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200.000 OUTPATIENT BEHAVIORAL HEALTH SERVICES GENERAL INFORMATION

201.000 Introduction

~~7-1-17~~1-1-19

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~~1-1-19

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)~~ Division of Provider Services and Quality Assurance (DPSQA). (See Section 202.100 for specific certification requirements.)

C. A copy of the current ~~DBHS~~ DPSQA 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~~Provider Services and Quality Assurance (DPSQA) ~~7-1-17~~1-1-19

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)~~ Provider Services and Quality Assurance, unless expressly exempted from this requirement. The ~~DBHS~~ DPSQA 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~~ DPSQA certification requirements in addition to accreditation.

210.000 PROGRAM COVERAGE

211.000 Coverage of Services ~~7-1-17~~1-1-19

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)~~Provider Services and Quality Assurance, 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~~ DPSQA 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~~A machine recorded voice mail 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~~ DPSQA must also maintain an Emergency Service Plan that complies with the ~~DBHS~~ DPSQA 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~~1-1-19

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~~ DPSQA 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~~1-1-19

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~~

PROVIDER TYPE	LICENSES	STATE CERTIFICATION REQUIRED	SUPERVISION
~~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 (LPC)	Yes, must be certified to provide services	Not Required
Non-independently Licensed Clinicians – Master's/Doctoral	Licensed Master Social Worker (LMSW) Licensed Associate Marital and Family Therapist (LAMFT)	Yes, must be supervised by appropriate Independently Licensed Clinician	Required

PROVIDER TYPE	LICENSES	STATE CERTIFICATION REQUIRED	SUPERVISION
	Licensed Associate Counselor (LAC) Licensed Psychological Examiner (LPE) Provisionally Licensed Psychologist (PLP)		
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~~ rendering 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~~1-1-19

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)~~Provider Services and Quality Assurance. The certification requirements for performing providers are located on the ~~DBHS~~ DPSQA website at **http://humanservices.arkansas.gov/dbhs/Pages/dbhs_docs.aspx**.

211.500 Non-Refusal Requirement

~~7-1-17~~1-1-19

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~~ Primary Care Physician (PCP) or Patient-Centered Medical Home (PCMH) for beneficiaries receiving Counseling Services so that appropriate provisions can be made.

212.000 Scope

~~7-1-17~~1-1-19

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~~ 5 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, child advocacy center, home, shelter, group home, 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

~~7-1-17~~1-1-19

Prior to continuing provision of Counseling Level Services, the provider must document medical necessity of Outpatient Behavioral Health Counseling Services. The documentation of medical necessity is a written intake 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. This documentation must be made part of the beneficiary's medical record.

The intake assessment , either the Mental Health Diagnosis (CPT Code 90791), Substance Abuse Assessment (CPT Code H0001), or Psychiatric Assessment (CPT Code 90792), must be completed prior to the provision of Counseling Level Services in the Outpatient Behavioral Health Services program. This intake will assist providers in determining services needed and desired outcomes for the beneficiary. The intake must be completed by a mental health professional qualified by licensure and experienced in the diagnosis and treatment of behavioral health and/or substance use disorders.

~~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~~Referral ~~7-1-17~~1-1-19

Please refer to the Independent Assessment Manual or the PASSE Manual for Independent Assessment Referral Process.

~~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. Children/Youth in custody of the Arkansas Department of Human Services, Division of Children and Family Services (DCFS)

B. Children/Youth in custody of the Arkansas Department of Human Services, Division of Youth Services (DYS)

C. Individuals discharged from acute psychiatric hospital stays

D. Individuals discharged from crisis residential stays

E. Individuals court ordered into the 911 program (otherwise known as the AR Conditional Released Program Act 911 of 1989)

F. Beneficiaries being discharged from the AR State Hospital

G. Clients identified and referred by DBHS

213.110 Presumptive Eligibility 7-1-17

The following beneficiaries will be deemed presumptively eligible for receipt of Rehabilitative Level Services and Therapeutic Communities in Intensive Level Services prior to the completion of an independent assessment. These populations are included in the priority population to receive an independent assessment within 7 days of notification of need for an independent assessment.

A. Children/Youth in custody of the Arkansas Department of Human Services, Division of Children and Family Services (DCFS)

B. Children/Youth in custody of the Arkansas Department of Human Services, Division of Youth Services (DYS)

C. Individuals court ordered into the 911 program (otherwise known as the AR Conditional Released Program Act 911 of 1989)

D. Beneficiaries being discharged from the AR State Hospital

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~~1-1-19

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, home, shelter, group home, 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~~1-1-19

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~~ DASBHS 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 ~~7-1-17~~1-1-19

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 Beneficiary Participation in the Development of the Treatment Plan 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 180 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 Beneficiary Participation in the Periodic Review of the Treatment Plan 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.

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.~~

~~219.300 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~~1-1-19

Regulation for Inpatient Hospital Services may be found in program specific manuals located at: **https://medicaid.mmis.arkansas.gov/Provider/Docs/Docs.aspx**

~~"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.")~~

~~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 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 1-1-19

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~~1-1-19

~~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 180-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 Psychiatric Assessment for a new patient must be completed within forty-five (45) calendar days of the beneficiary being determined eligible for Rehabilitative Level Services or receiving Therapeutic Communities/Planned Respite in Intensive Level Services. 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.~~

227.000 Prescription for Outpatient Behavioral Health Services

~~7-1-17~~1-1-19

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.

228.114 Cases Chosen for Review

~~7-1-17~~1-1-19

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~~

B~~C~~. Progress notes, including physician notes

C~~D~~. Physician orders and lab results

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

228.120 DMS/DBHS Work Group Reports and Recommendations

~~7-1-17~~1-1-19

The DMS/~~DBHS~~ DAABHS Work Group (comprised of representatives from the Behavioral Health Unit, the Arkansas Office of Medicaid Inspector General, the ~~Division of Behavioral Health Services~~Division of Aging Adult and Behavioral Health Services (DAABHS), the ~~Office of Quality Assurance~~Division of Provider Services and 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~~1-1-19

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~~Provider Services and Quality Assurance (DPSQA).

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~~1-1-19

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 Services and Quality Assurance (DPSQA) 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

228.132 Review Sample and the Record Request

~~7-1-17~~1-1-19

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~~electronic medium. **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.

228.133 Review Process

~~7-1-17~~1-1-19

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~~ in therapy (LCSW, LMSW, LPE, LPE-I, LPC, LAC, LMFT, LAMFT, ~~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.

231.100 Prior Authorization

~~2-1-18~~1-1-19

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	UC, UK, U4	Individual Behavioral Health Counseling – Age 3
90834	UC, UK U4	Individual Behavioral Health Counseling – Age 3
90837	UC, UK, U4	Individual Behavioral Health Counseling – Age 3
90847	UC, UK, U4	Marital/Family Behavioral Health Counseling with Beneficiary Present – Dyadic Treatment
H2027	UK, U4	Psychoeducation – Dyadic Treatment
~~H0015~~	~~U4~~	~~Intensive Outpatient Substance Abuse Treatment~~
~~H2023~~	~~U4~~	~~Supportive Employment~~

National Codes	Required Modifier	Service Title
~~H0043~~	~~U4~~	~~Supportive Housing~~

231.300 Substance Abuse Covered Codes 1-1-19

Certain Outpatient Behavioral Health Services are covered by Arkansas Medicaid for an individual whose primary diagnosis is substance abuse. Independently Licensed Practitioners may provide Substance Abuse Service within the scope of their practice. Behavioral Health Agency sites must be licensed by the Divisions of Provider Services and Quality Assurance in order to provide Substance Abuse Services. Allowable substance abuse services are listed below:

National Codes	Required Modifier	Service Title
90832	HF	Individual Behavioral Health Counseling – Substance Abuse
90834	HF	Individual Behavioral Health Counseling – Substance Abuse
90837	HF	Individual Behavioral Health Counseling – Substance Abuse
90853	HF	Group Behavioral Health Counseling – Substance Abuse
90846	HF	Marital/Family Behavioral Health Counseling – without Beneficiary Present – Substance Abuse
90847		Marital/Family Behavioral Health Counseling with Beneficiary Present – Substance Abuse
90849	HF	Multi-Family Behavioral Health Counseling – Substance Abuse
90791	U7	Mental Health Diagnosis
90887	U7	Interpretation of Diagnosis
H0001		Substance Abuse Assessment

Beneficiaries being treated by an Outpatient Behavioral Health Service 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 Service Agency providers that are certified to provide Substance Abuse services may also provider substance abuse treatment to their behavioral health clients. In the provision of Outpatient Behavioral Health 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.

A Behavioral Health Agency and Independently Licensed Practitioner may provide substance abuse treatment services to beneficiaries who they are also providing mental health/behavioral health services to. In this situation, the substance abuse disorder must be listed as the secondary diagnosis on the claim with the mental health/behavioral health diagnosis as the primary diagnosis.

240.000 REIMBURSEMENT

240.100 Reimbursement

~~7-1-17~~1-1-19

Reimbursement is based on the lesser of the billed amount or the Title XIX (Medicaid) maximum allowable for each procedure.

Reimbursement is contingent upon eligibility of both the beneficiary and provider at the time the service is provided and upon accurate completeness of the claim filed for the service. The provider is responsible for verifying that the beneficiary is eligible for Arkansas Medicaid prior to rendering services.

A. Outpatient Services

Fifteen-Minute Units, unless otherwise stated

Outpatient Behavioral Health Services must be billed on a per unit basis as indicated in the service definition, 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.

15 Minute Units	Timeframe
One (1) unit =	8 – 24 minutes
Two (2) units =	25 – 39 minutes
Three (3) units =	40 – 49 minutes
Four (4) units =	50 – 60 minutes

60 minute Units	Timeframe
One (1) unit =	50-60 minutes
Two (2) units =	110-120 minutes
Three (3) units =	170-180 minutes
Four (4) units =	230-240 minutes
Five (5) units =	290-300 minutes
Six (6) units =	350-360 minutes

Seven (7) units=	410-420 minutes
Eight (8) units=	470-480 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

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).*

241.000 Fee Schedule

~~7-1-17~~1-1-19

Arkansas Medicaid provides fee schedules on the Arkansas Medicaid website. The fee schedule link is located at ~~https://www.medicaid.state.ar.us~~https://medicaid.mmis.arkansas.gov/Provider/Docs/fees.aspx 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.

252.100 Procedure Codes for Types of Covered Services

~~7-1-17~~1-1-19

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 or per encounter 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.

252.111 Individual Behavioral Health Counseling

~~2-1-18~~1-1-19

CPT®/HCPCS PROCEDURE CODE	PROCEDURE CODE DESCRIPTION
90832, U4 90834, U4 90837, U4 90832, U4, U7 – Telemedicine 90834, U4, U7 – Telemedicine 90837, U4, U7 – Telemedicine 90832, U4, U5 – Substance Abuse 90834, U4, U5 – Substance Abuse 90837, U4, U5 – Substance Abuse 90832, UC, UK, U4 – Under Age 4 90834, UC, UK, U4 – Under Age 4 90837, UC, UK, U4 – Under Age 4	90832: psychotherapy, 30 min 90834: psychotherapy, 45 min 90837: psychotherapy, 60 min
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	• 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~~Mental Health Diagnosis • Beneficiary's response to treatment that includes current progress or regression and

deterioration. Additionally, tobacco cessation counseling is a component of this service.	prognosis • Any revisions indicated for the ~~master treatment plan,~~ diagnosis, or medication ~~(s)~~ concerns • Plan for next individual therapy session, including any homework assignments and/or advanced psychiatric directive or crisis plans • 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~~Mental Health Diagnosis. 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): Counseling Level Beneficiary: 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 Residents of Long Term Care Facilities	A provider may only bill one Individual Behavioral Health Counseling ~~/ Psychotherapy~~ Code per day per beneficiary. A provider cannot bill any other Individual Behavioral Health 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 26 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, Youth, 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, 04, 11, 12, 49, 50, 53, 57, 71, 72~~ 03 (School), 04 (Homeless Shelter), 11 (Office) 12 (Patient's Home), 49 (Independent Clinic), 50 (Federally Qualified Health Center), 53 (Community Mental Health Center), 57 Non-Residential Substance Abuse Treatment Facility), 71 (Public Health Clinic), 72 (Rural Health Clinic)

252.112 Group Behavioral Health Counseling

~~2-1-18~~1-1-19

CPT®/HCPCS PROCEDURE CODE	PROCEDURE CODE DESCRIPTION
90853, U4 90853, U4, U5 – 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. 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 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~~Mental Health Assessment • 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)~~concerns

<table>
<tr><td></td><td colspan="2">• Plan for next group session, including any homework assignments and/ or crisis plans
• Staff signature/credentials/date of signature</td></tr>
<tr><th>NOTES</th><th>UNIT</th><th>BENEFIT LIMITS</th></tr>
<tr><td>This does NOT include psychosocial groups. Beneficiaries eligible for Group ~~Outpatient – Group Psychotherapy~~Behavioral Health Counseling 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.</td><td>Encounter</td><td>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: 12 units

~~Rehabilitative/Intensive Level Beneficiary: 104 units~~</td></tr>
<tr><th>APPLICABLE POPULATIONS</th><th colspan="2">SPECIAL BILLING INSTRUCTIONS</th></tr>
<tr><td>Children, Youth, and Adults</td><td colspan="2">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 allowed 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.~~</td></tr>
<tr><th>ALLOWED MODE(S) OF DELIVERY</th><th colspan="2">TIER</th></tr>
<tr><td>Face-to-face</td><td colspan="2">Counseling</td></tr>
<tr><th>ALLOWABLE PERFORMING PROVIDERS</th><th colspan="2">PLACE OF SERVICE</th></tr>
<tr><td>• Independently Licensed Clinicians – Master's/Doctoral
• Non-independently Licensed Clinicians – Master's/Doctoral
• Advanced Practice Nurse</td><td colspan="2">03 (School), 11 (Office), 49 (Independent Clinic), 49 (Independent Clinic), 50 (Federally Qualified Health Center), 53 (Community Mental Health Center), 57 (Non-Residential Substances Abuse Treatment Facility), 71 (Public Health Clinic), 72 (Rural Health Clinic) ~~03, 11, 49, 50, 53, 57, 71, 72~~</td></tr>
</table>

• Physician	

252.113 Marital/Family Behavioral Health Counseling with Beneficiary Present

~~2-1-18~~1-1-19

CPT®/HCPCS PROCEDURE CODE	PROCEDURE CODE DESCRIPTION
90847, U4 90847, U4, U5 – Substance Abuse 90847, UC, UK, U4 – 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. 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 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**	• 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~~Mental Health Diagnosis 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 concerns~~(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

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).		
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~~documentation in the Mental Health Diagnosis. 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 90846 – Marital/Family Behavioral Health Counseling without Beneficiary Present	

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 (School), 04 (Homeless Shelter), 11 (Office) 12 (Patient's Home), 49 (Independent Clinic), 50 (Federally Qualified Health Center), 53 (Community Mental Health Center), 57 (Non-Residential Substance Abuse Treatment Facility), 71 (Public Health Clinic), 72 (Rural Health Clinic)~~03, 04, 11, 12, 49, 50, 53, 57, 71, 72~~

252.114 Marital/Family Behavioral Health Counseling without Beneficiary Present

~~2-1-18~~1-1-19

CPT®/HCPCS PROCEDURE CODE	PROCEDURE CODE DESCRIPTION
90846, U4 90846, U4, U5 – 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 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.	• 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~~Mental Health Diagnosis and improve the impact the beneficiary's condition has on the spouse/family and/or improve marital/family interactions between the

<table>
<tr><td>Services must be congruent with the age and abilities of the beneficiary or family member(s), client-centered and strength-based; with emphasis on needs as identified by the beneficiary and family and provided with cultural competence.</td><td colspan="2">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 concerns~~(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</td></tr>
<tr><td>NOTES</td><td>UNIT</td><td>BENEFIT LIMITS</td></tr>
<tr><td>Natural supports may be included in these sessions if justified in service documentation and if supported in ~~the master treatment plan~~Mental Health Diagnosis. Only one beneficiary per family per therapy session may be billed.</td><td>Encounter</td><td>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~~</td></tr>
<tr><td>APPLICABLE POPULATIONS</td><td colspan="2">SPECIAL BILLING INSTRUCTIONS</td></tr>
<tr><td>Children, Youth, and Adults</td><td colspan="2">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
91847 – Marital/Family Behavioral Health Counseling with Beneficiary Present</td></tr>
<tr><td>ALLOWED MODE(S) OF DELIVERY</td><td colspan="2">TIER</td></tr>
<tr><td>Face-to-face</td><td colspan="2">Counseling</td></tr>
</table>

ALLOWABLE PERFORMING PROVIDERS	PLACE OF SERVICE
• Independently Licensed Clinicians - Master's/Doctoral • Non-independently Licensed Clinicians – Master's/Doctoral • Advanced Practice Nurse • Physician	03 (School), 04 (Homeless Shelter), 11 (Office) 12 (Patient's Home), 49 (Independent Clinic), 50 (Federally Qualified Health Center), 53 (Community Mental Health Center), 57 (Non-Residential Substance Abuse Treatment Facility), 71 (Public Health Clinic), 72 (Rural Health Clinic) ~~03, 04, 11, 12, 49, 50, 53, 57, 71, 72~~

252.115 Psychoeducation

~~2-1-18~~1-1-19

CPT®/HCPCS PROCEDURE CODE	PROCEDURE CODE DESCRIPTION
H2027, U4 H2027, U4, U7 – Telemedicine H2027, UK, U4 – 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 beneficiary and/or 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~~Mental Health Diagnosis 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 concerns~~(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	15 minutes	DAILY MAXIMUM OF UNITS THAT MAY BE BILLED: 4 YEARLY MAXIMUM OF UNITS THAT MAY BE BILLED (extension

family per therapy session may be billed.		of benefits can be requested): 48
APPLICABLE POPULATIONS	**SPECIAL BILLING INSTRUCTIONS**	
Children, Youth, and Adults	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, Youth, 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 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 (School), 04 (Homeless Shelter), 11 (Office) 12 (Patient's Home), 49 (Independent Clinic), 50 (Federally Qualified Health Center), 53 (Community Mental Health Center), 57 (Non-Residential Substance Abuse Treatment Facility), 71 (Public Health Clinic), 72 (Rural Health Clinic) ~~03, 04, 11, 12, 49, 50, 53, 57, 71, 72~~	

252.116 Multi-Family Behavioral Health Counseling

~~2-1-18~~1-1-19

CPT®/HCPCS PROCEDURE CODE	PROCEDURE CODE DESCRIPTION
90849, U4 90849, U4, U5 – 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 Marital/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. Additionally, tobacco cessation counseling is a component of this service. 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 beneficiary and/or 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 provided as integrated treatment utilizing Family Psychotherapy.	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	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:** 90846 – Marital/Family Behavioral Health Counseling without Beneficiary Present 90847 – Marital/Family Behavioral Health Counseling with Beneficiary Present 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 (School), 11 (Office), 49 (Independent Clinic), 50 (Federally Qualified Health Center), 53 (Community Mental Health Center), 57 (Non-Residential Substance Abuse Treatment Facility), 71 (Public Health Clinic), 72 (Rural Health Clinic)~~03, 11, 49, 50, 53, 57, 71, 72~~

252.117 Mental Health Diagnosis

~~2-1-18~~1-1-19

CPT®/HCPCS PROCEDURE CODE	PROCEDURE CODE DESCRIPTION
90791, U4 90791, U4, U7 – Telemedicine 90791, UC, UK, U4 – 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	• 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

beneficiary and provided with cultural competence.	impressions • Current functioning plus strengths and needs in specified life domains • DSM diagnostic impressions ~~to include all axes~~ • Treatment recommendations, and prognosis for treatment • 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 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.**	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 Residents of Long Term Care	**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 o Non-independently Licensed Clinicians – Parent/Caregiver & Child (Dyadic treatment of Children age 0-47 months & Parent/Caregiver) Provider	03 (School), 04 (Homeless Shelter), 11 (Office) 12 (Patient's Home), 49 (Independent Clinic), 50 (Federally Qualified Health Center), 53 (Community Mental Health Center), 57 (Non-Residential Substance Abuse Treatment Facility), 71 (Public Health Clinic), 72 (Rural Health Clinic) ~~03, 04, 11, 12, 49, 50, 53, 57, 71, 72~~

252.118 Interpretation of Diagnosis

~~2-1-18~~1-1-19

CPT®/HCPCS PROCEDURE CODE	PROCEDURE CODE DESCRIPTION
90887, U4 90887, U4, U7 – Telemedicine 90887, UC, UK, U4 – 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. Services pertain to a beneficiary's (a) Mental Health and/or (b) Substance Abuse condition Consent forms may be required for family or significant other	• 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

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.	• Diagnosis • Rationale for and objective used that must coincide with the ~~master treatment plan or proposed master treatment plan or recommendations~~Mental Health Diagnosis • Participant(s) response and feedback • Recommendation for additional supports including referrals, resources and information • 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 ages 18 and above. This service can also be provided via telemedicine to beneficiaries ages 17 and under with documentation of parental or guardian involvement during the service. This documentation must be included in the medical record. ***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 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.**	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~~
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 This service can be provided via telemedicine to beneficiaries ages 18 and above. This service can also be provided via telemedicine to beneficiaries ages 17 and under with documentation of parental or guardian involvement during the service. This documentation must be included in the medical record.
ALLOWED MODE(S) OF DELIVERY	**TIER**
Face-to-face Telemedicine Adults, Youth 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 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 (School), 04 (Homeless Shelter), 11 (Office) 12 (Patient's Home), 49 (Independent Clinic), 50 (Federally Qualified Health Center), 53 (Community Mental Health Center), 57 (Non-Residential Substance Abuse Treatment Facility), 71 (Public Health Clinic), 72 (Rural Health Clinic)~~03, 04, 11, 12, 49, 50, 53, 57, 71, 72~~

252.119 Substance Abuse Assessment

~~2-1-18~~1-1-19

CPT®/HCPCS PROCEDURE CODE	PROCEDURE CODE DESCRIPTION
H0001, U4	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~~ DAABHS 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. 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 and strengths in specified life domains • DSM diagnostic impressions ~~to include all axes~~ • Treatment recommendations and prognosis for treatment • 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:** 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	03 (School), 04 (Homeless Shelter), 11 (Office) 12 (Patient's Home), 49 (Independent Clinic), 50 (Federally Qualified Health Center), 53 (Community Mental Health Center), 57 (Non-Residential Substance Abuse Treatment Facility),	

• Advanced Practice Nurse • Physician	71 (Public Health Clinic), 72 (Rural Health Clinic)~~03, 04, 11, 12, 49, 50, 53, 57, 71, 72~~

252.120 Psychological Evaluation

~~2-1-18~~1-1-19

CPT®/HCPCS PROCEDURE CODE	PROCEDURE CODE DESCRIPTION
96101, U4	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. 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 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 Mental Health Diagnosis or Psychiatric Assessment ~~psychiatric/diagnostic interview~~, observation in therapy, or an assessment for level of care at a mental health facility • the service provides information relevant to the beneficiary's continuation in treatment and assists in the treatment process	• 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

This code may not be billed for the completion of testing that is considered primarily educational or utilized for employment, disability qualification, or legal or court related purposes.	60 minutes	DAILY MAXIMUM OF UNITS THAT MAY BE BILLED: 4 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 (School), 11 (Office), 49 (Independent Clinic), 50 (Federally Qualified Health Center), 53 (Community Mental Health Center), 57 (Non-Residential Substance Abuse Treatment Facility), 71 (Public Health Clinic), 72 (Rural Health Clinic) ~~03, 11, 49, 50, 53, 57, 71, 72~~	

252.121 Pharmacologic Management

~~2-1-18~~1-1-19

CPT®/HCPCS PROCEDURE CODE	PROCEDURE CODE DESCRIPTION
99212, UB, U4 – Physician 99213, UB, U4 – Physician 99214, UB, U4 – Physician 99212, UB, U4, U7 – Physician, Telemedicine 99213, UB, U4, U7 – Physician, Telemedicine 99214, UB, U4, U7 – Physician, Telemedicine 99212, SA, U4 – APN 99213, SA, U4 – APN 99214, SA, U4 – APN 99212, SA, U4, U7– APN, Telemedicine 99213, SA, U4, U7 – APN, Telemedicine 99214, SA, U4, U7 – 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 with the goal of improving functioning, including management and reduction of 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. 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 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~~Psychiatric Assessment • 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~~Psychiatric Assessment.	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, Youth, and Children)	Counseling
ALLOWABLE PERFORMING PROVIDERS	**PLACE OF SERVICE**
• Advanced Practice Nurse	03 (School), 04 (Homeless Shelter), 11 (Office),

• Physician	12 (Patient's Home), 49 (Independent Clinic), 50 (Federally Qualified Health Center), 53 (Community Mental Health Center), 57 (Non-Residential Substance Abuse Treatment Facility), 71 (Public Health Clinic), 72 (Rural Health Clinic) ~~03, 04, 11, 12, 49, 50, 53, 57, 71, 72~~

252.122 Psychiatric Assessment ~~2-1-18~~1-1-19

CPT®/HCPCS PROCEDURE CODE	PROCEDURE CODE DESCRIPTION
90792, U4 90792, U4, 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.	• 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 • 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) • For beneficiaries under the age of 18 1. 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: a) Clarify the reason for the referral

	b) Clarify the nature of the current symptoms c) Obtain a detailed medical, family and developmental history •—. • ~~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 Intensive Level Services.	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 Telemedicine (Adults, Youth, and Children)	**The following codes cannot be billed on the Same Date of Service:** 90791 – Mental Health Diagnosis	
ALLOWED MODE(S) OF DELIVERY	**TIER**	
Face-to-face	Counseling	
ALLOWABLE PERFORMING PROVIDERS	**PLACE OF SERVICE**	
A. an Arkansas-licensed physician, preferably one with specialized training	03 (School), 04 (Homeless Shelter), 11 (Office), 12, (Patient's Home), 49 (Independent Clinic), 50 (Federally Qualified Health Center), 53	

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 ~~• Advanced Practice Nurse Physician~~	(Community Mental Health Center), 57 Non-Residential Substance Abuse Treatment Facility), 71 (Public Health Clinic), 72 (Rural Health Clinic) ~~03, 04, 11, 12, 49, 50, 53, 57, 71, 72~~

~~**253.000 Rehabilitative Level Services**~~

~~**253.001 Treatment Plan** 2-1-18~~

~~CPT®/HCPCS PROCEDURE CODE~~	~~PROCEDURE CODE DESCRIPTION~~
~~S0220, U4~~	~~S0220: Treatment Plan~~
~~SERVICE DESCRIPTION~~	~~MINIMUM DOCUMENTATION REQUIREMENTS~~
~~Treatment Plan is a plan developed in cooperation with the beneficiary (or parent or~~	~~• Date of Service (date plan is developed)~~ ~~• Start and stop times for development of plan~~

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.	• 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): 4

APPLICABLE POPULATIONS	**SPECIAL BILLING INSTRUCTIONS**
Children, Youth, and Adults	Must be reviewed every 180 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

253.002 Crisis Stabilization Intervention 271187

CPT®/HCPCS PROCEDURE CODE	PROCEDURE CODE DESCRIPTION
H2011, U4, U6 – Mental Health Professional H2011 – U4, 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	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 2-1-18

CPT®/HCPCS PROCEDURE CODE	PROCEDURE CODE DESCRIPTION
H0035, U4	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

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 2-1-18

CPT®/HCPCS PROCEDURE CODE	PROCEDURE CODE DESCRIPTION	
H2019, U4, UC – QBHP Bachelors or RN H2019, U4 – 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
EXAMPLE ACTIVITIES	
Behavioral Assistance is designed to support youth and their families in meeting behavioral 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 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 2-1-18

CPT®/HCPCS PROCEDURE CODE	**PROCEDURE CODE DESCRIPTION**
H2017, UB, U4 – QBHP Bachelors or RN H2017, UA, U4 – 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 training and assistance to live in and maintain a household of their choosing in the community.	• 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 treatment used address goals and objectives from the master treatment plan

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.	• 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**
Staff to Client Ratio – 1:15 ratio maximum with the provision that client ratio must be reduced when necessary to accommodate significant issues related to acuity, developmental status and clinical needs.	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

253.006 Peer Support 2-1-18

CPT®/HCPCS PROCEDURE CODE	PROCEDURE CODE DESCRIPTION
H0038, UC, U4 H0038, U4 - 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 are provided on an individual or group basis, and in either the beneficiary's home or community environment.	• 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 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 2-1-18

CPT®/HCPCS PROCEDURE CODE	**PROCEDURE CODE DESCRIPTION**
H2014, UC, U4 H2014, U4 - 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 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	• 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 used address goals and objectives from the master treatment plan • Information gained from contact and how it

family in securing community resources and developing natural supports.	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 2-1-18

CPT®/HCPCS PROCEDURE CODE	PROCEDURE CODE DESCRIPTION
H0034, TD, U4	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, related to their psychopharmological treatment. Individual Pharmaceutical counseling involves providing medication information orally or in written form to the beneficiary and/or	• Date of Service • Start and stop times of actual encounter with beneficiary • Place of service

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 lifestyle modification required.	• 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, Youth and Adults	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 2-1-18

CPT®/HCPCS PROCEDURE CODE	PROCEDURE CODE DESCRIPTION
H0034, HQ, TD, U4	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 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	• Date of Service • Start and stop times of actual encounter with beneficiary • Place of service • Diagnosis and pertinent interval history • Brief mental status and observations

need for the medication and any lifestyle modification required.	• 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, Youth and Adults	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 2-1-18

CPT®/HCPCS PROCEDURE CODE	**PROCEDURE CODE DESCRIPTION**
H0015, U4	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 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	• 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

"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.	• 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.	Per diem	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 Abuse Treatment provider.	11, 14, ,22, 49, 50, 53, 57, 71

253.011 Individual Life Skills Development **2-1-18**

CPT®/HCPCS PROCEDURE CODE	**PROCEDURE CODE DESCRIPTION**
H2017, UC, U4 – QBHP Bachelors or RN H2017, U4, U6 – 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.	• 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	03, 04, 11, 12, 14, 16, 22 , 49, 50, 53, 57, 71, 72	

• Registered Nurse (Use Code H2017 with HA, HN modifiers)	

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.

253.013 Group Life Skills Development 2-1-18

CPT®/HCPCS PROCEDURE CODE	PROCEDURE CODE DESCRIPTION
H2017, HQ, UC, U4 – QBHP Bachelors or RN H2017, HQ, U4, U6 – 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
	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 2-1-18

CPT®/HCPCS PROCEDURE CODE	PROCEDURE CODE DESCRIPTION
H2015, UC, U4 – QBHP Bachelors or RN H2015, U1, U4 – 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 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.	• 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

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.	• 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
	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

253.015 Supportive Employment 2-1-18

CPT®/HCPCS PROCEDURE CODE	PROCEDURE CODE DESCRIPTION
H2023, U4	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	• Date of Service • Names and relationship to the beneficiary of all persons involved • Start and stop times of actual encounter with collateral contact

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.	• 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	

253.016 Supportive Housing 2-1-18

CPT®/HCPCS PROCEDURE CODE	PROCEDURE CODE DESCRIPTION	
H0043, U4	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

253.017 Adult Life Skills Development 2-1-18

CPT®/HCPCS PROCEDURE CODE	PROCEDURE CODE DESCRIPTION
H2017, U3, U4 – QBHP Bachelors or RN H2017, U4, U5– 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 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
	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 2-1-18

CPT®/HCPCS PROCEDURE CODE	PROCEDURE CODE DESCRIPTION
H0019, HQ, UC, U4 – Level 1 H0019, HQ, U4 – 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

254.002 Planned Respite 2-1-18

CPT®/HCPCS PROCEDURE CODE	PROCEDURE CODE DESCRIPTION
H0045, U4	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	

254.003 Residential Community Reintegration Program 10-1-17

CPT®/HCPCS PROCEDURE CODE	**PROCEDURE CODE DESCRIPTION**
H2020, U4	Therapeutic behavioral services, per diem
SERVICE DESCRIPTION	**MINIMUM DOCUMENTATION REQUIREMENTS**
The Residential Community Reintegration Program is designed to serve as an intermediate level of care between Inpatient Psychiatric Facilities and Outpatient Behavioral Health Services. The program provides twenty-four hour per day intensive therapeutic care provided in a small group home setting for children and youth with emotional and/or behavior problems which cannot be remedied by less intensive treatment. The program is intended to prevent acute or sub-acute hospitalization of youth, or incarceration. The program is also offered as a step-down or transitional level of care to prepare a youth for less intensive treatment. Services include all allowable Outpatient Behavioral Health Services (OBHS) based upon the age of the beneficiary as well as any additional interventions to address the beneficiary's behavioral health needs.	• Date of Service • Place of Service • Diagnosis and pertinent interval history • Daily description of activities and interventions that coincide with master treatment plan and meet or exceed minimum service requirements • Mental Status and Observations • Rationale and description of the treatment used that must coincide with objectives on the master treatment plan • Staff signature/credentials/date of signature

A Residential Community Reintegration Program shall be appropriately certified by the Department of Human Services to ensure quality of care and the safety of beneficiaries and staff. A Residential Community Reintegration Program shall have, at a minimum, 2 direct service staff available at all times. Direct service staff may include any allowable performing provider in the Outpatient Behavioral Health Services (OBHS) manual, teachers, or other ancillary educational staff. A Residential Community Reintegration Program shall ensure the provision of educational services to all beneficiaries in the program. This may include education occurring on campus of the Residential Community Reintegration Program or the option to attend a school off campus if deemed appropriate in according with the Arkansas Department of Education.		
NOTES	**EXAMPLE ACTIVITIES**	
Eligibility for this service is determined by the standardized Independent Assessment. Prior to reimbursement for the Residential Community Reintegration Program in Intensive Level Services, a beneficiary must be eligible for Intensive Level Services as determined by the standardized Independent Assessment.		
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): 90
ALLOWED MODE(S) OF DELIVERY	**TIER**	
Face-to-face	Intensive	
ALLOWABLE PERFORMING PROVIDERS	**PLACE OF SERVICE**	
The Residential Community Reintegration Program must be provided in a facility that is	14	

~~certified by the Department of Human Services as a Residential Community Reintegration Program provider.~~	

255.001 Crisis Intervention ~~2-1-18~~1-1-19

CPT®/HCPCS PROCEDURE CODE	PROCEDURE CODE DESCRIPTION
H2011, HA, U4	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.) 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 • 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	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

of provision of this service if provided to a beneficiary who is not currently a client. If the beneficiary cannot be contacted or does not return for a Mental Health Diagnosis appointment, attempts to contact the beneficiary must be placed in the beneficiary's medical record. 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, 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 (School), 04 (Homeless Shelter), 11 (Office) 12 (Patient's Home), 15 (Mobile Unit), 23 (Emergency Room), 33 (Custodial Care facility), 49 (Independent Clinic), 50 (Federally Qualified Health Center), 53 (Community Mental Health Center), 57(Non-Residential Substance Abuse Treatment Facility), 71 (Public Health Clinic), 72 (Rural Health Clinic), 99 (Other Location)~~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~~		
~~**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

~~2-1-18~~1-1-19

CPT®/HCPCS PROCEDURE CODE	PROCEDURE CODE DESCRIPTION	
H0018, U4	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.		
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~~Acute Crisis Units must be certified by the Division of Provider Services and Quality Assurance as an Acute Crisis Unit Provider	~~21, 51, 55, 56~~	

255.004 Substance Abuse Detoxification ~~2-1-18~~1-1-19

CPT®/HCPCS PROCEDURE CODE	PROCEDURE CODE DESCRIPTION	
H0014, U4	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	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**	
Substance Abuse Detoxification must be provided in a facility that is certified by the Division of Provider Services and Quality Assurance as a Substance Abuse Detoxification provider. ~~N/A~~	21 (Inpatient Hospital), 55 (Residential Substance Abuse Treatment Facility)~~21, 55~~	

~~256.200 Telemedicine Services Billing Information~~ ~~2-1-18~~

~~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 257.100 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	U4, U7	Individual Behavioral Health Counseling – Telemedicine
90834	U4, U7	
90837	U4, U7	
H2027	U4, U7	Psychoeducation – Telemedicine
90792	U4, U7	Psychiatric Assessment – Physician, APN – Telemedicine
99212	UB, U4, U7	Pharmacologic Management – Physician, Telemedicine
99213	UB, U4, U7	
99214	UB, U4, U7	
99212	SA, U4, U7	Pharmacologic Management – APN, Telemedicine
99213	SA, U4, U7	
99214	SA, U4, U7	
90887	U4, U7	Interpretation of Diagnosis

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
90791	U4, U7	Mental Health Diagnosis

256.300 Services Available to Residents of Long Term Care Facilities Billing Information 2-1-18

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	U4	Mental Health Diagnosis
S0220	U4	Treatment Plan (payable only for beneficiaries eligible to receive Rehabilitative Level Services or Intensive Level Services)
90887	U4	Interpretation of Diagnosis
90832	U4	Individual Behavioral Health Counseling
90834	U4	
90837	U4	

~~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~~1-1-19

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

Place of Service	POS Codes
School (Including Licensed Child Care Facility)	03
Homeless Shelter	04
Office (Outpatient Behavioral Health Provider Facility Service Site)	11
Patient's Home	12
Group Home	14
Mobile Unit	15
Temporary Lodging	16
Inpatient Hospital	21
Custodial Care Facility	33
Independent Clinic	49
Federally Qualified Health Center	50
Inpatient Psychiatric Facility	51
Community Mental Health Center	53
Residential Substance Abuse Treatment Facility	55
Non-Residential Substance Abuse Treatment Facility	57
Public Health Clinic	71
Rural Health Clinic	72
Outpatient Behavioral Health Services Clinic (Telemedicine)	99

~~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~~

Place of Service	POS Codes
ICF/IDD	54
Other Locations	99
Outpatient Behavioral Health Services Clinic (Telemedicine)	99
Emergency Services in ER	23

257.200 Substance Abuse Covered Diagnosis Codes 2-1-18

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	U4, U5	Individual Behavioral Health Counseling – Substance Abuse
90834	U4, U5	
90837	U4, U5	
90853	U4, U5	Group Behavioral Health Counseling – Substance Abuse
90847	U4, U5	Marital/Family Behavioral Health Counseling with Beneficiary Present – Substance Abuse
90846	U4, U5	Marital/Family Behavioral Health Counseling without Beneficiary Present – Substance Abuse
90849	U4, U5	Multi-Family Behavioral Health Counseling – Substance Abuse
90791	U4	Mental Health Diagnosis
90887	U4	Interpretation of Diagnosis
H0001	U4	Substance Abuse Assessment
H0015	U4	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.

FINANCIAL IMPACT STATEMENT

PLEASE ANSWER ALL QUESTIONS COMPLETELY

DEPARTMENT Department of Human Services

DIVISION Aging, Adult and Behavioral Health Services

PERSON COMPLETING THIS STATEMENT Patricia Gann

TELEPHONE 501-686-9431 **FAX** _____ **EMAIL:** patricia.gann@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 Program 3-18 and Certification Manual

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	0	General Revenue	0
Federal Funds	0	Federal Funds	0
Cash Funds	0	Cash Funds	0
Special Revenue	0	Special Revenue	0
Other (Identify)	0	Other (Identify)	0
Total	0	Total	0

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

Current Fiscal Year	Next Fiscal Year
0	0

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
$ 0	$ 0

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.

Arkansas Department of Human Services

Behavioral Health Agency Certification Manual

Revised: 7/1/17

www.arkansas.gov/dhs/dhs

I. PURPOSE:

A. To assure that Outpatient Behavioral Health Services ("OBHS") care and services provided by certified Behavioral Health Agencies comply with applicable laws, which require, among other things, that all care reimbursed by the Arkansas Medical Assistance Program ("Medicaid") must be provided efficiently, economically, only when medically necessary, and is of a quality that meets professionally recognized standards of health care.

B. The requirements and obligations imposed by §§ I-XIII of this rule are substantive, not procedural.

II. SCOPE:

A. Current Behavioral Health Agency certification under this policy is a condition of Medicaid provider enrollment.

B. Department of Human Services ("DHS") Behavioral Health Agency certification must be obtained for each site before application for Medicaid provider enrollment. An applicant may submit one application for multiple sites, but DHS will review each site separately and take separate certification action for each site.

C. This certification policy applies only to providers in the provision of services in the AR Medicaid fee for service program.

III. DEFINITIONS:

A. "50 mile radius" means 50 miles from a certified site by driving distance. Driving distance is calculated by a method of utilizing a standardized mapping application.

B. "Accreditation" means full accreditation (preliminary, expedited, probationary, pending, conditional, deferred or provisional accreditations will not be accepted) as an outpatient behavioral health care provider issued by at least one of the following:

- Commission on Accreditation for Rehabilitative Facilities (CARF) Behavioral Health Standards Manual
- The Joint Commission (TJC) Comprehensive Accreditation Manual for Behavioral Health Care
- Council on Accreditation (COA) Outpatient Mental Health Services Manual

Accreditation timing for specific programs is defined in the applicable DHS Certification manual for that program.

C. "Adverse license action" means any action by a licensing authority that is related to client care, any act or omission warranting exclusion under DHS Policy 1088, or that imposes any restriction on the licensee's practice privileges. The action is deemed to exist when the licensing entity imposes the adverse action except as provided in Ark. Code Ann. § 25-15-211 (c).

D. “Applicant” means an outpatient behavioral health care agency that is seeking DHS certification as a Behavioral Health Agency.

E. “Certification” means a written designation, issued by DHS, declaring that the provider has demonstrated compliance as declared within and defined by this rule.

F. “Client” means any person for whom a Behavioral Health Agency furnishes, or has agreed or undertaken to furnish, Outpatient Behavioral Health services.

G. “Client Information System” means a comprehensive, integrated system of clinical, administrative, and financial records that provides information necessary and useful to deliver client services. Information may be maintained electronically, in hard copy, or both.

H. “Compliance” means conformance with:

1. Applicable state and federal laws, rules, and regulations including, without limitation:

    a. Titles XIX and XXI of the Social Security Act and implementing regulations;
    b. Other federal laws and regulations governing the delivery of health care funded in whole or in part by federal funds, for example, 42 U.S.C. § 1320c-5;
    c. All state laws and rules applicable to Medicaid generally and to Outpatient Behavioral Health services specifically;
    d. Title VI of the Civil Rights Act of 1964 as amended, and implementing regulations;
    e. The Americans With Disabilities Act, as amended, and implementing regulations;
    f. The Health Insurance Portability and Accountability Act (“HIPAA”), as amended and implementing regulations.

2. Accreditation standards and requirements.

I. “Contemporaneous” means by the end of the performing provider’s first work period following the provision of care of services to be documented, or as provided in the Outpatient Behavioral Health Services manual, whichever is longer.

J. “Coordinated Management Plan” means a plan that the provider develops and carries out to assure compliance and quality improvement.

K. “Corrective Action Plan” (CAP) means a document that describes both short- term remedial steps to achieve compliance and permanent practices and procedures to sustain compliance.

L. “Covered Health Care Practitioner” means: Any practitioner providing Outpatient Behavioral Health Services that is allowable to be reimbursed pursuant to the Outpatient Behavioral Health Services Medicaid Manual.

M. “Cultural Competency” means the ability to communicate and interact effectively with people of different cultures, including people with disabilities and atypical lifestyles.

N. “Deficiency” means an item or area of noncompliance.

O. “DHS” means the Arkansas Department of Human Services.

P. “Emergency Behavioral Health Agency services” means nonscheduled Behavioral Health Agency services delivered under circumstances where a prudent layperson with an average knowledge of behavioral health care would reasonably believe that Behavioral Health Agency services are immediately necessary to prevent death or serious impairment of health.

Q. “Medical Director” means a physician that oversees the planning and delivery of all Behavioral Health Agency services delivered by the provider.

R. “Mental health professional” or “MHP” means a person who possesses an Arkansas license to provide clinical behavioral health care. The license must be in good standing and not subject to any adverse license action.

S. “Mobile care” means a face-to-face intervention with the client at a place other than a certified site operated by the provider. Mobile care must be:

1. Either clinically indicated in an emergent situation or necessary for the client to have access to care in accordance with the care plan;

2. Delivered in a clinically appropriate setting; and

3. Delivered where Medicaid billing is permitted if delivered to a Medicaid eligible client.

Mobile care may include medically necessary behavioral health care provided in a school that is within a fifty (50) mile radius of a certified site operated by the provider.

T. “Multi-disciplinary team” means a group of professionals from different disciplines that provide comprehensive care through individual expertise and in consultation with one another to accomplish the client’s clinical goals. Multi- disciplinary teams promote coordination between agencies; provide a "checks and balances" mechanism to ensure that the interests and rights of all concerned parties are addressed; and identify service gaps and breakdowns in coordination or communication between agencies or individuals.

U. “NPDB” means the United States Department of Health and Human Services, Health Resources and Services Administration National Provider Data Bank.

V. “Performing provider” means the individual who personally delivers a care or service directly to a client.

W. “Professionally recognized standard of care” means that degree of skill and learning commonly applied under all the circumstances in the community by the average prudent reputable member of the profession. Conformity with Substance Abuse and Mental Health Services Administration (SAMHSA) evidence-based practice models is evidence of compliance with professionally recognized standards of care.

X. “Provider” means an entity that is certified by DHS and enrolled by DMS as a Behavioral Health Agency

Y. “Qualified Behavioral Health Provider” means a person who:

1. Does not possess an Arkansas license to provide clinical behavioral health care;

2. Works under the direct supervision of a mental health professional;

3. Has successfully completed prescribed and documented courses of initial and annual training sufficient to perform all tasks assigned by a mental health professional;

4. Acknowledges in writing that all qualified behavioral health provider services are controlled by client care plans and provided under the direct supervision of a mental health professional.

Z. “Quality assurance (QA) meeting” means a meeting held at least quarterly for systematic monitoring and evaluation of clinic services and compliance. See also, Medicaid Outpatient Behavioral Health Services Manual, § 212.000.

AA. “Reviewer” means a person employed or engaged by:

1. DHS or a division or office thereof;

2. An entity that contracts with DHS or a division or office thereof.

BB. “Site” means a distinct place of business dedicated to the delivery of Outpatient Behavioral Health Services within a fifty (50) mile radius. Each site must be a bona fide Behavioral Health Agency, meaning a behavioral health outpatient clinic providing all the services specified in this rule and the Medicaid Outpatient Behavioral Health Services Manual. Sites may not be adjuncts to a different activity such as a school, a day care facility, a long-term care facility, or the office or clinic of a physician or psychologist.

CC. “Site relocation” means closing an existing site and opening a new site no more than a fifty (50) mile radius from the original site.

DD. “Site transfer” means moving existing staff, program, and clients from one physical location to a second location that is no more than a fifty (50) mile radius from the original site.

EE. “Supervise” as used in this rule means to direct, inspect, observe, and evaluate performance.

FF. “Supervision documentation” means written records of the time, date, subject(s), and duration of supervisory contact maintained in the provider’s official records.

IV. COMPLIANCE TIMELINE:

A. Entities currently certified as Rehabilitative Services for Persons with Mental Illness (RSPMI) providers will be grandfathered in as certified Behavioral Health Agencies. Current RSPMI agency recertification procedures are based upon national accreditation timelines. Behavioral Health Agency recertification will also be based upon national accreditation timelines.

B. All entities in operation as of the effective date of this rule must comply with this rule within forty-five (45) calendar days in order to maintain certification.

C. DHS may authorize temporary compliance exceptions for new accreditation standards that require independent site surveys and specific service subset accreditations. Such compliance exceptions expire at the end of the provider's accreditation cycle and may not be renewed or reauthorized.

V. APPLICATION FOR DHS BEHAVIORAL HEALTH AGENCY CERTIFICATION:

A. New Behavioral Health Agency applicants must complete DHS BEHAVIORAL HEALTH AGENCY CERTIFICATION Form 100, DHS BEHAVIORAL HEALTH AGENCY FORM 200, and DHS BEHAVIORAL HEALTH AGENCY Form 210

B. DHS BEHAVIORAL HEALTH AGENCY CERTIFICATION Form 100, DHS BEHAVIORAL HEALTH AGENCY FORM 200, and DHS BEHAVIORAL HEALTH AGENCY Form 210 can be found at the following website: www.arkansas.gov/dhs/dhs

C. Applicants must submit the completed application forms and all required attachments for each proposed site to:

Department of Human Services
Division of Behavioral Health Services
Attn. Certification Office
305 S. Palm
Little Rock, AR 72205

D. Each applicant must be an outpatient behavioral health care agency:

1. Whose primary purpose is the delivery of a continuum of outpatient behavioral health services in a free standing independent clinic;

2. That is independent of any DHS certified Behavioral Health Agency.

E. Behavioral Health Agency certification is not transferable or assignable.

F. The privileges of a Behavioral Health Agency certification are limited to the certified site.

G. Providers may file Medicaid claims only for Outpatient Behavioral Health Services delivered by a performing provider engaged by the provider.

H. Applications must be made in the name used to identify the business entity to the Secretary of State and for tax purposes.

I. Applicants must maintain and document accreditation, and must prominently display certification of accreditation issued by the accrediting organization in a public area at each site. Accreditation must recognize and include all the applicant's Behavioral Health Agency programs, services, and sites.

1. Initial accreditation must include an on-site survey for each service site for which provider certification is requested. Accreditation documentation submitted to DHS must list all sites recognized and approved by the accrediting organization as the applicant's service sites.

2. Accreditation documentation must include the applicant's governance standards for operation and sufficiently define and describe all services or types of care (customer service units or service standards) the applicant intends to provide including, without limitation, crisis intervention/stabilization, in-home family counseling, outpatient treatment, day treatment, therapeutic foster care, intensive outpatient, medication management/pharmacotherapy.

3. Any outpatient behavioral health program associated with a hospital must have a free-standing behavioral health outpatient program national accreditation.

J. The applicant must attach the entity's family involvement policy to each application.

VI. APPLICATION REVIEW PROCESS:

A. Timeline:

1. DHS will review Behavioral Health Agency application forms and materials within ninety (90) calendar days after DHS receives a complete application package. (DHS will return incomplete applications to senders without review.)

2. For approved applications, a site survey will be scheduled within forty-five (45) calendar days of the approval date.

3. DHS will mail a survey report to the applicant within twenty-five (25) calendar days of the site visit. Providers having deficiencies on survey reports must submit an approvable corrective action plan to DHS within thirty-five (35) calendar days after the date of a survey report.

4. DHS will accept or reject each corrective action plan in writing within twenty (20) calendar days after receipt.

5. Within thirty (30) calendar days after DHS approves a corrective action plan, the applicant must document implementation of the plan and correction of the deficiencies listed in the survey report. Applicants who are unable, despite the exercise of reasonable diligence, to correct deficiencies within the time permitted

may obtain up to ten (10) additional days based on a showing of good cause.

6. DHS will furnish site-specific certificates via postal or electronic mail within ten (10) calendar days of issuing a site certification.

B. Survey Components: An outline of site survey components is available on the DHS website: www.arkansas.gov/dhs/dhs and is located in appendix # 7.

C. Determinations:

1. Application approved.

2. Application returned for additional information.

3. Application denied. DHS will state the reasons for denial in a written response to the applicant.

VII. DHS Access to Applicants/Providers:

A. DHS may contact applicants and providers at any time;

B. DHS may make unannounced visits to applicants/providers.

C. Applicants/providers shall provide DHS prompt direct access to applicant/provider documents and to applicant/provider staff and contractors, including, without limitation, clinicians, paraprofessionals, physicians, administrative, and support staff.

D. DHS reserves the right to ask any questions or request any additional information related to certification, accreditation, or both.

VIII. ADDITIONAL CERTIFICATION REQUIREMENTS:

A. Care and Services must:

1. Comply with all state and federal laws, rules, and regulations applicable to the furnishing of health care funded in whole or in part by federal funds; to all state laws and policies applicable to Arkansas Medicaid generally, and to Outpatient Behavioral Health Services specifically, and to all applicable Department of Human Services ("DHS") policies including, without limitation, DHS Participant Exclusion Policy § 1088.0.0. The Participant Exclusion Policy is available online at https://dhsshare.arkansas.gov/DHS%20Policies/Forms/By%20Policy.aspx

2. Conform to professionally recognized behavioral health rehabilitative treatment models.

3. Be established by contemporaneous documentation that is accurate and demonstrates compliance. Documentation will be deemed to be contemporaneous if recorded by the end of the performing provider's first work period following the provision of the care or services to be documented, or as provided in the Outpatient Behavioral Health Services manual, § 252.110, whichever is longer.

B. Applicants and Behavioral Health Agencies must:

1. Be a legal entity in good standing;

2. Maintain all required business licenses;

3. Adopt a mission statement to establish goals and guide activities;

4. Maintain a current organizational chart that identifies administrative and clinical chains of command.

C. Applicants/providers must establish and comply with operating policy that at a minimum implements credible practices and standards for:

1. Compliance;

2. Cultural competence;

3. Provision of services, including referral services, for clients that are indigent, have no source of third party payment, or both, including:

a. Procedures to follow when a client is rejected for lack of a third-party payment source or when a client is discharged for nonpayment of care.

b. Coordinated referral plans for clients that the provider lacks the capacity to provide medically necessary Outpatient Behavioral Health Services. Coordinated referral plans must:

i. Identify in the client record the medically necessary Outpatient Behavioral Health Services that the provider cannot or will not furnish;

ii. State the reason(s) in the client record that the provider cannot or will not furnish the care;

iii. Provide quality-control processes that assure compliance with care, discharge, and transition plans.

IX. STAFFING REQUIREMENTS FOR CERTIFICATION

A. At a minimum, Behavioral Health Agency staffing shall be sufficient to establish and implement services for each Behavioral Health Agency client, and must include the following:

1. **Chief Executive Officer/Executive Director (or functional equivalent) (full-time position or full-time equivalent positions)**: The person or persons identified to carry out CEO/ED functions:

a. Is/are ultimately responsible for applicant/provider organization, staffing, policies and practices, and Behavioral Health Agency service delivery;

b. Must possess a master's degree in behavioral health care, management, or a related field and experience, and meet any additional qualifications required by the provider's governing body. Other job- related education, experience, or both, may be substituted for all or part of these requirements upon approval of the provider's governing body.

2. **Clinical Director (or functional equivalent) (full-time position or full-time equivalent positions)**: The person or persons identified to carry out clinical director functions must:

   a. Report directly to the CEO/ED;

   b. Be the DHS contact for clinical and practice-related issues;

   c. Be accountable for all clinical services (professional and paraprofessional);

   d. Be responsible for Behavioral Health Agency care and service quality and compliance;

   e. Assure that all services are provided within each practitioner's scope of practice under Arkansas law and under such supervision as required by law for practitioners not licensed to practice independently;

   f. Assure and document in the provider's official records the direct supervision of MHP's, either personally or through a documented chain of supervision.

   g. Assure that licensed mental health professionals directly supervise Qualified Behavioral Health Providers. Direct supervision ratios must not exceed one licensed mental health professional to ten (10) Qualified Behavioral Health Providers;

   h. Possess independent Behavioral Health licensure in Arkansas as a Licensed Psychologist, Licensed Certified Social Worker, (LCSW), Licensed Psychological Examiner – Independent (LPE-I), Licensed Professional Counselor (LPC), Licensed Marriage and Family Therapist (LMFT), or an Advanced Practice Nurse or Clinical Nurse Specialist (APN or CNS) with a specialty in psychiatry or mental health and a minimum of two years clinical experience post master's degree.

3. **Mental Health Professionals (Independently Licensed Clinicians, Non-Independently Licensed Clinicians):**

   a. MHP's may:

      i. Provide direct behavioral health care;

      ii. Delegate and oversee work assignments of Qualified Behavioral Health Provider's;

      iii. Delegate and oversee work assignments of Certified Peer Specialists, Certified Youth Support Specialists, and Certified Family Support Partners

iv. Ensure compliance and conformity to the provider's policies and procedures;

v. Provide direct supervision of Qualified Behavioral Health Provider's;

vi. Provider direct supervision of Certified Peer Specialists, Certified Youth Support Specialists, and Certified Family Support Partners

vii. Provide case consultation and in-service training;

viii. Observe and evaluate performance of Qualified Behavioral Health Provider's.

ix. Observe and evaluate performance of Certified Peer Specialists, Certified Youth Support Specialists, and Certified Family Support Partners

b. MHP Supervision:

i. Communication between an MHP and the MHP's supervisor must include each of the following at least every twelve (12) months:

1. Assessment and referral skills, including the accuracy of assessments;

2. Appropriateness of treatment or service interventions in relation to the client needs;

3. Treatment/intervention effectiveness as reflected by the client meeting individual goals;

4. Issues of ethics, legal aspects of clinical practice, and professional standards;

5. The provision of feedback that enhances the skills of direct service personnel;

6. Clinical documentation issues identified through ongoing compliance review;

7. Cultural competency issues;

8. All areas noted as deficient or needing improvement.

ii. Documented client-specific face-to-face and other necessary communication regarding client care must occur between each MHP's supervisor and the MHP periodically (no less than every ninety (90) calendar days) in accordance with a schedule maintained in the provider's official records.

4. Qualified Behavioral Health Providers (Including Certified Peer Support

Specialist,):

a. Are MHP service extenders;

b. Qualified Behavioral Health Provider supervision must conform to the requirements for MHP supervision (See § IX (3)(b)) except that all requirements must be met every six (6) months, and one or more licensed health care professional(s) acting within the scope of his or her practice must have a face-to-face contact with each Qualified Behavioral Health Provider for the purpose of clinical supervision at least every fourteen (14) days, must have at least twelve (12) such face-to-face contacts every ninety (90) days, and such additional face-to-face contacts as are necessary in response to a client's unscheduled care needs, response or lack of response to treatment, or change of condition;

c. Providers must establish that Qualified Behavioral Health Provider supervision occurred via individualized written certifications created by a licensed mental health professional and filed in the provider's official records on a weekly basis, certifying:

    i. That the licensed mental health professional periodically (in accordance with a schedule tailored to the client's condition and care needs and previously recorded in the provider's official records) communicated individualized client-specific instructions to the mental health paraprofessional describing the manner and methods for the delivery of paraprofessional services;

    ii. That the licensed mental health professional periodically (in accordance with a schedule tailored to the client's condition and care needs and previously recorded in the provider's official records, but no less than every 30 days) personally observed the mental health paraprofessional delivering services to a client; that the observations were of sufficient duration to declare whether paraprofessional services complied with the licensed mental health professional's instructions;

    iii. The date, time, and duration of each supervisory communication with and observation of a Qualified Behavioral Health Provider.

d. The Behavioral Health Agency is responsible for ensuring Qualified Behavioral Health Providers that are not certified as Certified Peer Support Specialists, successfully complete training in behavioral health services provision from a licensed medical person experienced in the area of behavioral health, a certified Behavioral Agency, or a facility licensed by the State Board of Education before providing care to Medicaid beneficiaries.

    i. The Qualified Behavioral Health Provider must receive orientation to the Behavioral Health Agency.

    ii. The Qualified Behavioral Health Provider training course offered for those individuals not certified as Certified Peer Support Specialist, must total a minimum of forty (40) classroom hours and must be successfully completed within a maximum time of the first two (2) months of employment by the

Behavioral Health Agency.

iii. The training curriculum must contain information specific to the population being served, i.e. adult, dually diagnosed, etc. The curriculum must include, but is not limited to:

1. Communication skills.
2. Knowledge of behavioral health illnesses.
3. How to be an appropriate role model.
4. Behavior management.
5. Handling emergencies.
6. Record keeping: observing beneficiary, reporting or recording observations, time, or employment records.
7. Knowledge of clinical limitations.
8. Knowledge of appropriate relationships with beneficiary.
9. Group interaction.
10. Identification of real issues.
11. Listening techniques.
12. Confidentiality.
13. Knowledge of medications and side effects.
14. Daily living skills.
15. Hospitalization procedures single-point-of-entry.
16. Knowledge of the Supplemental Security Income (SSI) application process.
17. Knowledge of day treatment models proper placement levels.
18. Awareness of options.
19. Cultural competency.
20. Ethical issues in practice.
21. Childhood development, if serving the child and adolescent population.

iv. A written examination of the Qualified Behavioral Health Provider's that are not certified as Certified Peer Support Specialists, knowledge of the 40-hour classroom training curriculum must be successfully completed.

v. Evaluation of the Qualified Behavioral Health Provider's ability to perform daily living skills (DLS) for mental health services must be successfully completed by means of a skills test.

vi. The Qualified Behavioral Health Provider who successfully completes the training must be awarded a certificate. This certificate must state the person is qualified to work in an agency under professional supervision as a Qualified Behavioral Health Provider.

vii. In-service training sessions are required at a minimum of once per 12-month period after the successful completion of the initial 40-hour classroom training for Qualified Behavioral Health Specialists not certified as Certified Peer Support Specialist, The in-service training must total a minimum of eight (8) hours each 12-month period beginning with the date of certification as a Qualified Behavioral Health Provider and each 12-month period thereafter.

The in-service training may be conducted, in part, in the field. Documentation of in-service hours will be maintained in the employee's personnel record and will be available for inspection by regulatory agencies.

5. Corporate Compliance Officer:

a. Manages policy, practice standards and compliance, except compliance that is the responsibility of the medical records librarian;

b. Reports directly to the CEO/ED (except in circumstances where the compliance officer is required to report directly to a director, the board of directors, or an accrediting or oversight agency);

c. Has no direct responsibility for billings or collections;

d. Is the DHS and Medicaid contact for DHS certification, Medicaid enrollment, and compliance.

6. Medical Director:

a. Oversees Behavioral Health Agency care planning, coordination, and delivery, and specifically:

i. Diagnoses, treats, and prescribes for behavioral illness;

ii. Is responsible and accountable for all client care, care planning, care coordination, and medication storage;

iii. Assures that physician care is available 24 hours a day, 7 days a week;

iv. May delegate client care to other physicians, subject to documented oversight and approval;

v. Assures that a physician participates in treatment planning and reviews;

vi. If the medical director is not a psychiatrist, a psychiatrist certified by one of the specialties of the American Board of Medical Specialties must serve as a consultant to the medical director and to other staff, both medical and non-medical. If the provider serves clients under the age of twenty-one (21), the medical director shall have access to a board certified child psychiatrist, for example, through the Psychiatric Research Institute child/Adolescent Telephone Consultation Service;

vii. Medical director services may be acquired by contract.

b. If the medical director is not a psychiatrist then the medical director shall contact a consulting psychiatrist within twenty-four (24) hours in the following situations:

i. When antipsychotic or stimulant medications are used in dosages

higher than recommended in guidelines published by the Arkansas Department of Human Services Division of Medical Services;

ii. When two (2) or more medications from the same pharmacological class are used;

iii. When there is significant clinical deterioration or crisis with enhanced risk of danger to self or others.

c. The consulting psychiatrist(s) shall participate in quarterly quality assurance meetings.

7. **Privacy Officer:** Develops and implements policies to assure compliance with privacy laws, regulations, and rules. Applicants/providers may assign privacy responsibilities to the Corporate Compliance Officer, Grievance Officer, or Medical Records Librarian, but not the CEO/ED.

8. **Quality Control Manager:** Chairs the quality assurance committee and develops and implements quality control and quality improvement activities. Applicants/providers may assign quality control manager responsibilities to the Corporate Compliance Officer or Medical Records Manager, but not the CEO/ED.

9. **Grievance Officer:**

a. Develops and implements the applicant's/provider's employee and client grievance procedures.

b. Effectively communicates grievance procedures to staff, contractors, prospective clients, and clients. Communications to clients who are legally incapacitated shall include communication to the client's responsible party.

c. The grievance officer shall not have any duties that may cause him/her to favor or disfavor any grievant.

10. **Medical Records Librarian:**

a. Must be qualified by education, training, and experience to understand and apply:

i. Medical and behavioral health terminology and usages covering the full range of services offered by the provider;

ii. Medical records forms and formats;

iii. Medical records classification systems and references such as The American Psychiatric Association's Diagnostic and Statistical Manual – IV-TR (DSM-IV-TR) and subsequent editions, International Classification of Diseases (ICD), Diagnostic Related Groups (DRG's), Physician's Desk Reference (PDR), Current Procedural Terminology (CPT), medical dictionaries, manuals, textbooks, and glossaries.

iv. Legal and regulatory requirements of medical records to assure the record is acceptable as a legal document;

v. Laws and regulations on the confidentiality of medical records (Privacy Act and Freedom of Information Act) and the procedures for informed consent for release of information from the record.

vi. The interrelationship of record services with the rest of the facility's services.

b. Develops and implements:

i. The client information system;

ii. Operating methods and procedures covering all medical records functions.

iii. Insures that the medical record is complete, accurate, and compliant.

11. Licensed Psychologist, Licensed Psychological Examiner (LPE), or Licensed Psychological Examiner – Independent (LPE-I):

a. Provides psychological evaluations;

b. Each licensed psychological examiner or licensed psychological examiner-I must have supervision agreements with a doctoral psychologist to provide appropriate supervision or services for any evaluations or procedures that are required under or are outside the psychological examiner's scope of independent practice. Documentation of such agreements and of all required supervision and other practice arrangements must be included in the psychological examiner's personnel record;

c. Services may be acquired by contract.

B. Multidisciplinary Team(s): Any client identified as Tier 2 by the independent assessment shall be assigned a multidisciplinary team that includes professionals and qualified behavioral health providers as necessary to ensure coordination of each client's Outpatient Behavioral Health Services. All Tier 2 clients require the development of a Master Treatment Plan with ongoing reviews at least every one-hundred and eighty (180) calendar days.

For clients not eligible for Rehabilitative (Tier 2) Level or Intensive (Tier 3) Level services, he services offered in the Counseling Level (Tier 1) are a limited array of counseling services provided by a master's level clinician. Establishment of goals and a plan to reach those goals is part of good clinical practice and can be developed with the client during the Mental Health Diagnostic Assessment and Interpretation of Diagnosis. Clinicians should assess client's response to treatment at each session which should include a review of progress towards mutually agreed upon goals.

C. Quality Assurance Meetings:

Each provider must hold a quarterly quality assurance meeting.

D. Health Care Professional Notification/Disqualification:

1. Notice of covered health care practitioners:

a. Within twenty (20) days of the effective date of this rule, applicants/providers must notify the Office of Medicaid Inspector General (OMIG) of the names of covered health care practitioners who are providing Outpatient Behavioral Health Services.

b. On or before the tenth day of each month, providers must notify the Office of Medicaid Inspector General (OMIG) of the names of all covered health care practitioners who are providing Outpatient Behavioral Health Services and whose names were not previously disclosed.

2. Licensed health care professionals may not furnish Outpatient Behavioral Health Services during any time the professional's license is subject to adverse license action.

3. Applicants/providers may not employ/engage a covered health care practitioner after learning that the practitioner:

a. Is excluded from Medicare, Medicaid, or both;

b. Is debarred under Ark. Code Ann. § 19-11-245;

c. Is excluded under DHS Policy 1088; or

d. Was subject to a final determination that the provider failed to comply with professionally recognized standards of care, conduct, or both. For purposes of this subsection, "final determination" means a final court or administrative adjudication, or the result of an alternative dispute resolution process such as arbitration or mediation.

E. Applicants/providers must maintain documentation identifying the primary work location of all mental health professionals and qualified behavioral health providers providing services on behalf of the Behavioral Health Agency.

F. Providers must maintain copies of disclosure forms signed by the client, or by the client's parent or guardian before Outpatient Behavioral Health Services are delivered except in emergencies. Such forms must at a minimum:

1. Disclose that the services to be provided are Outpatient Behavioral Health Services;

2. Explain Outpatient Behavioral Health Services eligibility, SED and SMI criteria;

3. Contain a brief description of the Behavioral Health Agency services;

4. Explain that all Outpatient Behavioral Health Services care must be medically

necessary;

5. Disclose that third party (e.g., Medicaid or insurance) Outpatient Behavioral Health Service payments may be denied based on the third party payer's policies or rules;

6. Identify and define any services to be offered or provided in addition to those offered by the Behavioral Health Agency, state whether there will be a charge for such services, and if so, document payment arrangements;

7. Notify that services may be discontinued by the client at any time;

8. Offer to provide copies of Behavioral Health Agency and Outpatient Behavioral Health Services rules;

9. Provide and explain contact information for making complaints to the provider regarding care delivery, discrimination, or any other dissatisfaction with care provided by the Behavioral Health Agency;

10. Provide and explain contact information for making complaints to state and federal agencies that enforce compliance under § III(G)(1).

G. Outpatient Behavioral Health Services maintained at each site must include:

1. Psychiatric Evaluation and Medication Management;

2. Outpatient Services, including individual and family therapy at a minimum;

3. Crisis Services.

L. Providers must tailor all Outpatient Behavioral Health Services care to individual client need. If client records contain entries that are materially identical, DHS and the Division of Medical Services will, by rebuttable presumption, that this requirement is not met.

M. Outpatient Behavioral Health Services for individuals under age eighteen (18): Providers must establish and implement policies for family identification and engagement in treatment for persons under age eighteen (18), including strategies for identifying and overcoming barriers to family involvement.

N. Emergency Response Services: Applicants/providers must establish, implement, and maintain a site-specific emergency response plan, which must include:

1. A 24-hour emergency telephone number;

2. The applicant/provider must:

a. Provide the 24-hour emergency telephone number to all clients;

b. Post the 24-hour emergency number on all public entries to each site;

c. Include the 24-hour emergency phone number on answering machine greetings;

d. Identify local law enforcement and medical facilities within a 50-mile radius that may be emergency responders to client emergencies.

3. Direct access to a mental health professional within fifteen (15) minutes of an emergency/crisis call and face-to-face crisis assessment within two (2) hours;

4. Response strategies based upon:

   a. Time and place of occurrence;

   b. Individual's status (client/non-client);

   c. Contact source (family, law enforcement, health care provider, etc.).

5. Requirements for a face-to-face response to requests for emergency intervention received from a hospital or law enforcement agency regarding a current client.

6. All face-to-face emergency responses shall be:

   a. Available 24 hours a day, 7 days a week;

   b. Made by a mental health professional within two (2) hours of request (unless a different time frame is within clinical standards guidelines and mutually agreed upon by the requesting party and the MHP responding to the call).

7. Emergency services training requirements to ensure that emergency service are age-appropriate and comply with accreditation requirements. Providers shall maintain documentation of all emergency service training in each trainee's personnel file.

8. Requirements for clinical review by the clinical supervisor or emergency services director within 24 hours of each after-hours emergency intervention with such additional reporting as may be required by the provider's policy.

9. Requirements for documentation of all crisis calls, responses, collaborations, and outcomes;

10. Requirements that emergency responses not vary based on the client's funding source. If a client is eligible for inpatient behavioral health care funded through the community mental health centers and the provider is not a community mental health center with access to these funds, the provider must:

    a. Determine whether the safest, least restrictive alternative is psychiatric hospitalization; and

    b. Contact the appropriate community mental health center (CMHC) for consult and to request the CMHC to access local acute care funds for those over 21.

O. Each applicant/provider must establish and maintain procedures, competence, and capacity:

1. For assessment and individualized care planning and delivery;

2. For discharge planning integral to treatment;

3. For mobile care;

4. To assure that each mental health professional makes timely clinical disposition decisions;

5. To make timely referrals to other services;

6. To refer for inpatient services or less restrictive alternative;

7. To identify clients who need direct access to clinical staff, and to promptly provide such access.

P. Each applicant/provider must establish, maintain, and document a quality improvement program, to include:

1. Evidence based practices;

2. Use of agency wide outcomes measures to improve both client care and clinical practice that are approved by the agency's national accrediting organization. The following must be documented:

a. Measured outcomes

b. Sample report

c. Collection of outcomes, beginning at the initial mental health diagnosis service, which would be completed very close to the client's intake.

3. Requirements for informing all clients and clients' responsible parties of the client's rights while accessing services.

4. Regular (at least quarterly) quality assurance meetings that include:

a. Clinical Record Reviews: medical record reviews of a minimum number of randomly selected charts. The minimum number is the lesser of a statistically valid sample yielding 95% confidence with a 5% margin of error; or 10% of all charts open at any time during the past three (3) months;

b. Program and services reviews that:

i. Assess and document whether care and services meet client needs;

ii. Identify unmet behavioral health needs;

iii. Establish and implement plans to address unmet needs.

X. HOME OFFICE:

A. Each provider must maintain and identify a home office in the State of Arkansas;

B. The home office may be located at a site or may be solely an administrative office not requiring site certification;

C. The home office is solely responsible for governance and administration of all of the provider's Arkansas sites;

D. Home office governance and administration must be documented in a coordinated management plan;

E. The home office shall establish policies for maintaining client records, including policies designating where the original records are stored.

XI. SITE REQUIREMENTS

A. All sites must be located in the State of Arkansas;

B. Accreditation documentation must specifically include each site.

XII. SITE RELOCATION, OPENING, AND CLOSING (Note: temporary service disruptions caused by inclement weather or power outages are not "closings.")

A. Planned Closings:

1. Upon deciding to close a site either temporarily or permanently, the provider immediately must provide written notice to clients, DHS, the Division of Medical Services, the Medicaid fiscal agent, and the accrediting organization.

2. Notice of site closure must state the site closure date;

3. If site closure is permanent, the site certification expires at 12:00 a.m. the day following the closure date stated in the notice;

4. If site closing is temporary, and is for reasons unrelated to adverse governmental action, DHS may suspend the site certification for up to one (1) year if the provider maintains possession and control of the site. If the site is not operating and in compliance within the time specified in the site certification suspension, the site certification expires at 12:00 a.m. the day after the site certification suspension ends.

B. Unplanned Closings:

1. If a provider must involuntarily close a site due to, for example, fire, natural disaster, or adverse governmental action, the provider must immediately notify clients and families, DHS, the Division of Medical Services, the Medicaid fiscal agent, and the accrediting organization of the closure and the reason(s) for the closure.

2. Site certification expires in accordance with any pending regulatory action, or, if no regulatory action is pending, at 12:00 a.m. the day following permanent closure.

C. All Closings:

1. Providers must assure and document continuity of care for all clients who receive Outpatient Behavioral Health Services at the site;

2. Notice of Closure and Continuing Care Options:

a. Providers must assure and document that clients and families receive actual notice of the closure, the closure date, and any information and instructions necessary for the client to obtain transition services;

b. After documenting that actual notice to a specific client was impossible despite the exercise of due diligence, providers may satisfy the client notice requirement by mailing a notice containing the information described in subsection (a), above, to the last known address provided by the client; and

c. Before closing, providers must post a public notice at each site entry. The public notice must include the name and contact information for all Behavioral Health Agencies within a fifty (50) mile radius of the site.

3. An acceptable transition plan is described below:

Transition Plan:
1. Identify and list all certified sites within a 50 mile radius. Include telephone numbers and physical addresses on the list.
2. Provide clients/families with the referral information and have them sign a transfer of records form/release of information to enable records to be transferred to the provider of their choice.
3. Transfer records to the designated provider.

4. Designate a records retrieval process as specified in Section I of the Arkansas Medicaid Outpatient Behavioral Health Services Provider Policy Manual § 142.300.

5. Submit a reporting of transfer to DHS (Attn: Policy & Certification Office) including a list of client names and the disposition of each referral. See example below:

Name	Referred to:	Records Transfer Status:	RX Needs Met By:
Johnny	OP Provider Name	to be delivered 4/30/20XX	Provided 1 month RX
Mary	Private Provider Name	Delivered 4/28/20XX	No Meds
Judy	Declined Referral	XX	

6. DHS may require additional information regarding documentation of client transfers to ensure that client needs are addressed and met.

DHS BEHAVIORAL HEALTH AGENCY Form 220 shall be used when a site is to be closed.

D. New Sites: Use DHS BEHAVIORAL HEALTH AGENCY Form 250 to apply for new sites, which would include a new Medicaid provider ID number for that site.

E. Site Transfer:

1. At least forty-five (45) calendar days before a proposed transfer of an accredited site, the provider must apply to DHS to transfer site certification. The application must include documentation that:

   a. The provider notified the accrediting entity, and the accrediting entity has extended or will extend accreditation to the second site; or

   b. The accrediting entity has established an accreditation timeframe.

2. The provider must notify clients and families, DHS, the Division of Medical Services, the Medicaid fiscal agent, and the accrediting organization at least thirty (30) calendar days before the transfer;

3. DHS does not require an on-site survey, nor does the Division of Medical Services require a new Medicaid provider number. Please use DHS BEHAVIORAL HEALTH AGENCY Form 220 for a site move or transfers.

F. Site Relocation: The provider must follow the rules for closing the original site, and the rules for opening a new site.

XIII. PROVIDER RE-CERTIFICATION:

A. The term of DHS site certification is concurrent with the provider's national accreditation cycle, except that site certification extends six (6) months past the accreditation

expiration month if there is no interruption in the accreditation. (The six-month extension is to give the Behavioral Health Agency time to receive a final report from the accrediting organization, which the provider must immediately forward to DHS.)

B. Providers must furnish DHS a copy of:

1. Correspondence related to the provider's request for re-accreditation:

a. Providers shall send DHS copies of correspondence from the accrediting agency within five (5) business days of receipt;

b. Providers shall furnish DHS copies of correspondence to the accrediting organization concurrently with sending originals to the accrediting organization.

2. An application for provider and site recertification:

a. DHS must receive provider and site recertification applications at least fifteen (15) business days before the DHS Behavioral Health Agency certification expiration date;

b. The Re-Certification form with required documentation is DHS BEHAVIORAL HEALTH AGENCY Form 230 and is available at www.arkansas.gov/dhs/dhs.

C. If DHS has not recertified the provider and site(s) before the certification expiration date, certification is void beginning 12:00 a.m. the next day.

XIV. MAINTAINING DHS BEHAVIORAL HEALTH AGENCY CERTIFICATION:

A. Providers must:

1. Maintain compliance;

2. Assure that DHS certification information is current, and to that end must notify DHS within thirty (30) calendar days of any change affecting the accuracy of the provider's certification records;

3. Furnish DHS all correspondence in any form (e.g., letter, facsimile, email) to and from the accrediting organization to DHS within thirty (30) calendar days of the date the correspondence was sent or received except:

a. As stated in § XII;

b. Correspondence related to any change of accreditation status, which providers must send to DHS within three (3) calendar days of the date the correspondence was sent or received.

c. Correspondence related to changes in service delivery, site location, or organizational structure, which providers must send to DHS within ten (10) calendar days of the date the correspondence was sent or received.

4. Display the Behavioral Health Agency certificate for each site at a prominent public

location within the site

B. Annual Reports:

1. Providers must furnish annual reports to DHS before July 1 of each year that the provider has been in operation for the preceding twelve (12) months. Community Mental Health Centers and specialty clinics may meet this requirement by submitting the Annual Plan/Basic Services Plan to DHS.

1. Annual report shall be prepared by completing forms provided by DHS. Please use DHS BEHAVIORAL HEALTH AGENCY Form 240 for the Behavioral Health Agency annual report.

XV. NONCOMPLIANCE

A. Failure to comply with this rule may result in one or more of the following:

1. Submission and implementation of an acceptable corrective action plan as a condition of retaining Behavioral Health Agency certification;

2. Suspension of Behavioral Health Agency certification for either a fixed period or until the provider meets all conditions specified in the suspension notice;

3. Termination of Behavioral Health Agency certification.

XVI. APPEAL PROCESS

A. If DHS denies, suspends, or revokes any Behavioral Health Agency certification (takes adverse action), the affected proposed provider or provider may appeal the DHS adverse action. Notice of adverse action shall comply with Ark. Code Ann. §§ 20-77-1701-1705, and §§1708-1713. Appeals must be submitted in writing to the DHS. The provider has thirty (30) calendar days from the date of the notice of adverse action to appeal. An appeal request received within thirty-five (35) calendar days of the date of the notice will be deemed timely. The appeal must state with particularity the error or errors asserted to have been made by DHS in denying certification, and cite the legal authority for each assertion of error. The provider may elect to continue Medicaid billing under the Behavioral Health Agency program during the appeals process. If the appeal is denied, the provider must return all monies received for Behavioral Health Agency services provided during the appeals process.

B. Within thirty (30) calendar days after receiving an appeal DHS shall: (1) designate a person who did not participate in reviewing the application or in the appealed-from adverse decision to hear the appeal; (2) set a date for the appeal hearing; (3) notify the appellant in writing of the date, time, and place of the hearing. The hearing shall be set within sixty (60) calendar days of the date DHS receives the request for appeal, unless a party to the appeal requests and receives a continuance for good cause.

C. DHS shall tape record each hearing.

D. The hearing official shall issue the decision within forty-five (45) calendar days of the

date that the hearing record is completed and closed. The hearing official shall issue the decision in a written document that contains findings of fact, conclusions of law, and the decision. The findings, conclusions, and decision shall be mailed to the appellant except that if the appellant is represented by counsel, a copy of the findings, conclusions, and decision shall also be mailed to the appellant's counsel. The decision is the final agency determination under the Administrative Procedure Act.

E. Delays caused by the appealing party shall not count against any deadline. Failure to issue a decision within the time required is not a decision on the merits and shall not alter the rights or status of any party to the appeal, except that any party may pursue legal process to compel the hearing official to render a decision.

F. Except to the extent that they are inconsistent with this policy, the appeal procedures in the Arkansas Medicaid Outpatient Behavioral Health Services Provider Manual are incorporated by reference and shall control.

Arkansas Department of Human Services

Behavioral Health Agency Certification Manual

Revised: 7/1/17

www.arkansas.gov/dhs/dhs

I. PURPOSE:

A. To assure that Outpatient Behavioral Health Services ("OBHS") care and services provided by certified Behavioral Health Agencies comply with applicable laws, which require, among other things, that all care reimbursed by the Arkansas Medical Assistance Program ("Medicaid") must be provided efficiently, economically, only when medically necessary, and is of a quality that meets professionally recognized standards of health care.

B. The requirements and obligations imposed by §§ I-XIII of this rule are substantive, not procedural.

II. SCOPE:

A. Current Behavioral Health Agency certification under this policy is a condition of Medicaid provider enrollment.

B. Department of Human Services ("DHS") Behavioral Health Agency certification must be obtained for each site before application for Medicaid provider enrollment. An applicant may submit one application for multiple sites, but DHS will review each site separately and take separate certification action for each site.

~~B.~~C. This certification policy applies only to providers in the provision of services in the AR Medicaid fee for service program.

III. DEFINITIONS:

A. "50 mile radius" means 50 miles from a certified site by driving distance. Driving distance is calculated by a method of utilizing a standardized mapping application.

B. "Accreditation" means full accreditation (preliminary, expedited, probationary, pending, conditional, deferred or provisional accreditations will not be accepted) as an outpatient behavioral health care provider issued by at least one of the following:

- Commission on Accreditation for Rehabilitative Facilities (CARF) Behavioral Health Standards Manual
- The Joint Commission (TJC) Comprehensive Accreditation Manual for Behavioral Health Care
- Council on Accreditation (COA) Outpatient Mental Health Services Manual

Accreditation timing for specific programs is defined in the applicable DHS Certification manual for that program.

C. "Adverse license action" means any action by a licensing authority that is related to client care, any act or omission warranting exclusion under DHS Policy 1088, or that imposes any restriction on the licensee's practice privileges. The action is deemed to exist when the licensing entity imposes the adverse action except as provided in Ark. Code Ann. § 25-15-211 (c).

D. “Applicant” means an outpatient behavioral health care agency that is seeking DHS certification as a Behavioral Health Agency.

E. “Certification” means a written designation, issued by DHS, declaring that the provider has demonstrated compliance as declared within and defined by this rule.

F. “Client” means any person for whom a Behavioral Health Agency furnishes, or has agreed or undertaken to furnish, Outpatient Behavioral Health services.

G. “Client Information System” means a comprehensive, integrated system of clinical, administrative, and financial records that provides information necessary and useful to deliver client services. Information may be maintained electronically, in hard copy, or both.

H. “Compliance” means conformance with:

1. Applicable state and federal laws, rules, and regulations including, without limitation:

    a. Titles XIX and XXI of the Social Security Act and implementing regulations;
    b. Other federal laws and regulations governing the delivery of health care funded in whole or in part by federal funds, for example, 42 U.S.C. § 1320c-5;
    c. All state laws and rules applicable to Medicaid generally and to Outpatient Behavioral Health services specifically;
    d. Title VI of the Civil Rights Act of 1964 as amended, and implementing regulations;
    e. The Americans With Disabilities Act, as amended, and implementing regulations;
    f. The Health Insurance Portability and Accountability Act (“HIPAA”), as amended and implementing regulations.

2. Accreditation standards and requirements.

I. “Contemporaneous” means by the end of the performing provider’s first work period following the provision of care of services to be documented, or as provided in the Outpatient Behavioral Health Services manual, whichever is longer.

J. “Coordinated Management Plan” means a plan that the provider develops and carries out to assure compliance and quality improvement.

K. “Corrective Action Plan” (CAP) means a document that describes both short- term remedial steps to achieve compliance and permanent practices and procedures to sustain compliance.

L. “Covered Health Care Practitioner” means: Any practitioner providing Outpatient Behavioral Health Services that is allowable to be reimbursed pursuant to the Outpatient Behavioral Health Services Medicaid Manual.

M. “Cultural Competency” means the ability to communicate and interact effectively with people of different cultures, including people with disabilities and atypical lifestyles.

N. “Deficiency” means an item or area of noncompliance.

O. “DHS” means the Arkansas Department of Human Services.

P. “Emergency Behavioral Health Agency services” means nonscheduled Behavioral Health Agency services delivered under circumstances where a prudent layperson with an average knowledge of behavioral health care would reasonably believe that Behavioral Health Agency services are immediately necessary to prevent death or serious impairment of health.

Q. “Medical Director” means a physician that oversees the planning and delivery of all Behavioral Health Agency services delivered by the provider.

R. “Mental health professional” or “MHP” means a person who possesses an Arkansas license to provide clinical behavioral health care. The license must be in good standing and not subject to any adverse license action.

S. “Mobile care” means a face-to-face intervention with the client at a place other than a certified site operated by the provider. Mobile care must be:

1. Either clinically indicated in an emergent situation or necessary for the client to have access to care in accordance with the care plan;

2. Delivered in a clinically appropriate setting; and

3. Delivered where Medicaid billing is permitted if delivered to a Medicaid eligible client.

Mobile care may include medically necessary behavioral health care provided in a school that is within a fifty (50) mile radius of a certified site operated by the provider.

T. “Multi-disciplinary team” means a group of professionals from different disciplines that provide comprehensive care through individual expertise and in consultation with one another to accomplish the client’s clinical goals. Multi- disciplinary teams promote coordination between agencies; provide a "checks and balances" mechanism to ensure that the interests and rights of all concerned parties are addressed; and identify service gaps and breakdowns in coordination or communication between agencies or individuals.

U. “NPDB” means the United States Department of Health and Human Services, Health Resources and Services Administration National Provider Data Bank.

V. “Performing provider” means the individual who personally delivers a care or service directly to a client.

W. “Professionally recognized standard of care” means that degree of skill and learning commonly applied under all the circumstances in the community by the average prudent reputable member of the profession. Conformity with Substance Abuse and Mental Health Services Administration (SAMHSA) evidence-based practice models is evidence of compliance with professionally recognized standards of care.

X. “Provider” means an entity that is certified by DHS and enrolled by DMS as a Behavioral Health Agency

Y. “Qualified Behavioral Health Provider” means a person who:

1. Does not possess an Arkansas license to provide clinical behavioral health care;

2. Works under the direct supervision of a mental health professional;

3. Has successfully completed prescribed and documented courses of initial and annual training sufficient to perform all tasks assigned by a mental health professional;

4. Acknowledges in writing that all qualified behavioral health provider services are controlled by client care plans and provided under the direct supervision of a mental health professional.

Z. “Quality assurance (QA) meeting” means a meeting held at least quarterly for systematic monitoring and evaluation of clinic services and compliance. See also, Medicaid Outpatient Behavioral Health Services Manual, § 212.000.

AA. “Reviewer” means a person employed or engaged by:

1. DHS or a division or office thereof;

2. An entity that contracts with DHS or a division or office thereof.

BB. “Site” means a distinct place of business dedicated to the delivery of Outpatient Behavioral Health Services within a fifty (50) mile radius. Each site must be a bona fide Behavioral Health Agency, meaning a behavioral health outpatient clinic providing all the services specified in this rule and the Medicaid Outpatient Behavioral Health Services Manual. Sites may not be adjuncts to a different activity such as a school, a day care facility, a long-term care facility, or the office or clinic of a physician or psychologist.

CC. “Site relocation” means closing an existing site and opening a new site no more than a fifty (50) mile radius from the original site.

DD. “Site transfer” means moving existing staff, program, and clients from one physical location to a second location that is no more than a fifty (50) mile radius from the original site.

EE. “Supervise” as used in this rule means to direct, inspect, observe, and evaluate performance.

FF. “Supervision documentation” means written records of the time, date, subject(s), and duration of supervisory contact maintained in the provider’s official records.

IV. COMPLIANCE TIMELINE:

A. Entities currently certified as Rehabilitative Services for Persons with Mental Illness (RSPMI) providers will be grandfathered in as certified Behavioral Health Agencies. Current RSPMI agency recertification procedures are based upon national accreditation timelines. Behavioral Health Agency recertification will also be based upon national accreditation timelines.

B. All entities in operation as of the effective date of this rule must comply with this rule within forty-five (45) calendar days in order to maintain certification.

C. DHS may authorize temporary compliance exceptions for new accreditation standards that require independent site surveys and specific service subset accreditations. Such compliance exceptions expire at the end of the provider's accreditation cycle and may not be renewed or reauthorized.

V. APPLICATION FOR DHS BEHAVIORAL HEALTH AGENCY CERTIFICATION:

A. New Behavioral Health Agency applicants must complete DHS BEHAVIORAL HEALTH AGENCY CERTIFICATION Form 100, DHS BEHAVIORAL HEALTH AGENCY FORM 200, and DHS BEHAVIORAL HEALTH AGENCY Form 210

B. DHS BEHAVIORAL HEALTH AGENCY CERTIFICATION Form 100, DHS BEHAVIORAL HEALTH AGENCY FORM 200, and DHS BEHAVIORAL HEALTH AGENCY Form 210 can be found at the following website: www.arkansas.gov/dhs/dhs

C. Applicants must submit the completed application forms and all required attachments for each proposed site to:

Department of Human Services
Division of Behavioral Health Services
Attn. Certification Office
305 S. Palm
Little Rock, AR 72205

D. Each applicant must be an outpatient behavioral health care agency:

1. Whose primary purpose is the delivery of a continuum of outpatient behavioral health services in a free standing independent clinic;

2. That is independent of any DHS certified Behavioral Health Agency.

E. Behavioral Health Agency certification is not transferable or assignable.

F. The privileges of a Behavioral Health Agency certification are limited to the certified site.

G. Providers may file Medicaid claims only for Outpatient Behavioral Health Services delivered by a performing provider engaged by the provider.

H. Applications must be made in the name used to identify the business entity to the Secretary of State and for tax purposes.

I. Applicants must maintain and document accreditation, and must prominently display certification of accreditation issued by the accrediting organization in a public area at each site. Accreditation must recognize and include all the applicant's Behavioral Health Agency programs, services, and sites.

1. Initial accreditation must include an on-site survey for each service site for which provider certification is requested. Accreditation documentation submitted to DHS must list all sites recognized and approved by the accrediting organization as the applicant's service sites.

2. Accreditation documentation must include the applicant's governance standards for operation and sufficiently define and describe all services or types of care (customer service units or service standards) the applicant intends to provide including, without limitation, crisis intervention/stabilization, in-home family counseling, outpatient treatment, day treatment, therapeutic foster care, intensive outpatient, medication management/pharmacotherapy.

3. Any outpatient behavioral health program associated with a hospital must have a free-standing behavioral health outpatient program national accreditation.

J. The applicant must attach the entity's family involvement policy to each application.

VI. APPLICATION REVIEW PROCESS:

A. Timeline:

1. DHS will review Behavioral Health Agency application forms and materials within ninety (90) calendar days after DHS receives a complete application package. (DHS will return incomplete applications to senders without review.)

2. For approved applications, a site survey will be scheduled within forty-five (45) calendar days of the approval date.

3. DHS will mail a survey report to the applicant within twenty-five (25) calendar days of the site visit. Providers having deficiencies on survey reports must submit an approvable corrective action plan to DHS within thirty-five (35) calendar days after the date of a survey report.

4. DHS will accept or reject each corrective action plan in writing within twenty (20) calendar days after receipt.

5. Within thirty (30) calendar days after DHS approves a corrective action plan, the applicant must document implementation of the plan and correction of the deficiencies listed in the survey report. Applicants who are unable, despite the exercise of reasonable diligence, to correct deficiencies within the time permitted

may obtain up to ten (10) additional days based on a showing of good cause.

6. DHS will furnish site-specific certificates via postal or electronic mail within ten (10) calendar days of issuing a site certification.

B. Survey Components: An outline of site survey components is available on the DHS website: www.arkansas.gov/dhs/dhs and is located in appendix # 7.

C. Determinations:

1. Application approved.

2. Application returned for additional information.

3. Application denied. DHS will state the reasons for denial in a written response to the applicant.

VII. DHS Access to Applicants/Providers:

A. DHS may contact applicants and providers at any time;

B. DHS may make unannounced visits to applicants/providers.

C. Applicants/providers shall provide DHS prompt direct access to applicant/provider documents and to applicant/provider staff and contractors, including, without limitation, clinicians, paraprofessionals, physicians, administrative, and support staff.

D. DHS reserves the right to ask any questions or request any additional information related to certification, accreditation, or both.

VIII. ADDITIONAL CERTIFICATION REQUIREMENTS:

A. Care and Services must:

1. Comply with all state and federal laws, rules, and regulations applicable to the furnishing of health care funded in whole or in part by federal funds; to all state laws and policies applicable to Arkansas Medicaid generally, and to Outpatient Behavioral Health Services specifically, and to all applicable Department of Human Services ("DHS") policies including, without limitation, DHS Participant Exclusion Policy § 1088.0.0. The Participant Exclusion Policy is available online at https://dhsshare.arkansas.gov/DHS%20Policies/Forms/By%20Policy.aspx

2. Conform to professionally recognized behavioral health rehabilitative treatment models.

3. Be established by contemporaneous documentation that is accurate and demonstrates compliance. Documentation will be deemed to be contemporaneous if recorded by the end of the performing provider's first work period following the provision of the care or services to be documented, or as provided in the Outpatient Behavioral Health Services manual, § 252.110, whichever is longer.

B. Applicants and Behavioral Health Agencies must:

1. Be a legal entity in good standing;

2. Maintain all required business licenses;

3. Adopt a mission statement to establish goals and guide activities;

4. Maintain a current organizational chart that identifies administrative and clinical chains of command.

C. Applicants/providers must establish and comply with operating policy that at a minimum implements credible practices and standards for:

1. Compliance;

2. Cultural competence;

3. Provision of services, including referral services, for clients that are indigent, have no source of third party payment, or both, including:

a. Procedures to follow when a client is rejected for lack of a third-party payment source or when a client is discharged for nonpayment of care.

b. Coordinated referral plans for clients that the provider lacks the capacity to provide medically necessary Outpatient Behavioral Health Services. Coordinated referral plans must:

i. Identify in the client record the medically necessary Outpatient Behavioral Health Services that the provider cannot or will not furnish;

ii. State the reason(s) in the client record that the provider cannot or will not furnish the care;

iii. Provide quality-control processes that assure compliance with care, discharge, and transition plans.

IX. STAFFING REQUIREMENTS FOR CERTIFICATION

A. At a minimum, Behavioral Health Agency staffing shall be sufficient to establish and implement services for each Behavioral Health Agency client, and must include the following:

1. **Chief Executive Officer/Executive Director (or functional equivalent) (full-time position or full-time equivalent positions)**: The person or persons identified to carry out CEO/ED functions:

a. Is/are ultimately responsible for applicant/provider organization, staffing, policies and practices, and Behavioral Health Agency service delivery;

b. Must possess a master's degree in behavioral health care, management, or a related field and experience, and meet any additional qualifications required by the provider's governing body. Other job- related education, experience, or both, may be substituted for all or part of these requirements upon approval of the provider's governing body.

2. **Clinical Director (or functional equivalent) (full-time position or full-time equivalent positions)**: The person or persons identified to carry out clinical director functions must:

   a. Report directly to the CEO/ED;

   b. Be the DHS contact for clinical and practice-related issues;

   c. Be accountable for all clinical services (professional and paraprofessional);

   d. Be responsible for Behavioral Health Agency care and service quality and compliance;

   e. Assure that all services are provided within each practitioner's scope of practice under Arkansas law and under such supervision as required by law for practitioners not licensed to practice independently;

   f. Assure and document in the provider's official records the direct supervision of MHP's, either personally or through a documented chain of supervision.

   g. Assure that licensed mental health professionals directly supervise Qualified Behavioral Health Providers. Direct supervision ratios must not exceed one licensed mental health professional to ten (10) Qualified Behavioral Health Providers;

   h. Possess independent Behavioral Health licensure in Arkansas as a Licensed Psychologist, Licensed Certified Social Worker, (LCSW), Licensed Psychological Examiner – Independent (LPE-I), Licensed Professional Counselor (LPC), Licensed Marriage and Family Therapist (LMFT), or an Advanced Practice Nurse or Clinical Nurse Specialist (APN or CNS) with a specialty in psychiatry or mental health and a minimum of two years clinical experience post master's degree.

3. **Mental Health Professionals (Independently Licensed Clinicians, Non-Independently Licensed Clinicians):**

   a. MHP's may:

      i. Provide direct behavioral health care;

      ii. Delegate and oversee work assignments of Qualified Behavioral Health Provider's;

      iii. Delegate and oversee work assignments of Certified Peer Specialists, Certified Youth Support Specialists, and Certified Family Support Partners

iv. Ensure compliance and conformity to the provider's policies and procedures;

v. Provide direct supervision of Qualified Behavioral Health Provider's;

vi. Provider direct supervision of Certified Peer Specialists, Certified Youth Support Specialists, and Certified Family Support Partners

vii. Provide case consultation and in-service training;

viii. Observe and evaluate performance of Qualified Behavioral Health Provider's.

ix. Observe and evaluate performance of Certified Peer Specialists, Certified Youth Support Specialists, and Certified Family Support Partners

b. MHP Supervision:

i. Communication between an MHP and the MHP's supervisor must include each of the following at least every twelve (12) months:

1. Assessment and referral skills, including the accuracy of assessments;

2. Appropriateness of treatment or service interventions in relation to the client needs;

3. Treatment/intervention effectiveness as reflected by the client meeting individual goals;

4. Issues of ethics, legal aspects of clinical practice, and professional standards;

5. The provision of feedback that enhances the skills of direct service personnel;

6. Clinical documentation issues identified through ongoing compliance review;

7. Cultural competency issues;

8. All areas noted as deficient or needing improvement.

ii. Documented client-specific face-to-face and other necessary communication regarding client care must occur between each MHP's supervisor and the MHP periodically (no less than every ninety (90) calendar days) in accordance with a schedule maintained in the provider's official records.

4. Qualified Behavioral Health Providers (Including Certified Peer Support

Specialist, ~~Certified Youth Support Specialist, Certified Family Support Partners~~):

a. Are MHP service extenders;

b. Qualified Behavioral Health Provider supervision must conform to the requirements for MHP supervision (See § IX (3)(b)) except that all requirements must be met every six (6) months, and one or more licensed health care professional(s) acting within the scope of his or her practice must have a face-to-face contact with each Qualified Behavioral Health Provider for the purpose of clinical supervision at least every fourteen (14) days, must have at least twelve (12) such face-to-face contacts every ninety (90) days, and such additional face-to-face contacts as are necessary in response to a client's unscheduled care needs, response or lack of response to treatment, or change of condition;

c. Providers must establish that Qualified Behavioral Health Provider supervision occurred via individualized written certifications created by a licensed mental health professional and filed in the provider's official records on a weekly basis, certifying:

    i. That the licensed mental health professional periodically (in accordance with a schedule tailored to the client's condition and care needs and previously recorded in the provider's official records) communicated individualized client-specific instructions to the mental health paraprofessional describing the manner and methods for the delivery of paraprofessional services;

    ii. That the licensed mental health professional periodically (in accordance with a schedule tailored to the client's condition and care needs and previously recorded in the provider's official records, but no less than every 30 days) personally observed the mental health paraprofessional delivering services to a client; that the observations were of sufficient duration to declare whether paraprofessional services complied with the licensed mental health professional's instructions;

    iii. The date, time, and duration of each supervisory communication with and observation of a Qualified Behavioral Health Provider.

d. The Behavioral Health Agency is responsible for ensuring Qualified Behavioral Health Providers that are not certified as Certified Peer Support Specialists, ~~Certified Youth Support Specialists, or Certified Family Support Partners~~ successfully complete training in behavioral health services provision from a licensed medical person experienced in the area of behavioral health, a certified Behavioral Agency, or a facility licensed by the State Board of Education before providing care to Medicaid beneficiaries.

    i. The Qualified Behavioral Health Provider must receive orientation to the Behavioral Health Agency.

    ii. The Qualified Behavioral Health Provider training course offered for those individuals not certified as Certified Peer Support Specialist, ~~Certified Youth~~

~~Support Specialist, or Certified Family Support Partners,~~ must total a minimum of forty (40) classroom hours and must be successfully completed within a maximum time of the first two (2) months of employment by the Behavioral Health Agency.

iii. The training curriculum must contain information specific to the population being served, i.e. ~~child and adolescent,~~ adult, dually diagnosed, etc. The curriculum must include, but is not limited to:

1. Communication skills.
2. Knowledge of behavioral health illnesses.
3. How to be an appropriate role model.
4. Behavior management.
5. Handling emergencies.
6. Record keeping: observing beneficiary, reporting or recording observations, time, or employment records.
7. Knowledge of clinical limitations.
8. Knowledge of appropriate relationships with beneficiary.
9. Group interaction.
10. Identification of real issues.
11. Listening techniques.
12. Confidentiality.
13. Knowledge of medications and side effects.
14. Daily living skills.
15. Hospitalization procedures single-point-of-entry.
16. Knowledge of the Supplemental Security Income (SSI) application process.
17. Knowledge of day treatment models proper placement levels.
18. Awareness of options.
19. Cultural competency.
20. Ethical issues in practice.
21. Childhood development, if serving the child and adolescent population.

iv. A written examination of the Qualified Behavioral Health Provider's that are not certified as Certified Peer Support Specialists, ~~Certified Youth Support Specialists, or Certified Family Support Partners~~ knowledge of the 40-hour classroom training curriculum must be successfully completed.

v. Evaluation of the Qualified Behavioral Health Provider's ability to perform daily living skills (DLS) for mental health services must be successfully completed by means of a skills test.

vi. The Qualified Behavioral Health Provider who successfully completes the training must be awarded a certificate. This certificate must state the person is qualified to work in an agency under professional supervision as a Qualified Behavioral Health Provider.

vii. In-service training sessions are required at a minimum of once per 12-month period after the successful completion of the initial 40-hour classroom training

for Qualified Behavioral Health Specialists not certified as Certified Peer Support Specialist, ~~Certified Youth Support Specialist, or Certified Family Support Partners.~~ The in-service training must total a minimum of eight (8) hours each 12-month period beginning with the date of certification as a Qualified Behavioral Health Provider and each 12-month period thereafter. The in-service training may be conducted, in part, in the field. Documentation of in-service hours will be maintained in the employee's personnel record and will be available for inspection by regulatory agencies.

5. Corporate Compliance Officer:

a. Manages policy, practice standards and compliance, except compliance that is the responsibility of the medical records librarian;

b. Reports directly to the CEO/ED (except in circumstances where the compliance officer is required to report directly to a director, the board of directors, or an accrediting or oversight agency);

c. Has no direct responsibility for billings or collections;

d. Is the DHS and Medicaid contact for DHS certification, Medicaid enrollment, and compliance.

6. Medical Director:

a. Oversees Behavioral Health Agency care planning, coordination, and delivery, and specifically:

i. Diagnoses, treats, and prescribes for behavioral illness;

ii. Is responsible and accountable for all client care, care planning, care coordination, and medication storage;

iii. Assures that physician care is available 24 hours a day, 7 days a week;

iv. May delegate client care to other physicians, subject to documented oversight and approval;

v. Assures that a physician participates in treatment planning and reviews;

vi. If the medical director is not a psychiatrist, a psychiatrist certified by one of the specialties of the American Board of Medical Specialties must serve as a consultant to the medical director and to other staff, both medical and non-medical. If the provider serves clients under the age of twenty-one (21), the medical director shall have access to a board certified child psychiatrist, for example, through the Psychiatric Research Institute child/Adolescent Telephone Consultation Service;

vii. Medical director services may be acquired by contract.

b. If the medical director is not a psychiatrist then the medical director shall contact a consulting psychiatrist within twenty-four (24) hours in the following situations:

    i. When antipsychotic or stimulant medications are used in dosages higher than recommended in guidelines published by the Arkansas Department of Human Services Division of Medical Services;

    ii. When two (2) or more medications from the same pharmacological class are used;

    iii. When there is significant clinical deterioration or crisis with enhanced risk of danger to self or others.

c. The consulting psychiatrist(s) shall participate in quarterly quality assurance meetings.

7. **Privacy Officer:** Develops and implements policies to assure compliance with privacy laws, regulations, and rules. Applicants/providers may assign privacy responsibilities to the Corporate Compliance Officer, Grievance Officer, or Medical Records Librarian, but not the CEO/ED.

8. **Quality Control Manager:** Chairs the quality assurance committee and develops and implements quality control and quality improvement activities. Applicants/providers may assign quality control manager responsibilities to the Corporate Compliance Officer or Medical Records Manager, but not the CEO/ED.

9. **Grievance Officer:**

    a. Develops and implements the applicant's/provider's employee and client grievance procedures.

    b. Effectively communicates grievance procedures to staff, contractors, prospective clients, and clients. Communications to clients who are legally incapacitated shall include communication to the client's responsible party.

    c. The grievance officer shall not have any duties that may cause him/her to favor or disfavor any grievant.

10. **Medical Records Librarian:**

    a. Must be qualified by education, training, and experience to understand and apply:

        i. Medical and behavioral health terminology and usages covering the full range of services offered by the provider;

        ii. Medical records forms and formats;

        iii. Medical records classification systems and references such as The American Psychiatric Association's Diagnostic and Statistical Manual – IV-TR (DSM-IV-TR) and subsequent editions, International Classification

of Diseases (ICD), Diagnostic Related Groups (DRG's), Physician's Desk Reference (PDR), Current Procedural Terminology (CPT), medical dictionaries, manuals, textbooks, and glossaries.

iv. Legal and regulatory requirements of medical records to assure the record is acceptable as a legal document;

v. Laws and regulations on the confidentiality of medical records (Privacy Act and Freedom of Information Act) and the procedures for informed consent for release of information from the record.

vi. The interrelationship of record services with the rest of the facility's services.

b. Develops and implements:

i. The client information system;

ii. Operating methods and procedures covering all medical records functions.

iii. Insures that the medical record is complete, accurate, and compliant.

11. Licensed Psychologist, Licensed Psychological Examiner (LPE), or Licensed Psychological Examiner – Independent (LPE-I):

a. Provides psychological evaluations;

b. Each licensed psychological examiner or licensed psychological examiner-I must have supervision agreements with a doctoral psychologist to provide appropriate supervision or services for any evaluations or procedures that are required under or are outside the psychological examiner's scope of independent practice. Documentation of such agreements and of all required supervision and other practice arrangements must be included in the psychological examiner's personnel record;

c. Services may be acquired by contract.

B. Multidisciplinary Team(s): Any client identified as Tier 2 by the independent assessment shall be assigned a multidisciplinary team that includes professionals and qualified behavioral health providers as necessary to ensure coordination of each client's Outpatient Behavioral Health Services. All Tier 2 clients require the development of a Master Treatment Plan with ongoing reviews at least every one-hundred and eighty (180) calendar days.

For clients not eligible for Rehabilitative (Tier 2) Level or Intensive (Tier 3) Level services, he services offered in the Counseling Level (Tier 1) are a limited array of counseling services provided by a master's level clinician. Establishment of goals and a plan to reach those goals is part of good clinical practice and can be developed with the client during the Mental Health Diagnostic Assessment and Interpretation of Diagnosis. Clinicians should assess client's response to treatment at each session which should

include a review of progress towards mutually agreed upon goals.

C. Quality Assurance Meetings:

Each provider must hold a quarterly quality assurance meeting.

D. Health Care Professional Notification/Disqualification:

1. Notice of covered health care practitioners:

a. Within twenty (20) days of the effective date of this rule, applicants/providers must notify the Office of Medicaid Inspector General (OMIG) of the names of covered health care practitioners who are providing Outpatient Behavioral Health Services.

b. On or before the tenth day of each month, providers must notify the Office of Medicaid Inspector General (OMIG) of the names of all covered health care practitioners who are providing Outpatient Behavioral Health Services and whose names were not previously disclosed.

2. Licensed health care professionals may not furnish Outpatient Behavioral Health Services during any time the professional's license is subject to adverse license action.

3. Applicants/providers may not employ/engage a covered health care practitioner after learning that the practitioner:

a. Is excluded from Medicare, Medicaid, or both;

b. Is debarred under Ark. Code Ann. § 19-11-245;

c. Is excluded under DHS Policy 1088; or

d. Was subject to a final determination that the provider failed to comply with professionally recognized standards of care, conduct, or both. For purposes of this subsection, "final determination" means a final court or administrative adjudication, or the result of an alternative dispute resolution process such as arbitration or mediation.

E. Applicants/providers must maintain documentation identifying the primary work location of all mental health professionals and qualified behavioral health providers providing services on behalf of the Behavioral Health Agency.

F. Providers must maintain copies of disclosure forms signed by the client, or by the client's parent or guardian before Outpatient Behavioral Health Services are delivered except in emergencies. Such forms must at a minimum:

1. Disclose that the services to be provided are Outpatient Behavioral Health Services;

2. Explain Outpatient Behavioral Health Services eligibility, SED and SMI criteria;

3. Contain a brief description of the Behavioral Health Agency services;

4. Explain that all Outpatient Behavioral Health Services care must be medically necessary;

5. Disclose that third party (e.g., Medicaid or insurance) Outpatient Behavioral Health Service payments may be denied based on the third party payer's policies or rules;

6. Identify and define any services to be offered or provided in addition to those offered by the Behavioral Health Agency, state whether there will be a charge for such services, and if so, document payment arrangements;

7. Notify that services may be discontinued by the client at any time;

8. Offer to provide copies of Behavioral Health Agency and Outpatient Behavioral Health Services rules;

9. Provide and explain contact information for making complaints to the provider regarding care delivery, discrimination, or any other dissatisfaction with care provided by the Behavioral Health Agency;

10. Provide and explain contact information for making complaints to state and federal agencies that enforce compliance under § III(G)(1).

G. Outpatient Behavioral Health Services maintained at each site must include:

1. Psychiatric Evaluation and Medication Management;

2. Outpatient Services, including individual and family therapy at a minimum;

3. Crisis Services.

L. Providers must tailor all Outpatient Behavioral Health Services care to individual client need. If client records contain entries that are materially identical, DHS and the Division of Medical Services will, by rebuttable presumption, that this requirement is not met.

M. Outpatient Behavioral Health Services for individuals under age eighteen (18): Providers must establish and implement policies for family identification and engagement in treatment for persons under age eighteen (18), including strategies for identifying and overcoming barriers to family involvement.

N. Emergency Response Services: Applicants/providers must establish, implement, and maintain a site-specific emergency response plan, which must include:

1. A 24-hour emergency telephone number;

2. The applicant/provider must:

a. Provide the 24-hour emergency telephone number to all clients;

b. Post the 24-hour emergency number on all public entries to each site;

c. Include the 24-hour emergency phone number on answering machine greetings;

d. Identify local law enforcement and medical facilities within a 50-mile radius that may be emergency responders to client emergencies.

3. Direct access to a mental health professional within fifteen (15) minutes of an emergency/crisis call and face-to-face crisis assessment within two (2) hours;

4. Response strategies based upon:

   a. Time and place of occurrence;

   b. Individual's status (client/non-client);

   c. Contact source (family, law enforcement, health care provider, etc.).

5. Requirements for a face-to-face response to requests for emergency intervention received from a hospital or law enforcement agency regarding a current client.

6. All face-to-face emergency responses shall be:

   a. Available 24 hours a day, 7 days a week;

   b. Made by a mental health professional within two (2) hours of request (unless a different time frame is within clinical standards guidelines and mutually agreed upon by the requesting party and the MHP responding to the call).

7. Emergency services training requirements to ensure that emergency service are age-appropriate and comply with accreditation requirements. Providers shall maintain documentation of all emergency service training in each trainee's personnel file.

8. Requirements for clinical review by the clinical supervisor or emergency services director within 24 hours of each after-hours emergency intervention with such additional reporting as may be required by the provider's policy.

9. Requirements for documentation of all crisis calls, responses, collaborations, and outcomes;

10. Requirements that emergency responses not vary based on the client's funding source. If a client is eligible for inpatient behavioral health care funded through the community mental health centers and the provider is not a community mental health center with access to these funds, the provider must:

    a. Determine whether the safest, least restrictive alternative is psychiatric hospitalization; and

    b. Contact the appropriate community mental health center (CMHC) for consult and

to request the CMHC to access local acute care funds for those over 21.

O. Each applicant/provider must establish and maintain procedures, competence, and capacity:

1. For assessment and individualized care planning and delivery;

2. For discharge planning integral to treatment;

3. For mobile care;

4. To assure that each mental health professional makes timely clinical disposition decisions;

5. To make timely referrals to other services;

6. To refer for inpatient services or less restrictive alternative;

7. To identify clients who need direct access to clinical staff, and to promptly provide such access.

P. Each applicant/provider must establish, maintain, and document a quality improvement program, to include:

1. Evidence based practices;

2. Use of agency wide outcomes measures to improve both client care and clinical practice that are approved by the agency's national accrediting organization. The following must be documented:

a. Measured outcomes

b. Sample report

c. Collection of outcomes, beginning at the initial mental health diagnosis service, which would be completed very close to the client's intake.

3. Requirements for informing all clients and clients' responsible parties of the client's rights while accessing services.

4. Regular (at least quarterly) quality assurance meetings that include:

a. Clinical Record Reviews: medical record reviews of a minimum number of randomly selected charts. The minimum number is the lesser of a statistically valid sample yielding 95% confidence with a 5% margin of error; or 10% of all charts open at any time during the past three (3) months;

b. Program and services reviews that:

i. Assess and document whether care and services meet client needs;

ii. Identify unmet behavioral health needs;

iii. Establish and implement plans to address unmet needs.

X. HOME OFFICE:

A. Each provider must maintain and identify a home office in the State of Arkansas;

B. The home office may be located at a site or may be solely an administrative office not requiring site certification;

C. The home office is solely responsible for governance and administration of all of the provider's Arkansas sites;

D. Home office governance and administration must be documented in a coordinated management plan;

E. The home office shall establish policies for maintaining client records, including policies designating where the original records are stored.

XI. SITE REQUIREMENTS

A. All sites must be located in the State of Arkansas;

B. Accreditation documentation must specifically include each site.

XII. SITE RELOCATION, OPENING, AND CLOSING (Note: temporary service disruptions caused by inclement weather or power outages are not "closings.")

A. Planned Closings:

1. Upon deciding to close a site either temporarily or permanently, the provider immediately must provide written notice to clients, DHS, the Division of Medical Services, the Medicaid fiscal agent, and the accrediting organization.

2. Notice of site closure must state the site closure date;

3. If site closure is permanent, the site certification expires at 12:00 a.m. the day following the closure date stated in the notice;

4. If site closing is temporary, and is for reasons unrelated to adverse governmental action, DHS may suspend the site certification for up to one (1) year if the provider maintains possession and control of the site. If the site is not operating and in compliance within the time specified in the site certification suspension, the site certification expires at 12:00 a.m. the day after the site certification suspension ends.

B. Unplanned Closings:

1. If a provider must involuntarily close a site due to, for example, fire, natural disaster, or adverse governmental action, the provider must immediately notify clients and families, DHS, the Division of Medical Services, the Medicaid fiscal agent, and the accrediting organization of the closure and the reason(s) for the closure.

2. Site certification expires in accordance with any pending regulatory action, or, if no regulatory action is pending, at 12:00 a.m. the day following permanent closure.

C. All Closings:

1. Providers must assure and document continuity of care for all clients who receive Outpatient Behavioral Health Services at the site;

2. Notice of Closure and Continuing Care Options:

   a. Providers must assure and document that clients and families receive actual notice of the closure, the closure date, and any information and instructions necessary for the client to obtain transition services;

   b. After documenting that actual notice to a specific client was impossible despite the exercise of due diligence, providers may satisfy the client notice requirement by mailing a notice containing the information described in subsection (a), above, to the last known address provided by the client; and

   c. Before closing, providers must post a public notice at each site entry. The public notice must include the name and contact information for all Behavioral Health Agencies within a fifty (50) mile radius of the site.

3. An acceptable transition plan is described below:

Transition Plan:
1. Identify and list all certified sites within a 50 mile radius. Include telephone numbers and physical addresses on the list.
2. Provide clients/families with the referral information and have them sign a transfer of records form/release of information to enable records to be transferred to the provider of their choice.
3. Transfer records to the designated provider.

4. Designate a records retrieval process as specified in Section I of the Arkansas Medicaid Outpatient Behavioral Health Services Provider Policy Manual § 142.300.

5. Submit a reporting of transfer to DHS (Attn: Policy & Certification Office) including a list of client names and the disposition of each referral. See example below:

Name	Referred to:	Records Transfer Status:	RX Needs Met By:
Johnny	OP Provider Name	to be delivered 4/30/20XX	Provided 1 month RX
Mary	Private Provider Name	Delivered 4/28/20XX	No Meds
Judy	Declined Referral	XX	

6. DHS may require additional information regarding documentation of client transfers to ensure that client needs are addressed and met.

DHS BEHAVIORAL HEALTH AGENCY Form 220 shall be used when a site is to be closed.

D. New Sites: Use DHS BEHAVIORAL HEALTH AGENCY Form 250 to apply for new sites, which would include a new Medicaid provider ID number for that site.

E. Site Transfer:

1. At least forty-five (45) calendar days before a proposed transfer of an accredited site, the provider must apply to DHS to transfer site certification. The application must include documentation that:

   a. The provider notified the accrediting entity, and the accrediting entity has extended or will extend accreditation to the second site; or

   b. The accrediting entity has established an accreditation timeframe.

2. The provider must notify clients and families, DHS, the Division of Medical Services, the Medicaid fiscal agent, and the accrediting organization at least thirty (30) calendar days before the transfer;

3. DHS does not require an on-site survey, nor does the Division of Medical Services require a new Medicaid provider number. Please use DHS BEHAVIORAL HEALTH AGENCY Form 220 for a site move or transfers.

F. Site Relocation: The provider must follow the rules for closing the original site, and the rules for opening a new site.

XIII. PROVIDER RE-CERTIFICATION:

A. The term of DHS site certification is concurrent with the provider's national accreditation cycle, except that site certification extends six (6) months past the accreditation

expiration month if there is no interruption in the accreditation. (The six-month extension is to give the Behavioral Health Agency time to receive a final report from the accrediting organization, which the provider must immediately forward to DHS.)

B. Providers must furnish DHS a copy of:

1. Correspondence related to the provider's request for re-accreditation:

a. Providers shall send DHS copies of correspondence from the accrediting agency within five (5) business days of receipt;

b. Providers shall furnish DHS copies of correspondence to the accrediting organization concurrently with sending originals to the accrediting organization.

2. An application for provider and site recertification:

a. DHS must receive provider and site recertification applications at least fifteen (15) business days before the DHS Behavioral Health Agency certification expiration date;

b. The Re-Certification form with required documentation is DHS BEHAVIORAL HEALTH AGENCY Form 230 and is available at www.arkansas.gov/dhs/dhs.

C. If DHS has not recertified the provider and site(s) before the certification expiration date, certification is void beginning 12:00 a.m. the next day.

XIV. MAINTAINING DHS BEHAVIORAL HEALTH AGENCY CERTIFICATION:

A. Providers must:

1. Maintain compliance;

2. Assure that DHS certification information is current, and to that end must notify DHS within thirty (30) calendar days of any change affecting the accuracy of the provider's certification records;

3. Furnish DHS all correspondence in any form (e.g., letter, facsimile, email) to and from the accrediting organization to DHS within thirty (30) calendar days of the date the correspondence was sent or received except:

a. As stated in § XII;

b. Correspondence related to any change of accreditation status, which providers must send to DHS within three (3) calendar days of the date the correspondence was sent or received.

c. Correspondence related to changes in service delivery, site location, or organizational structure, which providers must send to DHS within ten (10) calendar days of the date the correspondence was sent or received.

4. Display the Behavioral Health Agency certificate for each site at a prominent public

location within the site

B. Annual Reports:

1. Providers must furnish annual reports to DHS before July 1 of each year that the provider has been in operation for the preceding twelve (12) months. Community Mental Health Centers and specialty clinics may meet this requirement by submitting the Annual Plan/Basic Services Plan to DHS.

1. Annual report shall be prepared by completing forms provided by DHS. Please use DHS BEHAVIORAL HEALTH AGENCY Form 240 for the Behavioral Health Agency annual report.

XV. NONCOMPLIANCE

A. Failure to comply with this rule may result in one or more of the following:

1. Submission and implementation of an acceptable corrective action plan as a condition of retaining Behavioral Health Agency certification;

2. Suspension of Behavioral Health Agency certification for either a fixed period or until the provider meets all conditions specified in the suspension notice;

3. Termination of Behavioral Health Agency certification.

XVI. APPEAL PROCESS

A. If DHS denies, suspends, or revokes any Behavioral Health Agency certification (takes adverse action), the affected proposed provider or provider may appeal the DHS adverse action. Notice of adverse action shall comply with Ark. Code Ann. §§ 20-77-1701-1705, and §§1708-1713. Appeals must be submitted in writing to the DHS. The provider has thirty (30) calendar days from the date of the notice of adverse action to appeal. An appeal request received within thirty-five (35) calendar days of the date of the notice will be deemed timely. The appeal must state with particularity the error or errors asserted to have been made by DHS in denying certification, and cite the legal authority for each assertion of error. The provider may elect to continue Medicaid billing under the Behavioral Health Agency program during the appeals process. If the appeal is denied, the provider must return all monies received for Behavioral Health Agency services provided during the appeals process.

B. Within thirty (30) calendar days after receiving an appeal DHS shall: (1) designate a person who did not participate in reviewing the application or in the appealed-from adverse decision to hear the appeal; (2) set a date for the appeal hearing; (3) notify the appellant in writing of the date, time, and place of the hearing. The hearing shall be set within sixty (60) calendar days of the date DHS receives the request for appeal, unless a party to the appeal requests and receives a continuance for good cause.

C. DHS shall tape record each hearing.

D. The hearing official shall issue the decision within forty-five (45) calendar days of the

date that the hearing record is completed and closed. The hearing official shall issue the decision in a written document that contains findings of fact, conclusions of law, and the decision. The findings, conclusions, and decision shall be mailed to the appellant except that if the appellant is represented by counsel, a copy of the findings, conclusions, and decision shall also be mailed to the appellant's counsel. The decision is the final agency determination under the Administrative Procedure Act.

E. Delays caused by the appealing party shall not count against any deadline. Failure to issue a decision within the time required is not a decision on the merits and shall not alter the rights or status of any party to the appeal, except that any party may pursue legal process to compel the hearing official to render a decision.

F. Except to the extent that they are inconsistent with this policy, the appeal procedures in the Arkansas Medicaid Outpatient Behavioral Health Services Provider Manual are incorporated by reference and shall control.