIVERY	TIER	
Face-to-face	N/A	
ALLOWABLE PERFORMING PROVIDERS	PLACE OF SERVICE	
Planned Respite must be provided in a facility that is certified by the Division of Behavioral Health Services as a Planned Respite provider.	04 , 12, 16, 49, 53, 57, 99	

255.000 Crisis Services

PROPOSED

255.001 Crisis Intervention **7-1-17**

CPT®/HCPCS PROCEDURE CODE	PROCEDURE CODE DESCRIPTION
H2011, HA	Crisis intervention service, per 15 minutes
SERVICE DESCRIPTION	MINIMUM DOCUMENTATION REQUIREMENTS
Crisis Intervention is unscheduled, immediate, short-term treatment activities provided to a Medicaid-eligible beneficiary who is experiencing a psychiatric or behavioral crisis. Services are to be congruent with the age, strengths, needed accommodation for any disability, and cultural framework of the beneficiary and his/her family. These services are designed to stabilize the person in crisis, prevent further deterioration and provide immediate indicated treatment in the least restrictive setting. (These activities include evaluating a Medicaid-eligible beneficiary to determine if the need for crisis services is present.)	• Date of service • Start and stop time of actual encounter with beneficiary and possible collateral contacts with caregivers or informed persons • Place of service • Specific persons providing pertinent information in relationship to beneficiary • Diagnosis and synopsis of events leading up to crisis situation • Brief mental status and observations • Utilization of previously established psychiatric advance directive or crisis plan as pertinent to current situation OR rationale for crisis intervention activities utilized • Beneficiary's response to the intervention that includes current progress or regression and prognosis • Clear resolution of the current crisis and/or

	plans for further services • Development of a clearly defined crisis plan or revision to existing plan • Staff signature/credentials/date of signature(s)

NOTES	UNIT	BENEFIT LIMITS
A psychiatric or behavioral crisis is defined as an acute situation in which an individual is experiencing a serious mental illness or emotional disturbance to the point that the beneficiary or others are at risk for imminent harm or in which to prevent significant deterioration of the beneficiary's functioning. This service can be provided to beneficiaries that have not been previously assessed or have not previously received behavioral health services. The provider of this service MUST complete a Mental Health Diagnosis (90791) within 7 days of provision of this service. If the beneficiary needs more time to be stabilized, this must be noted in the beneficiary's medical record and the Division of Medical Services Quality Improvement Organization (QIO) must be notified.	15 minutes PROPOSED	DAILY MAXIMUM OF UNITS THAT MAY BE BILLED: 12 YEARLY MAXIMUM OF UNITS THAT MAY BE BILLED (extension of benefits can be requested): 72

APPLICABLE POPULATIONS	SPECIAL BILLING INSTRUCTIONS
Children, Youth, and Adults	
ALLOWED MODE(S) OF DELIVERY	**TIER**
Face-to-face	Crisis
ALLOWABLE PERFORMING PROVIDERS	**PLACE OF SERVICE**
• Independently Licensed Clinicians - Master's/Doctoral (must be employed by Behavioral Health Agency) • Non-independently Licensed Clinicians – Master's/Doctoral (must be employed by Behavioral Health Agency) • Advanced Practice Nurse (must be employed by Behavioral Health Agency) • Physician (must be employed by Behavioral Health Agency)	03, 04, 11, 12, 14, 33, 49, 50, 53, 57, 71, 72 ,99

255.002 Acute Psychiatric Hospitalization 7-1-17

CPT®/HCPCS PROCEDURE CODE	PROCEDURE CODE DESCRIPTION	
N/A	N/A	
SERVICE DESCRIPTION	**MINIMUM DOCUMENTATION REQUIREMENTS**	
Acute Psychiatric Hospitalization is indicated when a lesser restrictive environment is not adequate to ensure the safety of the beneficiary and others.	Refer to Hospital/Critical Access Hospital/End-Stage Renal Disease Manual for adults and Inpatient Psychiatric Services for Under Age 21 Manual for Under Age 21	
NOTES	**EXAMPLE ACTIVITIES**	
Refer to Hospital/Critical Access Hospital/End-Stage Renal Disease Manual for adults and Inpatient Psychiatric Services for Under Age 21 Manual for Under Age 21	PROPOSED	
APPLICABLE POPULATIONS	**UNIT**	**BENEFIT LIMITS**
Children, Youth, and Adults	Per Diem	Refer to Hospital/Critical Access Hospital/End-Stage Renal Disease Manual for adults and Inpatient Psychiatric Services for Under Age 21 Manual for Under Age 21
	PROGRAM SERVICE CATEGORY	
	Crisis Service	
ALLOWED MODE(S) OF DELIVERY	**TIER**	
Face-to-face	N/A	
ALLOWABLE PERFORMING PROVIDERS	**PLACE OF SERVICE**	
N/A	21, 51	

255.003 Acute Crisis Units 7-1-17

CPT®/HCPCS PROCEDURE CODE	PROCEDURE CODE DESCRIPTION
H0018	Behavioral Health; short-term residential
SERVICE DESCRIPTION	**MINIMUM DOCUMENTATION REQUIREMENTS**
Acute Crisis Units provide brief (96 hours or less) crisis treatment services to persons over the age of 18 who are experiencing a psychiatry- and/or substance abuse-related crisis and may pose an escalated risk of harm to self or others. Acute Crisis Units provide hospital diversion and step-down services in a safe environment with psychiatry and/or	

substance abuse services on-site at all times as well as on-call psychiatry available 24 hours a day. Services provide ongoing assessment and observation; crisis intervention; psychiatric, substance, and co-occurring treatment; and initiate referral mechanisms for independent assessment and care planning as needed.	PROPOSED
NOTES	**EXAMPLE ACTIVITIES**

APPLICABLE POPULATIONS	UNIT	BENEFIT LIMITS
Youth and Adults	Per Diem	• 96 hours or less per encounter • 1 encounter per month • 6 encounters per SFY

	PROGRAM SERVICE CATEGORY
	Crisis Services
ALLOWED MODE(S) OF DELIVERY	**TIER**
Face-to-face	N/A
ALLOWABLE PERFORMING PROVIDERS	**PLACE OF SERVICE**
N/A	21, 51, 55, 56

255.004 Substance Abuse Detoxification **7-1-17**

CPT®/HCPCS PROCEDURE CODE	PROCEDURE CODE DESCRIPTION
H0014	Alcohol and/or drug services; detoxification
SERVICE DESCRIPTION	**MINIMUM DOCUMENTATION REQUIREMENTS**
Substance Abuse Detoxification is a set of interventions aimed at managing acute intoxication and withdrawal from alcohol or other drugs. Services help stabilize beneficiaries by clearing toxins from the beneficiary's body. Services are short-term and may be provided in a crisis unit, inpatient, or outpatient setting, and may include evaluation, observation, medical monitoring, and addiction treatment. Detoxification seeks to minimize the physical harm caused by the abuse of substances and prepares the beneficiary for ongoing treatment.	

NOTES	EXAMPLE ACTIVITIES	
APPLICABLE POPULATIONS	**UNIT**	**BENEFIT LIMITS**
Youth and Adults PROPOSED	N/A	• 1 encounter per month • 6 encounters per SFY
	PROGRAM SERVICE CATEGORY	
	Crisis Services	
ALLOWED MODE(S) OF DELIVERY	**TIER**	
Face-to-face	N/A	
ALLOWABLE PERFORMING PROVIDERS	**PLACE OF SERVICE**	
N/A	21, 55	

256.200 Telemedicine Services Billing Information **7-1-17**

The Arkansas licensed mental health professional may provide certain treatment services from a remote site to the Medicaid-eligible beneficiary who is located in a mental health clinic setting. See Section 252.410 for billing instructions.

The following services may be provided via telemedicine by an Arkansas licensed mental health professional to Medicaid-eligible beneficiaries under age 21 and Medicaid-eligible beneficiaries age 21 and over; bill with POS 99:

National Code	Required Modifier	Service Title
90832	U7	Individual Behavioral Health Counseling - Telemedicine
90834	U7	
90837	U7	
H2027	U7	Psychoeducation - Telemedicine
90792	U7	Psychiatric Assessment
99212	U7, UB	Pharmacologic Management – Physician, Telemedicine
99213	U7, UB	
99214	U7, UB	
99212	U7, SA	Pharmacologic Management – APN, Telemedicine
99213	U7, SA	
99214	U7, SA	

The following services may be provided via telemedicine by a mental health professional to Medicaid-eligible beneficiaries age 21 and over; bill with POS 99:

National Code	Required Modifier	Service Title

National Code	Required Modifier	Service Title
90791	U7	Mental Health Diagnosis
90887	U7	Interpretation of Diagnosis

256.300 Services Available to Residents of Long Term Care Facilities Billing Information 7-1-17

The following Outpatient Behavioral Health Services procedure codes are payable to an Outpatient Behavioral Health provider for services provided to residents of nursing homes who are Medicaid eligible when prescribed according to policy guidelines detailed in this manual:

National Code	Required Modifier	Procedure Code Description
90791		Mental Health Diagnosis
S0220		Treatment Plan (payable only for beneficiaries eligible to receive Rehabilitative Level Services or Intensive Level Services)
90887		Interpretation of Diagnosis
90832		Individual Behavioral Health Counseling
90834		
90837		

PROPOSED

Services provided to nursing home residents may be provided on or off site from the Outpatient Behavioral Health Services provider. The services may be provided in the long-term care (LTC) facility, if necessary.

256.400 Place of Service Codes 7-1-17

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

Place of Service	POS Codes
Outpatient Hospital	22
Office (Outpatient Behavioral Health Provider Facility Service Site)	11
Patient's Home	12
Nursing Facility	32
Skilled Nursing Facility	31
School (Including Licensed Child Care Facility)	03
Homeless Shelter	04
Assisted Living Facility (Including Residential Care Facility)	13
Group Home	14
ICF/IDD	54
Other Locations	99
Outpatient Behavioral Health Services Clinic (Telemedicine)	99

Place of Service	POS Codes
Emergency Services in ER	23

256.500 **Billing Instructions – Paper Only** PROPOSED 7-1-17

Hewlett Packard Enterprise 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 Outpatient Behavioral Health 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 Hewlett Packard Enterprise. **View or print Hewlett Packard Enterprise 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.

256.510 **Completion of the CMS-1500 Claim Form** 7-1-17

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 individual'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

Field Name and Number		Instructions for Completion
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) CITY STATE ZIP CODE TELEPHONE (Include Area Code)	Required if insured's address is different from the patient's address. PROPOSED
8.	PATIENT STATUS	Not required.
9.	OTHER INSURED'S NAME (Last name, First Name, Middle Initial)	If patient 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 individual.
	b. OTHER INSURED'S DATE OF BIRTH	Not required.
	SEX	Not required.
	c. EMPLOYER'S NAME OR SCHOOL NAME	Required when items 9 a-d are required. Name of the insured individual'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.

Field Name and Number	Instructions for Completion
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: 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.
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	Primary Care Physician (PCP) referral or PCMH sign-off is required for Outpatient Behavioral Health Services for all beneficiaries after 3 Counseling Level 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 individual's admission and discharge dates. Format: MM/DD/YY.
19. RESERVED FOR LOCAL USE	Not applicable to Outpatient Behavioral Health Services.
20. OUTSIDE LAB?	Not required.
$ CHARGES	Not required.

Field Name and Number	Instructions for Completion
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY	Enter the applicable ICD indicator to identify which version of ICD codes is being reported. Use "9" for ICD-9-CM. Use "0" for ICD-10-CM. Enter the indicator between the vertical, dotted lines in the upper right-hand portion of the field. Diagnosis code for the primary medical condition for which services are being billed. Use the appropriate International Classification of Diseases (ICD). List no more than 12 diagnosis codes. Relate lines A-L to the lines of service in 24E by the letter of the line. Use the highest level of specificity.
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.
24A. DATE(S) OF SERVICE	The "from" and "to" dates of service for each billed service. Format: MM/DD/YY. 1. On a single claim detail (one charge on one line), bill only for services provided within a single calendar month. 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	Enter "Y" for "Yes" or leave blank if "No". EMG identifies if the services was an emergency.
D. PROCEDURES, SERVICES, OR SUPPLIES	
CPT/HCPCS	Enter the correct CPT or HCPCS procedure codes from Sections 252.100 through 252.150.
MODIFIER	Use applicable modifier.

Field Name and Number	Instructions for Completion
E. DIAGNOSIS POINTER	Enter the diagnosis code reference letter (pointer) as shown in Item Number 21 to relate to the date of service and the procedures performed to the primary diagnosis. When multiple services are performed, the primary reference letter for each service should be listed first; other applicable services should follow. The reference letter(s) should be A-L or multiple letters as applicable. The "Diagnosis Pointer" is the line letter from Item Number 21 that relates to the reason the service(s) was performed.
F. $ CHARGES	The full charge for the service(s) totaled in the detail. This charge must be the usual charge to any client, patient, or other beneficiary 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.
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. RESERVED	Reserved for NUCC use.
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.

Field Name and Number	Instructions for Completion
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.

PROPOSED

257.000 Special Billing Procedures

257.100 Outpatient Behavioral Health Services Billing Instructions 7-1-17

Outpatient Behavioral Health Services Medicaid providers who provide covered telemedicine services must comply with the definitions and coding requirements outlined below when billing Medicaid.

A. Telemedicine transactions involve interaction between an Arkansas licensed mental health professional and a beneficiary who are in different locations. The beneficiary must be in a mental health clinic setting.

Telemedicine Site Definitions

Local Site: The local site is the patient's location.

Remote Site: The remote site is the location of the Arkansas licensed mental health professional performing a telemedicine service for the beneficiary at the local site.

B. The place of service code is determined by the patient's location (the local site). The remote site is ***never*** the place of service.

Telemedicine Place of Service Codes

Paper Claims Code = H, Electronic Claims Code = 99 Outpatient Behavioral Health Providers Clinic (Telemedicine)

257.200 Substance Abuse Covered Diagnosis Codes 7-1-17

Certain Outpatient Behavioral Health Services are covered by Arkansas Medicaid for an individual whose primary diagnosis is substance abuse. Those services are listed below:

National Code	Required Modifier	Procedure Code Description
90832	HF	Individual Behavioral Health Counseling – Substance Abuse
90834	HF	
90837	HF	
90853	HF	Group Behavioral Health Counseling – Substance Abuse
90847	HF	Marital/Family Behavioral Health Counseling with Beneficiary

National Code	Required Modifier	Procedure Code Description
		Present – Substance Abuse
90846	HF	Marital/Family Behavioral Health Counseling without Beneficiary Present – Substance Abuse
90849	HF	Multi-Family Behavioral Health Counseling – Substance Abuse
90791		Mental Health Diagnosis
90791	U7	
90887		Interpretation of Diagnosis
90887	U7	
H0001		Substance Abuse Assessment
H0015		Intensive Outpatient Substance Abuse Treatment

For an Outpatient Behavioral Health Services provider delivering an Outpatient Behavioral Health Services service, the primary diagnosis is the DSM mental health disorder that is the primary focus of the mental health treatment service being delivered.

For persons being treated by an Outpatient Behavioral Health Services provider for a mental health disorder who also have a co-occurring substance use disorder(s), this (these) substance use disorder(s) is (are) listed as a secondary diagnosis. Outpatient Behavioral Health Services providers that are certified to provider Substance Abuse services may also provide substance abuse treatment services to their behavioral health clients. In the provision of Outpatient Behavioral Health Services mental health services, the substance use disorder is appropriately focused on with the client in terms of its impact on and relationship to the primary mental health disorder. All Outpatient Behavioral Health Services must be focused toward and address the behavioral health needs of the client.