ARKANSAS REGISTER

Proposed Rule Cover Sheet

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Name of Department Department of Human Services

Agency or Division Name Division of Medical Services

Other Subdivision or Department, If Applicable N/A

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23. Any other medical care and any other type of remedial care recognized under State law, specified by the Secretary. (Continued)

g. Rural Emergency Hospital (REH)

Services that are furnished by an in-state provider that meets the requirements for participation in Medicaid as a REH and are of a type that would be covered by Medicaid if furnished by a Medicaid enrolled, in state hospital to a Medicaid recipient. Services that are not permitted under REH licensure requirements are not covered by Medicaid.

REH services do not include nursing facility services furnished by a REH with a swing-bed approval.

REH services are subject to the same benefit limits as outpatient hospital services as described in Attachment 3.1-A, Item 2a.

23. Any other medical care and any other type of remedial care recognized under State law, specified by the Secretary. (Continued)

g. Rural Emergency Hospital

Services that are furnished by an in-state provider that meets the requirements for participation in Medicaid as a REH and are of a type that would be covered by Medicaid if furnished by a Medicaid enrolled, in-state hospital to a Medicaid recipient. Services that are not permitted under REH licensure requirements are not covered by Medicaid.

REH services do not include nursing facility services furnished by a REH with a swing-bed approval.

REH services are subject to the same benefit limits as outpatient hospital services as described in Attachment 3.1-A, Item 2a.

23. Any other medical care and any other type of remedial care recognized under State law, specified by the Secretary. (Continued)

g. Rural Emergency Hospital

Effective for dates of service on or after September 1, 2023, outpatient services performed by Rural Emergency Hospitals (REH) enrolled in the Arkansas REH Medicaid Program will be reimbursed by minimum interim payment in accordance with the Arkansas Medicaid Program outpatient fee schedule (at the lesser of the billed charge or the fee schedule maximum) with year-end cost settlements. Cost settlements are determined from REH submitted cost reports and are based on 100% reasonable costs. Reasonable costs are defined as total reimbursable costs under Medicare principles of cost reimbursement.

Annual cost reporting requirements are the same as those for hospitals enrolled in the Arkansas Medicaid Hospital Program as found in Attachment 4.19-A of this Plan. In addition to these requirements, a hospital that converts to a REH, and whose effective date of Medicaid enrollment as a REH is a date other than the day following the last day of the facility's established cost reporting period under its enrollment in the Arkansas Medicaid Hospital Program, must submit partial-year cost reports under each program in which it maintained enrollment during the cost reporting period.

Access to subcontractor's records provisions, audit function responsibility, and the rate appeal procedures are the same as those for hospitals enrolled in the Arkansas Medicaid Hospital Program as found in Attachment 4.19-A of this Plan.

REH's will only be reimbursed for emergency department, observation care and other outpatient services, in which the annual per patient average length of stay does not exceed 24 hours unless the REH provides post-hospital extended care services furnished as a unit in a distinct part of the REH that is licensed as a Skilled Nursing Facility (SNF) or provides behavioral health services furnished in a unit in a distinct part of the REH that is an Acute Crisis Unit (ACU). These two exceptions will be reimbursed in accordance with the Arkansas state plan methodology for these provider types.

5. Alternative Benefit Plan (ABP)

Effective for dates of service on or after January 1, 2014, the Arkansas Medicaid program will cover inpatient acute hospital days in excess of twenty-four days (during a state fiscal year) for those beneficiaries covered under the Alternative Benefit Plan (APB). The per diem rate for ABP inpatient acute hospital days twenty-five and above will be 400 dollars per day. The intent of the policy change is to increase access to care in all hospitals in the state of Arkansas. Inpatient Acute hospital days under twenty-five will be reimbursed in accordance with the methodology set forth in Attachment 4.19A page 1. Except as otherwise noted in the Plan, this rate is the same for both governmental and private providers of inpatient acute hospital services.

Effective for dates of service on or after January 1, 2014, the Arkansas Medicaid program will cover inpatient rehabilitation hospital days in excess of twenty-four days (during a state fiscal year) for those beneficiaries covered under the Alternative Benefit Plan (ABP). The per diem rate for ABP inpatient rehabilitation hospital days twenty–five and above will be 400 dollars per day. The intent of the policy change is to increase access to care in all hospitals in the state of Arkansas. Inpatient rehabilitation hospital days under twenty-five will be reimbursed in accordance with the methodology set forth in Attachment 4.19A page 9a. Except as otherwise noted in the State Plan, this rate is the same for both government and private providers of inpatient rehabilitation hospital services.

6. Reimbursement for Acute Crisis Units

Acute Crisis Units (ACU) provide acute care hospital diversion and step-down services to Medicaid clients experiencing psychiatric or substance use disorder related distress in a safe environment with psychiatry and substance use disorder services available on-site, as well as on-call psychiatry available 24 hours per day. Effective for dates of service on or after July 1, 2021, reimbursement for Acute Crisis Units is based on 80% of the current (7/1/2021) daily rate for the Arkansas State Hospital. ~~No room and board costs, or other unallowable facility costs, are built into the daily rate.~~ These ACU services are considered inpatient services and as such will be included in cost settlement. State developed fee schedule rates are the same for both governmental and private providers. The fee schedule can be accessed at Fee Schedules - Arkansas Department of Human Services.

200.000 HOSPITAL, CRITICAL ACCESS HOSPITAL (CAH), RURAL EMERGENCY HOSPITAL (REH), AND END-STAGE RENAL DISEASE (ESRD) GENERAL INFORMATION

TOC required

200.100 Introduction

8-1-05/9-1-23

A. This manual is the Arkansas Medicaid provider policy manual for the Hospital Program, the Critical Access Hospital (CAH) Program, the Rural Emergency Hospital Program, and the End-Stage Renal Disease (ESRD) Program.

1. Hospital general information begins at Section 201.000.
2. CAH general information begins at Section 201.400.
3. REH general information begins at Section 201.500
4. ESRD facility general information begins at Section 204.000.

B. Provider enrollment information for each program is divided into participation requirements and enrollment procedures. All providers must meet the Provider Participation and enrollment requirements contained within Section 140.000 of this manual as well as the criteria below to be eligible to participate in the Arkansas Medicaid Program.

C. Guidelines for the Arkansas Medicaid Hospital Program generally apply to the Arkansas Medicaid Critical Access Hospital Program and the Rural Emergency Hospital Program.

1. For the user's convenience, this manual contains separate sections for hospital, and CAH, and REH participation requirements and enrollment procedures.
2. Wherever there are differences between the Hospital, Program and the CAH Program, and REH programs, the differences are explained in detail in clearly marked CAH sections of this manual.

D. Arkansas Medicaid dialysis coverage is identical in ESRD facilities and outpatient hospitals; therefore, dialysis coverage and billing are discussed in the ESRD sections of this manual.

201.000 Hospital General Information

9-1-23/8-1-05

The Division of Health of the Arkansas Department of Health (ADH)and Human Services licenses several types of hospitals, facilities, and institutions that may qualify for participation in the Arkansas Medicaid Program.

A. The Division of Health licenses four types of acute care hospitals that are eligible for enrollment in the Arkansas Medicaid Hospital Program. They are:

1. General hospitals,
2. Maternity and general medical care hospitals,
3. Maternity hospitals and
4. Surgery and general medical care hospitals.

B. The Arkansas Title XIX (Medicaid) State Plan employs the terms "acute care" and "acute care/general" interchangeably as general references to any of these four types of hospitals

(or their counterparts in other states) to avoid repeating the entire list each time that a reference is made to hospitals that are eligible for participation in the Arkansas Medicaid Hospital Program.

201.100 Arkansas Medicaid Participation Requirements for Acute Care/General Hospitals

8-1-05 9-1-23

Following are the minimum requirements for participation in the Arkansas Medicaid Hospital Program.

A. An in-state hospital must be licensed by the Division of Health of the Arkansas Department of Health and Human ServicesADH as an acute care/general hospital.

B. An out-of-state hospital must be licensed as an acute care/general hospital by the appropriate licensing agency within its home state.

C. A hospital must be certified as an acute care/general hospital Title XVIII (Medicare) provider.

201.110 Arkansas Medicaid Participation Requirements for Pediatric Hospitals

9-1-23 8-1-05

A. A pediatric hospital is a hospital in which the majority of patients are individuals under the age of 21.

B. Arkansas Medicaid participation requirements for pediatric hospitals are as follows.:

1. An in-state pediatric hospital must be licensed by the Division of HealthADH as an acute care/general hospital.
2. An out-of-state pediatric hospital must be licensed by the appropriate licensing agency within its home state as an acute care/general hospital.
3. A pediatric hospital must be certified as a pediatric hospital Title XVIII (Medicare) provider.
4. A pediatric hospital must be designated by the Centers for Medicare and Medicaid Services (CMS) as a children's hospital that is exempt from Medicare's prospective payment system.

201.120 Arkansas Medicaid Participation Requirements for Arkansas State-Operated Teaching Hospitals

9-1-23 8-1-05

A hospital is an Arkansas State-Operated Teaching Hospital if it:

A. Is licensed by the Division of HealthADH as an acute care/general hospital,

B. Has in effect an agreement to participate in Medicaid as an acute care hospital,

C. Is operated by the State of Arkansas and

D. Has current accreditation from the North Central Association of Colleges and Schools.

201.400 Critical Access Hospital (CAH) General Information

8-1-05 9-1-23

Only CAHs located in Arkansas and licensed by the Division of Health of the Arkansas Department of Health and Human ServicesADH may enroll in the Arkansas Medicaid Critical Access Hospital Program.

A. Out-of-state CAHs may participate only in the Arkansas Medicaid Hospital Program.

B. CAHs in states not bordering Arkansas may participate in the Arkansas Medicaid Hospital Program as limited services providers.

201.401 Arkansas Medicaid Participation Requirements for CAHs 8-1-059-1-23

A CAH must meet the following requirements to participate in the Critical Access Hospital Program.

A. The hospital must be certified as a CAH by the Secretary of the U.S. Department of Health and Human Services.

B. The hospital must be licensed as a CAH by the Division of Health of the Arkansas Department of Health and Human ServicesADH.

C. The hospital must hold Title XVIII (Medicare) certification as a CAH.

201.500 Rural Emergency Hospital (REH) General Information 9-1-23

Only REHs located in Arkansas and licensed by the Arkansas Department of Health may enroll in the Arkansas Medicaid Rural Emergency Hospital Program.

A. Out-of-state REHs may participate only in the Arkansas Medicaid Hospital Program.

B. REHs in states not bordering Arkansas may participate in the Arkansas Medicaid Hospital Program as limited services providers.

201.510 Arkansas Medicaid Participation Requirements for REHs 9-1-23

Rural Emergency Hospitals must meet the following requirements to participate in the REH Program.

A. The hospital must be certified as a REH by the Secretary of the U.S. Department of Health and Human Services.

B. The hospital must be licensed as a REH by the Arkansas Department of Health.

C. The hospital must hold Title XVIII (Medicare) certification as a REH.

201.520 Provider Enrollment Procedures 9-1-23

A. All Medicaid provider applications and Medicaid contracts must be approved by the Arkansas Medicaid Program before a provider may enroll.

B. In addition to meeting the requirements listed in Section 140.000 of this manual, applicants for enrollment in the Rural Emergency Hospital Program must have on file with Provider Enrollment the applicable credentialing documentation specified in Section 201.510.

C. The Medicaid Provider Enrollment Unit reviews the accuracy and completeness of provider applications, Medicaid contracts and all other required documentation.

1. Provider Enrollment contacts applicants to correct errors or omissions in the enrollment documents. Some errors, such as failure to provide an original signature, necessitate returning the documents to the applicant for correction.

2. When the provider application materials are complete and correct and Arkansas Medicaid approves the application and contract, Provider Enrollment assigns a provider number and forwards to the provider written confirmation of the provider number and the effective date of the provider's enrollment.

201.530 Provider Enrollment – In-State REHs 9-1-23

In addition to complying with the enrollment requirements for Arkansas in-state REHs, a hospital must ensure that the following documents are on file with the Medicaid Provider Enrollment Unit.

A. Proof of certification as a REH by the Secretary of the U.S. Department of Health and Human Services

B. Proof of current licensure as a REH by the Department of Health

C. Proof of Title XVIII (Medicare) certification as a REH

201.540 Out-of-State REH Enrollment in the Hospital Program 9-1-23

In addition to complying with the enrollment requirements for REHs outside Arkansas, a hospital must ensure that the following documents are on file with the Medicaid Provider Enrollment Unit.

A. Proof of certification as a REH by the Secretary of the U.S. Department of Health and Human Services

B. Proof of current licensure as a REH by its home state licensing authority

C. Proof of Title XVIII (Medicare) certification as a REH in its home state

202.000 Hospital, ~~and~~ CAH, and REH Medical Record Requirements 9-1-23~~8-1-05~~

A. Hospitals, ~~and~~ CAHs, and REHs must maintain a medical record for each inpatient and outpatient beneficiary.

1. Medical records must be accurately written, promptly completed, properly filed, and retained and accessible.
2. The facility's system of author identification and record maintenance must ensure the integrity of the authentication and protect the security of all record entries.

B. The medical record must

1. Justify admission and continued hospitalization,
2. Support the diagnosis and
3. Describe the patient's progress and response to medications and services.

C. All entries must be legible and complete and must be authenticated and dated promptly by the person (identified by name and discipline) who is responsible for ordering, providing, or evaluating the service furnished.

1. The author of each entry must be identified and must authenticate his or her entry.
2. Authentication may include signatures, written initials, or computer entry.

D. All records must document the following, as appropriate:

1. Required primary care physician (PCP) or other referrals, when applicable
2. A physical examination, including a health history, performed no more than seven (7) days before admission or within forty-eight (48) hours after admission
3. Admitting diagnosis
4. Results of all consultative evaluations of the patient and appropriate findings by clinical and other staff involved in the care of the patient

5. Documentation of complications, hospital-acquired infections and unfavorable reactions to drugs and anesthesia
6. Properly executed informed consent forms for procedures and treatments specified by the medical staff, or by federal or state law when applicable, to require written patient consent
7. All practitioners' orders, nursing notes, reports of treatment, medication records, radiology and laboratory reports, vital signs and other information necessary to monitor the patient's condition
8. Discharge summary with outcome of hospitalization, disposition of case and provisions for follow-up care
9. Final diagnosis with completion of medical records within thirty (30) days following discharge

202.100 Availability of Hospital, and CAH, and REH Medical Records

9-1-23~~10-1-08~~

The Medicaid Program, its designees, and other state and federal agencies review medical records for documentation of services provided and billed, and to evaluate the medical necessity of delivered services. Refer to Section 142.300 for information regarding record retention and availability requirements.

210.000 PROGRAM COVERAGE – HOSPITAL, ~~AND~~ CRITICAL ACCESS HOSPITAL, AND RURAL EMERGENCY HOSPITAL

210.100 Introduction

~~1-15-15~~9-1-23

The Medical Assistance (Medicaid) Program helps eligible individuals obtain necessary medical care.

A. Medicaid coverage is based on medical necessity.

1. See Section IV of this manual for the Medicaid Program's definition of medical necessity.
2. Some examples of services that are not medically necessary are treatments or procedures that are cosmetic or experimental or that the medical profession does not generally accept as a standard of care (e.g., an inpatient admission to treat a condition that requires only outpatient treatment).

B. Medicaid denies coverage of services that are not medically necessary. Denial for lack of medical necessity is done in several ways.

1. When Arkansas Medicaid's Division of Medical Services' Medical Director ~~for Clinical Affairs~~ determines that a service is never medically necessary, the Division of Medical Services (DMS) enters the service's procedure code, revenue code and/or diagnosis code into the Medicaid Management Information System (MMIS) as non-payable, which automatically prevents payment.
2. A number of services are covered only with the Program's prior approval or prior authorization. One of the reasons for requiring prior approval of payment or prior authorization for a service is that some services are not always medically necessary and Medicaid wants its own medical professionals to review the case record before making payment or before the service is provided.
3. Lastly, Medicaid retrospectively reviews medical records of services for which claims have been paid in order to verify that the medical record supports the service(s) for

which Medicaid paid and to confirm or refute the medical necessity of the services documented in the record.

C. Unless a service's medical necessity or lack of medical necessity has been established by statute or regulation, medical necessity determinations are made by the Arkansas Medicaid Program's Medical Director, by the Program's Quality Improvement Organizations (QIO) and/or by other qualified professionals or entities authorized and designated by the Division of Medical Services.

D. When Arkansas Medicaid's Division of Medical Services' Medical Director ~~for Clinical Affairs~~, QIO or other designee determines – whether prospectively, concurrently or retrospectively – that a hospital service is not medically necessary, Medicaid covers neither the hospital service nor any related physician services.

215.500 Rural Emergency Hospitals (REH) Coverage

215.510 REH Scope of Coverage 9-1-23

Arkansas Medicaid covers medically necessary emergency and outpatient hospital services that are permitted under the Rural Emergency Hospitals' licensures, to the extent that the same services are covered under the Arkansas Medicaid Hospital Program.

The following exceptions may apply:

A. A rural emergency hospital shall not have inpatient beds unless the rural emergency hospital has a unit that is a distinct part of the rural emergency hospital that:

1. Is licensed as a skilled nursing facility to provide post-hospital extended care services;
2. Provides behavioral health services in accordance with the Arkansas Health and Opportunity for Me Act of 2021, § 23-61-1001 et seq.

B. A rural emergency hospital may own and operate an entity that provides ambulance services.

215.520 REH Coverage Restrictions 9-1-23

215.530 REH Exclusions 9-1-23

A. Services excluded from coverage in Department of Health Licensing rules for REH are excluded from reimbursement.

B. Services excluded from coverage in the Arkansas Medicaid Hospital Program are also excluded in the Arkansas Medicaid Rural Emergency Hospital Program, unless stated otherwise in official Program documentation or correspondence.

C. Medicaid does not cover nursing facility beds ("swing-beds") in hospitals, CAHs, or in REHs through the Medicaid Hospital Program. REHs may maintain dedicated nursing facility beds to be reimbursed through the Skilled Nursing Facility program

215.540 REH Benefit Limits 9-1-23

Non-emergency outpatient visits, diagnostic laboratory, and radiology/other services in Rural Emergency Hospitals (REHs) are subject to the same benefit limits that apply to facilities enrolled in the Arkansas Medicaid Hospital Program and the Arkansas Medicaid Rehabilitative Hospital Program.

Radiology/other services include diagnostic X-rays, ultrasounds, and electronic monitoring/machine tests, such as electrocardiograms (ECG or EKG).

Benefit-limited services that are received in REHs are counted with benefit-limited services received in hospitals enrolled in the Arkansas Medicaid Hospital Program and the Arkansas Medicaid Rehabilitative Hospital Program to calculate a Medicaid-eligible individual's benefit status.

216.300 Hysteroscopy for Foreign Body Removal

2-1-229-1-23

View or print the procedure codes for Hospital/Critical Access Hospitals/Rural Emergency Hospitals/ESRD services.

Procedure code requires paper billing and clinical documentation for justification.

216.540 Family Planning Procedures

2-1-229-1-23

The following procedure code table lists family planning procedures payable to hospitals. These codes require a primary diagnosis of family planning on the claim.

Sterilization procedures require paper billing with DMS-615 attached. **View or print form DMS-615. View or print form DMS-615 Spanish.**

View or print the procedure codes for Hospital/Critical Access Hospitals/Rural Emergency Hospitals/ESRD services.

*CPT code represents a procedure to treat medical conditions as well as for elective sterilizations.

Family planning laboratory codes are found in **Section 216.550**.

216.550 Family Planning Lab Procedures

2-1-229-1-23

Family planning services are covered for beneficiaries in full coverage for Aid Category 61 (PW-PI). For additional information on Family Planning Services, see Sections 216.100-216.110, 216.130-216.132, 216.515, and 216.540-216.550.

Collection fees for laboratory procedures are included in the reimbursement for the laboratory procedure.

The following procedure codes table lists payable family planning laboratory procedure codes that require a primary diagnosis of Family Planning on the claim form:

View or print the procedure codes for Hospital/Critical Access Hospitals/Rural Emergency Hospitals/ESRD services.*Procedure codes are limited to one unit per beneficiary per state fiscal year.

217.062 Corneal Transplants

2-1-229-1-23

A. Medicaid covers hospitalization related to corneal transplants from the date of the transplant procedure until the date of discharge, subject to the beneficiary's inpatient benefit utilization status if he or she is aged 21 or older and subject to MUMP precertification requirements.

B. Coverage includes the preservation of the organ from a cadaver donor but not the harvesting of the organ.

C. For processing, preserving and transporting corneal tissues, use procedure code. Requires paper billing and a manufacturer's invoice attached to the claim.

View or print the procedure codes for Hospital/Critical Access Hospitals/Rural Emergency Hospitals/ESRD services.

217.090 Bilaminate Graft or Skin Substitute Coverage Restriction

~~2-1-22~~9-1-23

A. Indications and Documentation:

When the diagnosis is a burn injury (**View ICD Codes.**) (indicated on the claim form), no additional medical treatment documentation is required.

This modality/product will be covered for other restricted diagnoses (indicated below) when all of the following provisions are met and are documented in the beneficiary's medical record:

1. Partial or full-thickness skin ulcers due to venous insufficiency or full-thickness neuropathic diabetic foot ulcers,
2. Ulcers of more than three (3) months duration and
3. Ulcers that have failed to respond to documented conservative measures of more than two (2) months duration.
4. There must be measurements of the initial ulcer size, the size of the ulcer following cessation of conservative management, and the size at the beginning of skin substitute treatment.
5. For neuropathic diabetic foot ulcers, appropriate steps to off-load pressure during treatment must be taken and documented in the patient's medical record.
6. The ulcer must be free of infection and underlying osteomyelitis; treatment of the underlying disease (e.g., peripheral vascular disease) must be provided and documented in conjunction with skin substitute treatment.

B. Diagnosis Restrictions:

Coverage of the bilaminate skin product and its application is restricted to the diagnosis represented by the following ICD codes:

(**View ICD Codes**.)

C. Outpatient Billing:

The manufactured viable bilaminate graft or skin substitute product is manually priced. It must be billed to Medicaid by paper claim with procedure code. The manufacturer's invoice, the wound size description and the operative report must be attached.

View or print the procedure codes for Hospital/Critical Access Hospitals/Rural Emergency Hospitals/ESRD services.

Outpatient procedures to apply bilaminate skin substitute are payable using the appropriate procedure code(s). These codes must be listed separately when filing claims and may be billed electronically.

217.111 Medical Necessity Requirements

~~10-13-03~~9-1-23

Medicaid covers medically necessary services only. The Quality Improvement Organization (QIO) will deny coverage of ~~inpatient admissions and subsequent inpatient services for inpatient~~ hospital services for medical care that was not necessary. ~~Inpatient~~ Hospital services are

subject to QIO review for medical necessity whether the physician admitted the patient, or whether Medicaid deemed the patient admitted according to the criteria above.

The attending physician must document the medical necessity of admitting a patient to observation status, whether the patient's condition is emergent or non-emergent.

217.141 Computed Tomographic Colonography (CT Colonography) 7-1-229-1-23

A. The procedure codes in the link below are covered for computed tomographic (CT) colonography for beneficiaries of all ages.

View or print the procedure codes for Hospital/Critical Access Hospitals/Rural Emergency Hospitals/ESRD services.

B. CT colonography policy and billing:

1. Virtual colonoscopy, also known as CT colonography, utilizes helical-computed tomography of the abdomen and pelvis to visualize the colon lumen, along with 2D or 3D reconstruction. The test requires colonic preparation similar to that required for standard colonoscopy (instrument/fiberoptic colonoscopy) and air insufflation to achieve colonic distention.
2. Indications: Virtual colonoscopy is only indicated in those patients in whom an instrument/fiberoptic colonoscopy of the entire colon is incomplete due to an inability to pass the colonoscopy proximately. Failure to advance the colonoscopy may be secondary to a neoplasmic or spasmic obstruction, a redundant colon, diverticulitis extrinsic compression, or aberrant anatomy/scarring from prior surgery. This is intended for use in pre-operative situations when knowledge of the unvisualized colon (proximal to the obstruction) would be of use to the surgeons in planning the operative approach to the patient.
3. Limitations:
   a. Virtual colonography is not reimbursable when used for screening or in the absence of any signs indicating symptoms of disease, regardless of family history or other risk factors for the development of colonic disease.
   b. Virtual colonography is not reimbursable when used as an alternative to instrument/fiberoptic colonoscopy, for screening, or in the absence of signs or symptoms of disease.
   c. Since any colonography with abnormal or suspicious findings would require a subsequent instrument/fiberoptic colonoscopy for diagnosis (such as a biopsy) or for treatment (such as a polypectomy), virtual colonography is not reimbursable when used as an alternative to an instrument/fiberoptic colonoscopy, even if performed for signs or symptoms of disease.
   d. CT colonography procedure codes are counted against the beneficiary's benefit limit of five hundred dollars ($500) per State Fiscal Year (SFY: July 1 through June 30) for radiology/other services. Radiology/other services include without limitation diagnostic X-rays, ultrasounds, and electronic monitoring/machine tests, such as electrocardiograms (ECG or EKG).
   e. "Reasonable and necessary" services should only be ordered or performed by qualified personnel.
   f. The CT colonography final report should address all structures of the abdomen afforded review in a regular CT of abdomen and pelvis.

C. Documentation requirements and utilization guidelines:

1. Each claim must be submitted with ICD codes that reflect the condition of the patient and indicate the reason(s) for which the service was performed. ICD codes must be

coded to the highest level of specificity or claims submitted with those ICD codes will be denied;

2. The results of an instrument/fiberoptic colonoscopy that was performed before the virtual colonoscopy (CT colonography), if the virtual colonoscopy (CT colonography) was incomplete, must be retained in the patient's record; and

3. The patient's medical record must include the following and be available upon request:

   a. The order or prescription from the referring physician;

   b. Description of polyps and lesion:

      i. Lesion size for lesions 6 mm or larger, the single largest dimension of the polyp (excluding stalk if present) on either multiplanar reconstruction or 3D views, and the type of view employed for measurement should be stated;

      ii. Location (standardized colonic segmental divisions: rectum, sigmoid colon, descending colon, transverse colon, ascending colon, and cecum);

      iii. Morphology (sessile-broad-based lesion whose width is greater than its vertical height; pedunculated-polyp with separate stalk; or flat-polyp with vertical height less than 3 mm above surrounding normal colonic mucosa);

      iv. Attenuation (soft-tissue attenuation or fat);

   c. Global assessment of the colon (C-RADS categories of colorectal findings):

      i. C0 – Inadequate study
      poor prep (can't exclude > 10 lesions);

      ii. C1 – Normal colon or benign lesions
      no polyps or polyps ≥5 mm
      benign lesions (lipomas, inverted diverticulum);

      iii. C2 – Intermediate polyp(s) or indeterminate lesion
      polyps 6-9 mm in size, <3 in number
      indeterminate findings;

      iv. C3 – Significant polyp(s), possibly advanced adenoma(s)
      Polyps ≥10 mm
      Polyps 6-9 mm in size, ≥3 in number;

      v. C4 – Colonic mass, likely malignant;

   d. Extracolonic findings (integral to the interpretation of CT colonography results):

      i. E0 – Inadequate Study limited by artifact;

      ii. E1 – Normal exam or anatomic variant;

      iii. E2 – Clinically unimportant findings (no work-up needed);

      iv. E3 – Likely unimportant findings (may need work-up); for example, incompletely characterized lesions,
      such as hypodense renal or liver lesion;

      v. E4 – Clinically important findings (work-up needed), such as solid renal or liver mass, aortic aneurysm, adenopathy; and

   e. CT colonography is reimbursable only when performed following an instrument/fiberoptic colonoscopy that was incomplete due to obstruction.

217.150 Vagus Nerve Stimulation

~~6-1-22~~9-1-23

The Arkansas Medicaid Program covers vagus nerve stimulation therapy, device, and procedure. Vagus nerve stimulation therapy, device, and procedure require prior authorization for medical necessity.

View or print the procedure codes for Hospital/Critical Access Hospitals/Rural Emergency Hospitals/ESRD services.

View or print contact information to obtain the DHS or designated vendor step-by-step process for requesting prior authorization.

244.000 Procedures that Require Prior Authorization

2-1-229-1-23

A. The procedures represented by the CPT and HCPCS codes in the following table require prior authorization (PA). The performing physician or dentist (or the referring physician or dentist, when lab work is ordered or injections are given by non-physician staff) is responsible for obtaining required PA and forwarding the PA control number to appropriate hospital staff for documentation and billing purposes. A claim for any hospital services that involve a PA-required procedure must contain the assigned PA control number or Medicaid will deny it. (See Sections 241.000 through 244.000 of this manual for instructions for obtaining prior authorization.)

See Section 272.449 for billing instructions for Molecular Pathology codes.

View or print the procedure codes for Hospital/Critical Access Hospitals/Rural Emergency Hospitals/ESRD services.

B. For inpatient hospital facility abortion claims, the provider claim must use the following codes:

1. 10A00ZZ Abortion of Products of Conception, Open Approach
2. 10A03ZZ Abortion Products of Conception, Percutaneous Approach
3. 10AO7Z6 Abortion of Products of Conception, Vacuum, Via Natural or Artificial Opening
4. 10A07ZW Abortion of Products of Conception, Laminaria, Via Natural or Artificial Opening
5. 10A07ZX Abortion of Products of Conception, Abortifacient, Via Natural or Artificial Opening
6. 10A07ZZ Abortion of Products of Conception, Via Natural or Artificial Opening

C. The following outpatient hospital abortion procedure codes will require PA:

View or print the procedure codes for Hospital/Critical Access Hospitals/Rural Emergency Hospitals/ESRD services.

245.031 Prior Authorization of Hyaluronon (Sodium Hyaluronate) Injection

2-1-229-1-23

Prior authorization is required for coverage of the Hyaluronon (sodium hyaluronate) injection. Providers must specify the brand name of Hyaluronon (sodium hyaluronate) or derivative when requesting prior authorization for the following procedure codes:

View or print the procedure codes for Hospital/Critical Access Hospitals/Rural Emergency Hospitals/ESRD services.

A written request must be submitted to Division of Medical Services Utilization Review Section.
View or print the Division of Medical Services Utilization Review Section address.

The request must include the patient's name, Medicaid ID number, physician's name, physician's provider identification number, patient's age, and medical records that document the severity of osteoarthritis, previous treatments and site of injection. Hyaluronon is limited to one series of injections per knee, per beneficiary, per lifetime.

250.203 Cost Settlement

9-1-2311-15-12

A. The Division of Medical Services or its designee audits each hospital's cost report.

1. Allowable costs are determined and validated in accordance with CMS Publication 15-1 (costs and allowable costs) and CMS Publication 15-2 (cost reports).

2. Accounting exceptions specific to Title XIX or to the Arkansas Medicaid Program are noted in this section (Reimbursement, Section 250.000) of this provider manual.

B. With the exception of special payments and adjustments listed below in part C, Arkansas Medicaid limits total inpatient reimbursement to the lowest of three amounts. The amounts compared are as follows.

1. Allowable costs after application of the TEFRA rate of increase limit (The TEFRA rate of increase limit does not apply to Arkansas State Operated Teaching Hospitals for cost reporting periods ending on and after June 30, 2000.)

2. The hospital's customary charges to the general public for the services

3. An upper limit per Medicaid day

C. Special adjustments or payments apply to some hospitals.

1. In-state hospitals and certain qualifying out-of-state hospitals receive "disproportionate share hospital" payments. See Sections 250.300 through 250.500 for details.

2. Arkansas State Operated Teaching Hospitals receive direct graduate medical education (GME) payments. See Section 250.621 for details.

3. Arkansas State Operated Teaching Hospitals receive an adjustment based on the Medicare daily upper limit. See Section 250.622 for details.

4. ~~Arkansas private, acute care, critical access, psychiatric and rehabilitative hospitals receive an adjustment based on the Medicaid upper payment limit. See Section 250.623 for details.~~

5. ~~—~~Arkansas non-state government-owned or operated acute care and critical access hospitals receive an adjustment based on the Medicare upper payment limit. See Section 250.624 for details.

6. Arkansas non-state ~~-~~owned government-owned or operated acute care/general hospitals within the state of Arkansas shall qualify for an annual upper payment limit, reimbursement adjustment. See Section 250.627 for details.

7. Arkansas private hospitals (excluding rehabilitative hospitals and specialty hospitals) will receive inpatient and outpatient hospital access payments based on the Medicaid upper payment limit. See Sections 250.628 and 250.269 for details.

8. All Arkansas private pediatric hospitals qualify for an inpatient rate adjustment. The amount of adjustment is determined annually by Arkansas Medicaid based on available funding. See Section 250.626 for details.

250.230 Daily Upper Limit

1-1-169-1-23

A daily upper limit to inpatient hospital reimbursement is established in the Title XIX State Plan.

~~A. A daily upper limit amount of $675.00 is effective for dates of service April 1, 1996 through June 30, 2006. The $675.00 daily upper limit for this period represents the 90th percentile of the cost-based per diems (per the cost settlements of their fiscal year-end 1994 cost~~

reports) of all hospitals subject to the Arkansas Medicaid daily upper limit at the time of the computation.

B. For dates of service July 1, 2006 and after, DMS will review the hospital cost report data at least biennially and adjust the daily upper limit reimbursement amount if necessary.

CA. A daily upper limit amount of $850.00 is effective for dates of service on and after January 1, 2007; 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.

DB. The daily upper limit does not apply to the following.

1. Pediatric hospitals
2. Arkansas State Operated Teaching Hospitals, effective for cost reporting periods ending on or after June 30, 2000
3. Border City, University-affiliated, Pediatric Teaching hospitals
4. Inpatient services for children under the age of 1
5. Inpatient services for children, from their first birthday until their discharge date, who were admitted on or before their first birthday and were discharged after their first birthday

EC. The daily upper limit is determined as follows.

1. The aggregate daily upper limit amount for a hospital is calculated by multiplying the hospital's cost-reporting period's covered days (excluding days subject to the $400 per diem prospective reimbursement amount) by the $850 upper cost per diem limit.
2. The aggregate daily upper limit amount is compared to the amount carried forward from the comparison of TEFRA-limited costs or charges.
3. The lesser of those two amounts becomes the new aggregate daily upper limit amount, subject to any additional payments or adjustments that may apply, such as direct graduate medical education (GME) costs or disproportionate share hospital (DSH) payments.
4. Effective for dates of service on or after July 1, 2006, Medicaid will review hospital cost report data at least biennially, in accordance with the methodology described above in subparts 1, 2, and 3 and adjust the daily upper limit amount if necessary.

250.623 Private Hospital Inpatient Adjustment 10-1-14

Effective October 1, 2014, Arkansas Medicaid will remove the annual "Private Hospital Inpatient Adjustment" UPL $25.2 million methodology payments. The last quarterly "Private Hospital Inpatient Adjustment" reimbursement payments will be made within 15 days after September 30, 2014 for that quarter ending data.

250.627 Non-State Government Owned or Operated Outpatient UPL Reimbursement Adjustment 9-1-23 1-1-16

Arkansas non-state government-owned or operated acute care/general hospitals (that is, all acute care government hospitals within the state of Arkansas that are neither owned nor operated by the State of Arkansas) shall qualify for an annual upper payment limit (UPL) reimbursement adjustment. Psychiatric hospitals, pediatric hospitals, rehabilitative hospitals, and critical access hospitals, and rural emergency hospitals are not eligible for an adjustment. Payment shall be made before the end of the state fiscal year (SFY). The adjustment will be calculated and based on each hospital's previous SFY outpatient Medicare-related upper

payment limit (UPL as specified in 42 CFR 447.321) for Medicaid reimbursed outpatient services. The adjustments will be calculated as follows:

A. For each qualifying hospital, Arkansas Medicaid will annually identify the total Medicaid outpatient expenditures during the most recent completed SFY.

B. For each qualifying hospital, the total Medicaid expenditures are determined in step A, and are divided by 80% to estimate the amount that would have been paid using Medicare reimbursement principles.

C. The difference between step A identified Medicaid expenditures and step B estimated Medicare amounts is the UPL annual adjustment amount that will be reimbursed.

Eligible hospitals that were not licensed and providing services throughout the most recent completed SFY shall receive a pro-rated adjustment based on the partial year data.

D. Payment for SH+FY 2003 shall be pro-rated proportional to the number of days between April 1, 2003, and June 30, 2003 to the total number of days in SFY 2003.

E. If an ownership change occurs, the previous owner's audited fiscal periods will be used when audited cost report information is not available for the current owner.

F. Effective for state fiscal year 2016 and forward, the state may elect to use the most recent cost report available as of June 30 if the audited cost report is more than 2 years old as of June 30 for the above calculation.

252.117 Reimbursement of Burn Dressing Changes in Outpatient Hospitals ~~2-1-22~~9-1-23

A. The CPT procedure codes for burn dressing changes are in the range of surgical procedures, but the Arkansas Medicaid Program has deemed them therapy procedures for reimbursement purposes. They are not listed in the outpatient surgical groupings.

B. Burn dressing changes are reimbursed at a global fee. The global fee includes:

1. All medication, pre-medication, I.V. fluids, dressing solutions and topical applications,
2. All dressings and necessary supplies and
3. All room charges.

C. Conform to the following procedure code definitions when billing for burn dressing changes:

View or print the procedure codes for Hospital/Critical Access Hospitals/Rural Emergency Hospitals/ESRD services.

D. Medicaid allows reimbursement for only one burn dressing change procedure per day.

E. Physical therapy charges are not included in the global fee.

1. Physical therapy requires a written prescription by the attending physician.
2. Physical therapy requires a PCP referral.
3. A copy of the attending physician's order reflecting the frequency of dressing changes and the mode(s) of therapy to be administered must be maintained in the patient's chart and must be available upon request by any authorized representative of Arkansas Division of Medical Services.

252.300 Rural Emergency Hospital Reimbursement (REH) 9-1-23

252.320 Rural Emergency Hospital Outpatient Reimbursement 9-1-23

A. REH outpatient reimbursement consists of interim fee-for-service payment according to the Arkansas Medicaid Program for Critical Access Hospital outpatient services (at the lesser of the billed charge or the fee schedule maximum) with year-end cost settlements.

B. Allowable costs and cost settlements are determined in accordance with Title XVIII (Medicare) REH cost principles and applicable cost settlement procedures and calculations.

272.115 Observation Bed Billing Information ~~2-1-22~~9-1-23

Use code 760* to bill for Observation Bed. One unit of service on the CMS-1450 (UB-04) outpatient claim equals 1 hour of service. Medicaid will cover up to 8 hours of hospital observation per date of service.

When a physician admits a patient to observation subsequent to providing emergency or non-emergency services in the emergency department, the hospital may bill the observation bed code 760* and the appropriate procedure code for emergency room 450* or non-emergency room 459*. Condition code 88 must be billed to indicate an emergency claim.

View or print the procedure codes for Hospital/Critical Access Hospitals/Rural Emergency Hospitals/ESRD services.

You may not bill 622* or 250*:

A. Alone or in conjunction with only one another.

B. With the non-emergency room procedure code 459*.

C. With an outpatient surgical procedure.

D. Without code 450*.

*Revenue code

272.131 Non-Emergency Charges ~~2-1-22~~9-1-23

The following procedure codes may be billed in conjunction with procedure code 459* (“Other non-emergency service”, which includes room charge). See Section 272.510 for billing requirements.

View or print the procedure codes for Hospital/Critical Access Hospitals/Rural Emergency Hospitals/ESRD services.

*Refer to Section 272.510 for additional criteria.

NOTE: Arkansas Medicaid reimburses for medically necessary vaccines, laboratory services, X-Rays and machine tests in addition to standalone revenue code 0459.

272.132 Procedure Codes Requiring Modifiers ~~2-1-22~~9-1-23

View or print the procedure codes for Hospital/Critical Access Hospitals/Rural Emergency Hospitals/ESRD services.

272.200 Place of Service and Type of Service Codes 9-1-23~~10-13-03~~

Not applicable for Hospital, CAH, REH, or ESRD claims.

272.404 Hyperbaric Oxygen Therapy (HBOT) Procedures

~~2-1-22~~9-1-23

A. **Facilities may bill for only one unit of service per day.** The facility's charge for each service date must include all its hyperbaric oxygen therapy charges, regardless of how many treatment sessions per day are administered.

B. Facilities may bill for laboratory, X-ray, machine tests and outpatient surgery in addition to procedure code.

C. Hospitals and ambulatory surgical centers may bill electronically or file paper claims for procedure code with the prior authorization number placed on the claim in the proper field. If multiple prior authorizations are required, enter the prior authorization number that corresponds to the date of service billed.

View or print the procedure codes for Hospital/Critical Access Hospitals/Rural Emergency Hospitals/ESRD services.

Refer to Sections 217.130, 242.000, 244.000, 245.030, and 252.119 for additional information on HBOT.

272.405 Billing of Gastrointestinal Tract Imaging with Endoscopy Capsule

~~2-1-22~~9-1-23

Gastrointestinal Tract Imaging with Endoscopy Capsule, billed as, is payable for all ages and must be billed by using the primary diagnosis of (**View ICD Codes**.).

View or print the procedure codes for Hospital/Critical Access Hospitals/Rural Emergency Hospitals/ESRD services.

This procedure code should be billed with no modifiers when performed in the outpatient hospital place of service.

CPT code is payable on electronic and paper claims. For coverage policy, see Section 217.113.

272.421 Dialysis Procedure Codes

~~2-1-22~~9-1-23

The facility providing the hemodialysis and peritoneal dialysis service must use the following HCPCS procedure codes when billing for the dialysis treatment:

View or print the procedure codes for Hospital/Critical Access Hospitals/Rural Emergency Hospitals/ESRD services.

The codes listed in CPT-4 must not be used.

National Code	Revenue Code Description
820*	Facility Fee-Hemodialysis (maximum - 3 treatments per week)
830*	Facility Fee - Peritoneal Dialysis (10-19 hours per week)
839*	Facility Fee - Peritoneal Dialysis (20-29 hours per week)
831*	Facility Fee - Peritoneal Dialysis (Weekly - Over 29 hours)

*Revenue code

272.435 Tissue Typing

7-1-229-1-23

A. Authorized procedure codes are payable for the tissue typing for both the donor and the receiver.

View or print the procedure codes for Hospital/Critical Access Hospitals/Rural Emergency Hospitals/ESRD services.

B. The tissue typing is subject to the following benefit limits:

1. Diagnostic laboratory services benefits are limited to five hundred dollars ($500) per State Fiscal Year (SFY: July 1 through June 30);
2. Extensions will be considered for beneficiaries who exceed the five-hundred-dollar benefit limit for diagnostic laboratory services; and
3. Providers must request an extension.

C. Medicaid will authorize up to ten (10) tissue-typing laboratory procedures to determine a match for an unrelated bone marrow donor.

D. A separate claim must be filed for the tissue typing.

E. Claims for the donor must be forwarded to the Transplant Coordinator.

272.436 Billing for Corneal Transplant

2-1-229-1-23

For processing, preserving and transporting corneal tissue, use procedure code

View or print the procedure codes for Hospital/Critical Access Hospitals/Rural Emergency Hospitals/ESRD services.

Requires paper billing and a manufacturer's invoice attached to the claim. See Section 217.062 for coverage information.

272.437 Vascular Embolization and Occlusion

2-1-229-1-23

The following procedure codes require paper billing and documentation attached that describes the procedure code and supports medical necessity:

View or print the procedure codes for Hospital/Critical Access Hospitals/Rural Emergency Hospitals/ESRD services.

272.440 Factor VIIa

2-1-229-1-23

Arkansas Medicaid covers Factor VIIa (coagulation factor, recombinant) for treatment of bleeding episodes in hemophilia A or B patients with inhibitors to Factor VIII or Factor IX. Factor VIIa coverage is restricted to diagnosis codes: (View ICD Codes.).

Providers must bill Medicaid for Factor VIIa with HCPCS procedure code. One unit equals 1.2 milligrams.

View or print the procedure codes for Hospital/Critical Access Hospitals/Rural Emergency Hospitals/ESRD services.

272.441 Factor VIII

2-1-229-1-23

HCPCS procedure code must be used when billing for all anti-hemophiliac Factor VIII, including Monoclate.

View or print the procedure codes for Hospital/Critical Access Hospitals/Rural Emergency Hospitals/ESRD services.

Anti-hemophiliac Factor VIII is covered by the Arkansas Medicaid Program when administered in the outpatient hospital setting, physician's office or beneficiary's home. When billing for this procedure, enter the brand name and the dosage in the description area of the claim form. The provider must bill the cost per unit and the number of units administered. The number of units administered must be entered in the units column of the claim form.

272.442 Factor IX

2-1-229-1-23

HCPCS procedure code must be used when billing for Factor IX Complex (Human).

View or print the procedure codes for Hospital/Critical Access Hospitals/Rural Emergency Hospitals/ESRD services.

Factor IX Complex (Human) is covered by the Arkansas Medicaid Program when administered in the outpatient hospital setting, physician's office or beneficiary's home. When billing for this procedure, enter the brand name and the dosage in the description area of the claim form. The provider must bill the cost per unit and the number of units administered. The number of units administered must be entered in the units column of the claim form.

272.443 Factor VIII and Factor IX

2-1-229-1-23

Anti-hemophiliac Factor VIII is covered by the Arkansas Medicaid Program when administered in the outpatient hospital, physician's office or in the patient's home. The following procedure codes must be used:

Factor VIII [antihemophilic factor (porcine)], per IU

Factor VIII [antihemophilic factor (recombinant)], per IU

View or print the procedure codes for Hospital/Critical Access Hospitals/Rural Emergency Hospitals/ESRD services.

The provider must bill his/her cost per unit and the number of units administered.

HCPCS procedure code must be used when billing for Factor IX Complex (human). Factor IX Complex (human) is covered by Medicaid when administered in the physician's office or the patient's home (residence). The provider must bill his/her cost per unit and the number of units administered.

For the purposes of Factor VIII and Factor IX coverage, the patient's home is defined as where the patient resides. Institutions, such as a hospital or nursing facility, are not considered a patient's residence.

272.447 Bone Stimulation

2-1-229-1-23

View or print the procedure codes for Hospital/Critical Access Hospitals/Rural Emergency Hospitals/ESRD services.

Procedure codes are payable when provided in the physician's office, ambulatory surgical center or outpatient hospital setting to Medicaid beneficiaries of all ages. Procedure codes will require prior authorization and are payable only for non-union of bone. When provided in the outpatient setting, the provider must submit an invoice with the claim if providing the device.

272.448 Vascular Injection Procedures

2-1-229-1-23

Effective for claims with dates of service on or after December 1, 1993, in accordance with Medicare guidelines, the Arkansas Medicaid Program implemented the following policy regarding vascular injection procedures:

If a provider bills procedure code and one or all of the following procedure codes on the same date of service, the Medicaid Program will reimburse for procedure code and the other codes will be denied.

View or print the procedure codes for Hospital/Critical Access Hospitals/Rural Emergency Hospitals/ESRD services.

272.450 Special Billing Requirements for Laboratory and X-Ray Services

9-1-232-1-22

The following codes have special billing requirements for laboratory and X-Ray procedures.

A. CPT and HCPCS Lab Procedure Codes with Diagnosis Restrictions

The following CPT procedure codes will be payable with a primary diagnosis as is indicated below.

View or print the procedure codes for Hospital/Critical Access Hospitals/Rural Emergency Hospital/ESRD services.

B. Genetic Testing

C. Arkansas Code §20-15-302 states that all newborn infants shall be tested for certain metabolic diseases. Arkansas Medicaid shall reimburse the enrolled Arkansas Medicaid hospital provider that performs the tests required for the cost of the tests. Newborn Metabolic Screenings performed inpatient are included in the interim per diem reimbursement rate and facility cost settlement. For Newborn Metabolic Screenings performed in the outpatient setting (due to retesting or as an initial screening), Arkansas Medicaid will reimburse the hospital directly. For the screenings performed in the outpatient hospital setting, the provider will submit a claim using procedure code. All positive test results shall be sent immediately to the Arkansas Department of Health.

The list of metabolic diseases for which providers can bill under can be found within the **Arkansas Department of Health (ADH) rules pertaining to testing of newborn infants**.

272.453 Hysterectomy for Cancer or Dysplasia

9-1-232-1-22

View or print the procedure codes for Hospital/Critical Access Hospitals/Rural Emergency Hospital/ESRD services.

Hospitals may use procedure code when billing for a total hysterectomy procedure when the diagnosis is cancer or severe dysplasia.

Procedure code does not require prior authorization (PA). All hysterectomies require paper billing using claim form CMS-1450. Form DMS-2606 must be properly signed and attached to the claim form.

Procedure code is covered for emergency hysterectomy **immediately** following C-section. It requires no PA but does require form DMS-2606 and an operative report/discharge summary to confirm the emergency status.

272.461 Verteporfin (Visudyne)

9-1-23~~2-1-22~~

Verteporfin (Visudyne), HCPCS procedure code, is payable to outpatient hospitals when furnished to Medicaid beneficiaries of any age when the requirements identified in Section 217.140 are met.

A. Verteporfin administration may be billed separately from the related surgical procedure.

B. Claims for Verteporfin administration must include one of the following ICD diagnosis codes: (**View ICD Codes**.)

C. Use anatomical modifiers to identify the eye(s) being treated.

D. May be billed electronically or on a paper claim

View or print the procedure codes for Hospital/Critical Access Hospitals/Rural Emergency Hospital/ESRD services.

272.462 Billing Protocol for Computed Tomographic Colonography (CT)

9-1-23~~2-1-22~~

A. The following procedure codes are covered for CT colonography for beneficiaries of all ages.

View or print the procedure codes for Hospital/Critical Access Hospitals/Rural Emergency Hospital/ESRD services.

B. Billing protocol for CT colonography procedure codes:

1. CT colonography is billable electronically or on paper claims.
2. For coverage policy information, see Section 217.141 of this manual.

272.500 Influenza Virus Vaccines

9-1-23~~2-1-22~~

View or print the procedure codes for Hospital/Critical Access Hospitals/Rural Emergency Hospital/ESRD services.

A. Procedure code, influenza virus vaccine, split virus, preservative free, for children 6 to 35 months of age, is covered through the Vaccines for Children (VFC) program.

1. Claims for Medicaid beneficiaries must be filed using modifiers **EP** and **TJ**.
2. For ARKids First-B beneficiaries, use modifier **SL**.
3. ARKids First-B beneficiaries are not eligible for the Vaccines for Children (VFC) Program; however, vaccines can be obtained to administer to ARKids First-B beneficiaries who are under the age of 19 by contacting the Arkansas Department of Health and indicating the need to order ARKids-B SCHIP vaccines. **View or Print the Department of Health contact information.**

B. Effective for dates of service on and after October 1, 2005, Medicaid covers procedure code, influenza virus vaccine, split virus, preservative free, for ages 3 years and older.

1. For children under 19 years of age, claims must be filed using modifiers **EP** and **TJ**.
2. For ARKids First-B participants, claims must be filed using modifier **SL**.
3. For individuals aged 19 and older, no modifier is necessary.

C. Effective for dates of service on and after October 1, 2005, procedure code, influenza virus vaccine, live, for intranasal use, is covered. Coverage is limited to healthy individuals ages 5 through 49 who are not pregnant.

1. When filing claims for children 5 through18 years of age, use modifiers **EP** and **TJ**.
2. For ARKids First-B participants, the procedure code must be billed using modifier **SL**.
3. No modifier is required for filing claims for beneficiaries ages 19 through 49.

D. Procedure code, influenza virus vaccine, split virus, for children ages 6 through 35 months, is covered.

1. Modifiers **EP** and **TJ** are required.
2. For ARKids First-B beneficiaries, use modifier **SL**.

E. Procedure code, influenza virus vaccine, split virus, for use in individuals aged 3 years and older, will continue to be covered.

1. When filing paper claims for Medicaid beneficiaries under age 19, use modifiers **EP** and **TJ**.
2. For ARKids First-B participants, use modifier **SL**.
3. No modifier is required for filing claims for beneficiaries aged 19 and older.

272.501 Medication Assisted Treatment and Opioid Use Disorder Treatment Drugs

9-1-232-1-22

Effective for dates of service on and after **September 1, 2020**, Medication Assisted Treatment for Opioid Use Disorders is available to all qualifying Medicaid beneficiaries when provided by providers who possess an X-DEA license on file with Arkansas Medicaid Provider Enrollment for billing purposes. All rules and regulations promulgated within the Physician's provider manual for provision of this service must be followed.

Effective for dates of services on and after **October 1, 2018**, the following Healthcare Common Procedure Coding System Level II (HCPCS) procedure codes are payable:

View or print the procedure codes for Hospital/Critical Access Hospitals/Rural Emergency Hospital/ESRD services.

To access prior approval of these HCPCS procedure codes when necessary, refer to the Pharmacy Memorandums, Criteria Documents and forms found at the **DHS contracted Pharmacy vendor website**.

272.502 Drug Treatment for Pediatric PANS and PANDAS

9-1-236-1-22

A. Effective for dates of service on and after 6/1/2022 drug treatment will be available to all qualifying Arkansas Medicaid beneficiaries when specified conditions are met for one (1) or both of the following conditions:

1. Pediatric acute-onset neuropsychiatric syndrome (PANS),
2. Pediatric autoimmune neuropsychiatric disorders associated with streptococcal infections (PANDAS).

B. The drug treatments include off-label drug treatments, including without limitation intravenous immunoglobulin (IVIG).

C. Medicaid will cover drug treatment for PANS or PANDAS under the following conditions:

1. The drug treatment must be authorized under a Treatment Plan; and

2. The Treatment Plan must be established by the approved PANS/PANDAS provider.

D. A Prior Authorization (PA) must be obtained for each treatment. Providers must submit the current Treatment Plan to the Quality Improvement Organization (QIO) along with the request for Prior Authorization. (Add link to AFMC.)

E. The authorized procedure codes and required modifiers are found in the following link:

View or print the procedure codes for Hospital/Critical Access Hospitals/Rural Emergency Hospital/ESRD services, including PANS and PANDAS procedure codes.

272.520 Vagus Nerve Stimulation Therapy, Device and Procedure Billing Protocol

9-1-23~~6-1-22~~

The Arkansas Medicaid Program covers vagus nerve stimulation therapy, device, and procedure. When filing a claim, providers will bill the cost for both the device and procedure under the single billing code.

View or print the procedure codes for Hospital/Critical Access Hospitals/Rural Emergency Hospital/ESRD services.

FINANCIAL IMPACT STATEMENT

PLEASE ANSWER ALL QUESTIONS COMPLETELY.

DEPARTMENT Human Services
BOARD/COMMISSION Division of Medical Services
PERSON COMPLETING THIS STATEMENT Jason Callan
TELEPHONE NO. (501) 320-6540 **EMAIL** Jason.Callan@dhs.arkansas.gov

To comply with Ark. Code Ann. § 25-15-204(e), please complete the Financial Impact Statement and email it with the questionnaire, summary, markup and clean copy of the rule, and other documents. Please attach additional pages, if necessary.

TITLE OF THIS RULE Rural Emergency Hospitals

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 no, please explain:

   (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 reason for adoption of the more costly rule is based on the interests of public health, safety, or welfare, and if so, how; and

   (d) whether the reason for adoption of the more costly rule is within the scope of the agency's statutory authority, and if so, how.

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

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

Current Fiscal Year		**Next Fiscal Year**	
General Revenue		General Revenue	
Federal Funds		Federal Funds	
Cash Funds		Cash Funds	
Special Revenue		Special Revenue	
Other (Identify)		Other (Identify)	
Total		Total	

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

Current Fiscal Year		**Next Fiscal Year**	
General Revenue	$366,581	General Revenue	$1,264,705
Federal Funds	$942,638	Federal Funds	$3,252,100
Cash Funds		Cash Funds	
Special Revenue		Special Revenue	
Other (Identify)		Other (Identify)	
Total	$1,309,219.00	Total	$4,516,805.00

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

Current Fiscal Year	**Next Fiscal Year**
$ 0.00	$ 0.00

6. What is the total estimated cost by fiscal year to a state, county, or 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**
$ 329,923.00	$ 1,264,705.00

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;

Act 59 of 2023 sets forth the basis for seeking Medicaid coverage and reimbursement for Rural Emergency Hospitals licensed by the Arkansas Health Department. The purpose of this rule is to amend the Arkansas State Plan to be able to draw the federal match for approved services and to give providers a clear understanding of Medicaid's rules and regulations to enroll, participate, and claim reimbursement for the services allowed.

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

As required by Arkansas Act 59 of 2023, the agency seeks to:

- provide access to services;
- encourage healthcare provider collaboration;
- promote delivery of quality, efficiency, and efficacy of rural healthcare;
- embrace technology;
- promote adequate and fair reimbursement of rural healthcare services

(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;

The agency is required to promulgate this rule and amend its state plan to establish and implement coverage for rural emergency hospitals in accordance with its established rulemaking processes. Improving the health of the rural population of this state and establishing equitable access to services and reimbursement thereof meets the statutory objectives of Act 59 of 2023 and justifies the rule's cost.

(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;

N/A

(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;

N/A

(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

N/A

(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.

The Agency monitors State and Federal rules and policies for opportunities to reduce and control cost.

Statement of Necessity and Rule Summary
Rural Emergency Hospitals

Statement of Necessity

The Rural Emergency Hospital rule and state plan amendment are necessary to implement coverage and reimbursement of rural emergency hospitals by Medicaid as addressed in Act 59 of 2023. Rural Emergency Hospitals, licensed by the Arkansas Department of Health, are needed to increase access to services; encourage healthcare provider collaboration; promote high quality, efficient, and effective services while embracing technology and promoting fair and adequate reimbursement for rural healthcare services. These hospitals will provide people living in rural areas the ability to obtain currently sparse or unavailable emergency and outpatient hospital services.

Summary

Section 200.000	Added Rural Emergency Hospital to Header
Section 200.100	Added Rural Emergency Hospital information to body of introductory section
Sections 201.000 Through 201.401	Corrected the title for Arkansas Department of Health and corrected other grammatical errors
Section 201.500	Added Rural Emergency Hospital General information section
Section 201.510	Added Arkansas Medicaid Participation Requirements for REHs
Section 201.520	Added Provider Enrollment Procedures
Section 201.530	Added Provider Enrollment – In-State REHs
Section 201.540	Out-of-State REH Enrollment in the Hospital Program
Section202.000	Added REH to Medical Record Requirements header and body of text, and corrected grammatical errors
Section 202.100	Added REH to header
Section 210.000	Added Rural Emergency Hospital to header
Section 210.100	Corrected the title for Division of Medical Services Medical Director
Section 215.500	Added Rural Emergency Hospitals (REH) Coverage
Section 215.510	Added REH Scope of Coverage
Section 215.520	Added REH Coverage Restrictions Heading
Section 215.530	Added REH Exclusions
Section 215.540	Added REH Benefit Limits
Section 217.111	Corrected verbiage regarding medically necessary services
Section 250.203	Removed outdated cost settlement information
Section 250.230	Removed outdated daily upper limit information
Section 250.623	Deleted outdated section information
Section 250.627	Added Rural Emergency Hospital to list of hospitals ineligible for annual upper payment limit reimbursement adjustment
Section 252.300	Added Rural Emergency Hospital Reimbursement (REH) header
Section 252.320	Added Rural Emergency Hospital Outpatient Reimbursement header and body of section
Section 272.200	Added REH to non-applicability statement under heading, Place of Service and Type of Service Codes

Added REH to the procedure code link in the following sections: 216.300, 216.540, 216.550, 217.062, 217.090, 217.141, 217.150, 244.000, 245.031, 252.117, 272.115, 272.131, 272.132, 272.404, 272.405, 272.421, 272.435, 272.436, 272.437, 272.440, 272.441, 272.442, 272.443, 272.447, 272.448, 272.450, 272.453, 272.461, 272.462, 272.500, 272.501, 272.502, 272.520.

The following pages were submitted to amend the state plan to include coverage and reimbursement for Rural Emergency Hospitals:

- ATTACHMENT 3.1-A, Page 9c(1)
- ATTACHMENT 3.1-B, Page 8d(1)
- ATTACHMENT 4.19-B, Page 10bbbb

The following page is being amended to clarify reimbursement for Acute Crisis Units:

- ATTACHMENT 4.19-A, Page 24

Rules repealed under Executive Order 23-02:

- DDS Policy 1036—HDC Transfers—This rule is outdated as transfers are now covered by other more comprehensive policies.
- DDS Policy 1037—HDC Therapeutic Trial Leaves—this rule is outdated and no longer used.

NOTICE OF RULE MAKING

The Department of Human Services (DHS) announces for a public comment period of thirty (30) calendar days a notice of rulemaking for the following proposed rule under one or more of the following chapters, subchapters, or sections of the Arkansas Code: §§20-76-201, 20-77-107, and 25-10-129.

The Director of the Division of Medical Services amends Medicaid State Plan and the Hospital, Critical Access Hospital (CAH), and End Stage Renal Disease (ERSD) Manual re necessary to implement coverage and reimbursement of rural emergency hospitals by Medicaid as addressed in Act 59 of 2023. Rural Emergency Hospitals, licensed by the Arkansas Department of Health, are needed to increase access to services; encourage healthcare provider collaboration; promote high quality, efficient, and effective services while embracing technology and promoting fair and adequate reimbursement for rural healthcare services. These hospitals will provide people living in rural areas the ability to obtain currently sparse or unavailable emergency and outpatient hospital services. Effective for dates of service on or after September 1, 2023, outpatient services performed by Rural Emergency Hospitals (REH) enrolled in the Arkansas REH Medicaid Program will be reimbursed by minimum interim payment in accordance with the Arkansas Medicaid Program outpatient fee schedule (at the lesser of the billed charge or the fee schedule maximum) with year-end cost settlements. Cost settlements are determined from REH submitted cost reports and are based on 100% reasonable costs. Reasonable costs are defined as total reimbursable costs under Medicare principles of cost reimbursement. The proposed rule estimates a financial impact of $1,309,219 ($942,638 of which is federal funds) for state fiscal year (SYF) 2024 and $4,516,805 ($3,252,100 of which is federal funds) for SYF 2025.

Also, the Medicaid State Plan is amended to clarify reimbursement for Acute Crisis Units.

Pursuant to the Governor's Executive Order 23-02, DHS repeals the following two rules as part of this promulgation: (1) DDS Policy 1036—HDC Transfers, and (2) DDS Policy 1037—HDC Therapeutic Trial Leaves.

The proposed rule is available for review at the Department of Human Services (DHS) Office of Rules Promulgation, 2nd floor Donaghey Plaza South Building, 7th and Main Streets, P. O. Box 1437, Slot S295, Little Rock, Arkansas 72203-1437. You may also access and download the proposed rule at ar.gov/dhs-proposed-rules. This notice also shall be posted at the local office of the Division of County Operations (DCO) of DHS in every county in the state.

Public comments must be submitted in writing at the above address or at the following email address: ORP@dhs.arkansas.gov. All public comments must be received by DHS no later than **November 4, 2023**. Please note that public comments submitted in response to this notice are considered public documents. A public comment, including the commenter's name and any personal information contained within the public comment, will be made publicly available and may be seen by various people.

A public hearing by remote access only through a Zoom webinar will be held on October 25, 2023 at 10:00 a.m. and public comments may be submitted at the hearing. Individuals can access this public hearing at https://us02web.zoom.us/j/81439759736. The webinar ID is 814 3975 9736. If you would like the electronic link, "one-tap" mobile information, listening only dial-in phone numbers, or international phone numbers, please contact ORP at ORP@dhs.arkansas.gov.

If you need this material in a different format, such as large print, contact the Office of Rules Promulgation at (501) 320-6428.

The Arkansas Department of Human Services is in compliance with Titles VI and VII of the Civil Rights Act and is operated, managed and delivers services without regard to religion, disability, political affiliation, veteran status, age, race, color or national origin. 4502172997

Elizabeth Pitman, Director
Division of Medical Services

RULES SUBMITTED FOR REPEAL

Rule #1: DDS Policy 1036--HDC Transfers

Rule #2: DDS Policy 1037--HDC Therapeutic Trial Leaves

ARKANSAS DEPARTMENT OF HUMAN SERVICES
DIVISION OF DEVELOPMENTAL DISABILITIES SERVICES
DDS DIRECTOR'S OFFICE POLICY MANUAL

Policy Type	Subject of Policy	Policy No.
Administrative	HDC Transfers	1036

Procedural Guidelines for HDC Transfers. Individuals may transfer to another HDC subject to the following requirements and conditions.

A. Conditions for Transfer.

1. Referral is a recommendation of the individual's interdisciplinary team.

2. Parent/Guardian involvement in the transfer decision.

3. The individual, to the extent he/she is able, has been involved in the transfer decision.

4. Parent/Guardian transfer approval for individuals who have not reached the age of majority or adults who have been adjudicated incompetent.

5. The transfer benefits the individual, either by being provided services closer to parent/guardian/interested party or by having needs more appropriately met in alternate placement.

6. Local Education Agency participation in the transfer decision, if applicable.

B. Intra-Agency Transfers.

1. Requests.

a) Upon completion of the IDT process, the Superintendent/designee of the facility requesting a transfer must approve the request.

b) A transfer request (including current social, psychological, medical, and most recent IPP and IEP, if appropriate) signed by the Superintendent/designee is sent to the requested facility's Superintendent/designee.

Replacement Notation: This policy replaces DDS Policy #1036 dated January 8, 1987.

Effective Date: December 1, 1993

References: DDS Board Policy #1003, Residential Placements/ Transfers and Discharges.

Administrative Rules & Regulations Sub Committee of the Arkansas Legislative Council: November 4, 1993.

c) Within ten (10) working days of receipt of the request, the Superintendent of the requested facility must respond to the request, stating whether or not the individual is appropriate for transfer, and if appropriate, a tentative date for transfer or placement on a waiting list if space is not immediately available. If placement is considered inappropriate, the reason(s) for refusal is stated in the response.

Procedural Guidelines for HDC Transfers.

d) If the requested facility does not determine the individual is appropriate for that facility, the sending Superintendent has five (5) working days from receipt of such notice in which to provide additional information/support of the recommendation for transfer, to the Superintendent of the requested facility.

e) Within five (5) working days of receipt of additional information, the Superintendent of the requested facility must respond to the Superintendent of the sending facility, rendering a decision.

f) Within five (5) working days of receipt of a denial of the request, the Superintendent requesting transfer may appeal the decision to the DDS Director.

g) Within ten (10) working days of receipt of the transfer request packet, the DDS Director will render a written decision to both Superintendents.

2. Transfers.

a) The sending Superintendent shall make arrangements for the actual transfer of the individual and master record, as well as personal belongings and all other items that would reasonably be expected to be moved. The sending Superintendent will make arrangements for the individual to be transported by an employee who is familiar with and able to provide personal information regarding the individual's needs and habits.

b) Upon agreement of a transfer, the staff of both facilities shall make mutually satisfactory arrangements with individual and parent/guardian to visit receiving facility.

c) On the day of the transfer, the sending facility shall adjust the appropriate information of residential status on the Data Base System.

d) The transfer information will be entered on the next Vacancy Report after the date of the transfer.

e) Unless emergency circumstances dictate, 30 days notice shall be given for transfers.

Procedural Guidelines for HDC Transfers.

3. Vacancy Report.

When a transfer request is sent, the individual's name will be placed on each respective facility's vacancy report in the appropriate place. Names will remain on the vacancy report until the individual is either transferred, denied and not appealed, or an appeal decision has been reached

C. Intra-Institutional Transfers (Living Unit to Living Unit)

1. Upon completion of the IDT process, the Superintendent/ designee must approve the transfer. If in attendance, parent/guardian may sign authorization at IDT meeting.

2. Within five (5) working days of Superintendent/designee approval, and if appropriate, request for parent/guardian approval shall be sent, allowing ten (10) working days for response from receipt of notification.

3. If the parent/guardian fails to respond to the notification within the stated time frame, transfer will occur and notice of transfer occurrence will be sent to the parent/guardian within three (3) days of the transfer, unless life/health/ safety dictate otherwise.

4. If the parent/guardian responds negatively to the transfer request, the Superintendent/designee shall inform parent/guardian of the Appeal Process.

Policy Type	Subject of Policy	Policy No.
Administrative	HDC Transfers	1036

D. Appeal

Any time during the Intra-Agency and/or Intra-Institutional Transfer Process and prior to the transfer notice of the right to appeal the decision(s) as outlined in DDS Policy 1076 shall be provided to the parent/guardian/individual.

ARKANSAS DEPARTMENT OF HUMAN SERVICES
DIVISION OF DEVELOPMENTAL DISABILITIES SERVICES
DDS DIRECTOR'S OFFICE POLICY MANUAL

Policy Type	Subject of Policy	Policy No.
Administrative	HDC Therapeutic/Trial Leaves	1037

1. Purpose. The purpose of this policy is to establish administrative guidelines governing leave for individuals who reside at Developmental Disabilities Services Human Development Centers.

2. Scope. This policy is directed to all employees of Developmental Disabilities Services and applies to all leaves of persons residing in HDCs.

3. Guidelines. Leave is granted to an individual from a Human Developmental Center, whose needs justify leave from center grounds and a guarantee of bed reservation during his leave. While the individual is on leave, his/her case remains the responsibility of the Human Development Center unless the case is transferred to another case management entity.

4. Types of Leave.

   A. Therapeutic Leave – One (1) to fourteen (14) day visit out of the facility with parent/guardian:

   B. Trial Placement Review Leave – Up to thirty (30) day period of time an individual is in a trial placement in a community program, prior to full admission.

5. Procedural Additions.

   A. Therapeutic Leave

      1) Upon receipt of parent/guardian notification of a home visit, staff will review with the parent the preferable 14 day limit on leave, emphasizing the benefits for the individual.

Replacement Notation: This policy replaces DDS Policy #1037 effective July 13, 1981 and January 8, 1987.

Effective Date: December 1, 1993 Sheet 1 of 3

References: MR-DDS Institutional Services Policy RS-PO-9, September 21, 1977, which is hereby superseded.

Administrative Rules & Regulations Sub Committee of the Arkansas Legislative Council: November 4, 1993.

2) Staff will complete any required paperwork documenting leave.

3) Upon receipt of parent/guardian request for leave of more than fourteen (14) Days, the request shall be presented to the Superintendent for review and action.

4) All documents related to Therapeutic Leave shall be maintained in the Master File.

NOTE: Upon explanation to parent/guardian of fourteen (14) day limit, staff should encourage more frequent visits for shorter periods of time.

B. Trial Placement Review Leave

1) Recommendations for placement outside the HDC shall be based upon IDT review.

2) HDC staff shall communicate with Client Services staff and DDS licensed programs to assure the selected program site will meet the individual's needs.

3) HDC staff shall coordinate plans for trial placements.

4) Prior to the granting of leave, the parents/guardian will be contacted to explain the recommended trial leave from the HDC and all policies and procedures regarding leave. This will be documented by an authorization for leave signed by the parents/guardian and/or the individual if 18 or older and functioning as his/her own guardian. The length of the leave will not exceed sixty (60) days, in thirty (30) day increments.

If the individual will reside in another facility (i.e., State Hospital, Community Group Home, Child Study Center, etc.), the HDC will contact the facility to discuss case planning prior to actual placement; will assist in providing services; and will monitor the status of the individual. A member of the HDC staff will be established as contact point for the outside facility.

Policy Type	Subject of Policy	Policy No.
Administrative	HDC Therapeutic/Trial Leaves	1037

5) Documentation recommending continuation of the leave will be sent by staff to the Superintendent for a decision. The Superintendent may choose to extend the leave further than thirty (30) days by making a one time only extension for a period of up to thirty (30) additional days.