Division of Medical Services
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MEMORANDUM

TO: Interested Persons and Providers

FROM: Elizabeth Pitman, Director, Division of Medical Services

DATE: October 12, 2023

SUBJ: Outpatient Behavioral Health Counseling Services and Rates (Rule 219)

As a part of the Arkansas Administrative Procedure Act process, attached for your review and comment are proposed rule revisions.

Public comments must be submitted in writing at the above address or at the following email address: ORP@dhs.arkansas.gov 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.

If you have any comments, please submit those comments in writing, no later than November 12, 2023.

All DHS proposed rules, public notices, and recently finalized rules may also be viewed at: Proposed Rules & Public Notices.

NOTICE OF RULE MAKING

The Department of Human Services 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.

Good quality, easily accessible counseling services utilized for early intervention can prevent beneficiaries' needs for higher cost, longer-term home and community-based or institutional services. Based upon a study of outpatient behavioral health rates conducted in 2022, the Division of Medical Services (DMS) issues a rule amending counseling rates and removing the primary care provider referral requirement to receive behavioral counseling services. The Medicaid State Plan amendment proposes to make permanent the increase to individual counseling rates that was instituted during the pandemic and to rebalance group rates as recommended in the rate study. Beginning January 1, 2024, the updates to the Behavioral Health Counseling are as follows: Individual Behavioral Health Counseling, Marital or Family Behavioral Health Counseling (both with and without the client present), and Mental Health Diagnosis will be calculated at eighty percent (80%) of the 2022 Medicare non-rural rate for the State of Arkansas; and Group Behavioral Health Counseling and Multi-Family Behavioral Health Counseling will be calculated at one hundred percent (100%) of the 2022 Medicare non-rural rate for the State of Arkansas. The rate changes were set using a state comparison methodology based on the Medicare rate. As a result, individual counseling rates that were below 80% of the Medicare rate were raised to 80% and the group and multi-group family therapy rates that were well above 100% of the Medicare rate were lowered to 100%. The projected annual cost of this change for State fiscal year (SFY) 2024 is $3,610,316.00 (federal share of $2,599,427.00) and for SFY 2025 is $7,220,632.00 (federal share of $5,198,855.00).

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 12, 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 November 1, 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/81376434723. The webinar ID is 813 7643 4723 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. 4502172997

Elizabeth Pitman, Director
Division of Medical Services

4.b. Early and Periodic Screening and Diagnosis of Individuals Under 21 Years of Age and Treatment of Conditions Found (Continued)

Outpatient Behavioral Health Services

The fee schedule was set as of July 1, 2017 and is effective for services provided on or after this date. Except as noted in the plan, state developed fee schedule rates are the same for both governmental and private providers of behavioral health services. ~~The fee schedule can be accessed at https://www.medicaid.state.ar.us/Provider/docs/fees.aspx.~~ Based on the information gained from the peer state analysis and the consideration of adjustment factors such as Bureau of Labor Statistics (BLS) along with Geographic Pricing Cost Index (GPCI) to account for economic differences, the state was able to select appropriate rates from fee schedules published by peer states. Once this rate information was filtered according to Arkansas requirements a "state average rate" was developed. This "state average rate" consisting of the mean from every peer state's published rate for a given procedure served as the base rate for the service, which could then be adjusted by previous mentioned factors (BLS), (GPCI) etc.

Effective January 1, 2024, the following services will be set to pay eighty percent (80%) of the 2022 Medicare non-rural rate for the State of Arkansas:

- **Individual Behavioral Health Counseling;**
- **Marital or Family Behavioral Health Counseling without Beneficiary Present;**
- **Marital or Family Behavioral Health Counseling with Beneficiary Present; and**
- **Mental Health Diagnosis.**

Effective January 1, 2024, the following services will be adjusted to pay one hundred percent (100%) of the 2022 Medicare non-rural rate for the State of Arkansas:

- **Group Behavioral Health Counseling; and**
- **Multi-Family Behavioral Health Counseling.**

All rates are published on the agency's website: Fee Schedules - Arkansas Department of Human Services

13. Other diagnostic, screening, preventive and rehabilitative services, i.e., other than those provided elsewhere in this plan. (Continued)

Outpatient Behavioral Health Services

The fee schedule was set as of July 1, 2017, and is effective for services on or after this date. Rates for services provided under the Residential Community Reintegration Program are effective for dates of service on or after October 1, 2017. Except as noted in the plan, state developed fee schedule rates are the same for both governmental and private providers of behavioral health services. ~~The fee schedule can be accessed at https://www.medicaid.state.ar.us/Provider/docs/fees.aspx.~~ Based on the information gained from the peer state analysis and the consideration of adjustment factors such as Bureau of Labor Statistics (BLS) along with Geographic Pricing Cost Index (GPCI) to account for economic differences, the state was able to select appropriate rates from fee schedules published by peer states. Once this rate information was filtered according to Arkansas requirements a "state average rate" was developed. This "state average rate" consisting of the mean from every peer state's published rate for a given procedure served as the base rate for the service, which could then be adjusted by previous mentioned factors (BLS), (GPCI) etc.

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- **Individual Behavioral Health Counseling;**
- **Marital or Family Behavioral Health Counseling without Beneficiary Present;**
- **Marital or Family Behavioral Health Counseling with Beneficiary Present; and**
- **Mental Health Diagnosis.**

Effective January 1, 2024, the following services will be adjusted to pay one hundred percent (100%) of the 2022 Medicare non-rural rate for the State of Arkansas:

- **Group Behavioral Health Counseling; and**
- **Multi-Family Behavioral Health Counseling.**

All rates are published on the agency's website: Fee Schedules - Arkansas Department of Human Services

Acute Crisis Units is being moved to NEW page 4.19-B, page 5aaa

~~**Acute Crisis Units**~~

~~The fee schedule was set as of July 1, 2017 and is effective for services provided on or after this date. Except as noted in the plan, state developed fee schedule rates are the same for both governmental and private providers of behavioral health services. The fee schedule can be accessed at https://www.medicaid.state.ar.us/Provider/docs/fees.aspx. Effective for dates of service on or after July 1, 2017, reimbursement for Acute Crisis Unit is based on prospective rate of $350.00 per day with no cost settlement and no budget submission necessary for all certified Acute Crisis Unit providers. No room and board costs, or other unallowable facility costs, are built into the daily rate. Based on the information gained from the peer state analysis and the consideration of adjustment factors such as Bureau of Labor Statistics (BLS) along with Geographic Pricing Cost Index (GPCI) to account for economic differences, the state was able to select appropriate rates from fee schedules published by peer states. Once this rate information was filtered~~

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~~Each provider furnishing this service must keep any records necessary to disclose the extent of services the provider furnishes to beneficiaries and, on request, furnish the Medicaid agency any information maintained and any information regarding payments claimed by the provider for furnishing this service. The Division of Provider Services and Quality Assurance (DPSQA), in conjunction with the State's contracted review entity, will provide ongoing monitoring to assure that services provided under the bundled rate are of the type, quantity and intensity of services required to meet the medical need of beneficiaries.~~

13. Other diagnostic, screening, preventive and rehabilitative services, i.e., other than those provided elsewhere in this plan. (Continued)

Acute Crisis Units

The fee schedule was set as of July 1, 2017 and is effective for services provided on or after this date. Except as noted in the plan, state developed fee schedule rates are the same for both governmental and private providers of behavioral health services. The fee schedule can be accessed at Fee Schedules - Arkansas Department of Human Services. Effective for dates of service on or after July 1, 2017, reimbursement for Acute Crisis Unit is based on prospective rate of $350.00 per day with no cost settlement and no budget submission necessary for all certified Acute Crisis Unit providers. No room and board costs, or other unallowable facility costs, are built into the daily rate. Based on the information gained from the peer state analysis and the consideration of adjustment factors such as Bureau of Labor Statistics (BLS) along with Geographic Pricing Cost Index (GPCI) to account for economic differences, the state was able to select appropriate rates from fee schedules published by peer states. Once this rate information was filtered according to Arkansas requirements a "state average rate" was developed. This "state average rate" consisting of the mean from every peer state's published rate for a given procedure served as the base rate for the service, which could then be adjusted by previous mentioned factors (BLS), (GPCI) etc.

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TOC required

202.000 Arkansas Medicaid Participation Requirements for Counseling Services 1-1-2~~34~~

All behavioral health providers approved to receive Medicaid reimbursement for services to Medicaid clients must meet specific qualifications.

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. Must be certified by the ~~Divisions of Provider Services and Quality Assurance (DPSQA)~~ appropriate DHS division as a Behavioral Health Agency, a Community Support Systems Provider Agency- Intensive or Enhanced, or be certified by the Dept. of Education as a school-based mental health provider.

1. ~~or be il~~Independently licensed ~~as a~~ practitioners (ILPs) can enroll directly as an Independently Licensed Practitioner without certification: ILPs include:
   - a~~1~~. Licensed Clinical Certified Social Worker (LCSW)
   - b~~2~~. Licensed Marital and Family Therapist (LMFT)
   - c~~3~~. Licensed Psychologist (LP)
   - d~~4~~. Licensed Psychological Examiner – Independent (LPEI)
   - e~~5~~. Licensed Professional Counselor (LPC)
   - f~~6~~. Licensed Alcohol and Drug Abuse Counselor (LADAC)
2. Group practices of Independently Licensed Practitioners can enroll directly without certification.

C. 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.

D~~M~~HS 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.

2110.1000 Coverage of Services 1-1-234

Counseling Services are limited to enrolled providers as indicated in 202.000 who offer core counseling services for the treatment of behavioral disorders.

An Counseling Services providers must establish an emergency response plan. Each provider must have 24-hour emergency response capability to meet the emergency treatment needs of the Counseling Services clients served by the provider. The provider must implement and maintain a written policy reflecting the specific coverage plan to meet this requirement. 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.

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

2110.200 Staff Requirements 1-1-234

Each Counseling Services provider must ensure that they employ staff which are able and available to provide appropriate and adequate services offered by the provider. Counseling Services 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. Non-independently licensed clinicians must serve as a rendering provider through a certified agency provider.

PROVIDER TYPE	LICENSES	STATE CERTIFICATION REQUIRED	SUPERVISION
Independently Licensed Clinicians – Master's/Doctoral	Licensed Certified Social Worker (LCSW) Licensed Marital and Family Therapist (LMFT) Licensed Psychologist (LP) Licensed Psychological Examiner – Independent (LPEI) Licensed Professional Counselor (LPC)	Yes, must be licensed through the relevant licensing board to provide services	Not Required
Non-independently	Licensed Master	Yes, must be licensed	Required

PROVIDER TYPE	LICENSES	STATE CERTIFICATION REQUIRED	SUPERVISION
Licensed Clinicians – Master's/Doctoral	Social Worker (LMSW) Licensed Associate Marital and Family Therapist (LAMFT) Licensed Associate Counselor (LAC) Licensed Psychological Examiner (LPE) Provisionally Licensed Psychologist (PLP) Provisionally Licensed Master Social Worker (PLMSW)	through the relevant licensing board to provide services and be employed or contracted by a certified Behavioral Health Agency, Community Support System Agency, or certified by the Dept. of Education as a school-based mental health provider	
Licensed Alcoholism and Drug Abuse Counselor Master's	Licensed Alcoholism and Drug Abuse Counselor (LADAC) Master's Doctoral	Yes, must be licensed through the relevant licensing board to provide services	
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	Must be employed or contracted by a certified Behavioral Health Agency, or Community Support System Agency	Collaborative Agreement with Physician Required
Physician	Doctor of Medicine (MD) Doctor of Osteopathic Medicine (DO)	Must be employed or contracted by a certified Behavioral Health Agency, or Community Support System Agency	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 a Counseling Services provider files a claim with Arkansas Medicaid, the staff member who actually performed the service must be identified on the claim as the 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 1-1-234

As illustrated in the chart in § 211.200, certain Counseling Services billing providers are required to be certified by ~~the Division of Provider Services and Quality Assurance~~DHS. The certification requirements for performing providers are located on the **D~~PSQA~~HS website**.

212.000 Scope 1-1-234

The Counseling Services Program provides treatment and services ~~which~~ that are provided by a certified Behavioral Health Services provider to Medicaid-eligible clients ~~that~~ who have a Behavioral Health diagnosis as described in the American Psychiatric Association Diagnostic and Statistical Manual (DSM-5 and subsequent revisions).

Eligibility for services depends on the needs of the client. Counseling ~~s~~Services and Crisis Services can be provided to any client as long as the services are medically necessary.

~~COUNSELING SERVICES~~

~~T~~Counseling services are time-limited behavioral health services provided by qualified licensed practitioners in an allowable 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.

213.000 Counseling Services Program Entry 1-1-234

The intake assessment, either the Mental Health Diagnosis, Substance Abuse Assessment, or Psychiatric Assessment, must be completed prior to the provision of counseling services in the Counseling Services ~~p~~Program manual. This intake will assist providers in determining services needed and desired outcomes for the client. The intake must be completed by a behavioral health professional qualified by licensure and experienced in the diagnosis and treatment of behavioral health disorders.

Prior to continuing provision of counseling services, the provider must document medical necessity of Counseling Services. The documentation of medical necessity is a written intake assessment that evaluates the client's mental condition, and~~,~~ based on the client's diagnosis, determines whether treatment in the Counseling Services Program is appropriate. This documentation must be made part of the client's medical record.

View or print the procedure codes for counseling services.

214.100 Parent/Caregiver & Child (Dyadic treatment of Children age 0-47 months & Parent/Caregiver) 1-1-234

Counseling Services providers may provide dyadic treatment of clients age zero through forty-seven (0-47) months and the parent/caregiver of the eligible client. 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 Counseling Services MUST be certified by ~~DAABHS~~ the appropriate DHS division to provide those services.

Providers will diagnose children through the age of forty-seven (47) months based on the most current version of the Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood. Providers will then crosswalk the diagnosis to an allowable ~~DMS~~behavioral health diagnosis. Specified Z and T codes and conditions that may be the focus of clinical attention according to DSM 5 or subsequent editions will be allowable for this population.

214.300 Substance Abuse Covered Codes 1-1-2~~34~~

Certain Counseling Services are covered by Arkansas Medicaid for an individual whose primary diagnosis is substance abuse. Licensed Practitioners may provide Substance Abuse Service within the scope of their practice. Individuals solely licensed as Licensed Alcoholism and Drug Abuse Counselors (LADAC) may only provide services to individuals with a primary substance use diagnosis. Behavioral Health Agency and Community Support System Providers Intensive and Enhanced sites must be licensed by the ~~Divisions of Provider Services and Quality Assurance~~ appropriate DHS division ~~in order~~ to provide Substance Abuse Services.

~~217.100 Primary Care Physician (PCP) Referral 1-1-23~~

~~Each client that receives counseling services in the Counseling Services program can receive a limited amount of counseling 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 client's medical record.~~

~~A client can receive ten (10) counseling services before a PCP/PCMH referral is necessary. Crisis Intervention (Section 255.001) does not count toward the ten (10) counseling services. The PCP/PCMH referral must be kept in the client's medical record.~~

~~The Patient Centered Medical Home (PCMH) will be responsible for coordinating care with a client's PCP or physician for counseling services. Medical responsibility for clients receiving counseling services shall be vested in a physician licensed in Arkansas.~~

~~The PCP referral or PCMH authorization for counseling 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 client'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.~~

224.000 Physician's Role 1-1-2~~34~~

Counseling ~~s~~Services providers are responsible for communication with the client's primary care physician ~~in order~~ to ensure psychiatric and medical conditions are monitored and addressed by appropriate physician oversight and that medication evaluation and prescription services are available to individuals requiring pharmacological management.

226.100 Documentation 1-1-2~~34~~

All Counseling Services providers must develop and maintain sufficient written documentation to support each medical or remedial therapy, service, activity, or session for which Medicaid reimbursement is sought. This documentation, at a minimum, must:

A. Be individualized to the client and specific to the services provided, duplicated notes are not allowed

B. Include the date and actual time the services were provided

C. Contain original signature, name, and credentials of the person~~,~~ who provided the services

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

E. Document the relationship of the services to the treatment regimen described in the Treatment Plan

F. Contain updates describing the patient's progress

G. Document involvement, for services that require contact with anyone other than the client, evidence of conformance with HIPAA regulations, including presence in documentation of Specific Authorizations, if required

Documentation must be legible and concise. The name and title of the person providing the service must reflect the appropriate professional level in accordance with the staffing requirements found in Section 211.200.

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

~~**227.000 Prescription for Counseling Services** 1-1-23~~

~~The approval by the PCP or PCMH will serve as the prescription for counseling services in the Counseling 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.~~

~~Prescriptions shall be based on consideration of an evaluation of the enrolled client. The prescription for the services and subsequent renewals must be documented in the client's medical record.~~

228.000 Provider Reviews 1-1-2~~3~~4

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

228.130 Retrospective Reviews 1-1-2~~3~~4

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

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

228.132 Review Sample and the Record Request 1-1-2~~3~~4

On a calendar quarterly basis, the DHS contractor will select a statistically valid random sample from an electronic data set of all Counseling Services ~~clients~~ beneficiaries whose dates of service occurred during the three (3) -month selection period. This sample will include a sample from each enrolled provider. If a client was selected in any of the three (3) calendar quarters prior to the current selection period, then the~~y~~ client will be excluded from the sample and an alternate client 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~~sent to each provider ~~who provided services to the clients selected for the random sample~~ along with their identified client served and instructions for submitting the medical record. The request will include the client's name, date of birth, Medicaid identification number, and dates of service. The request also 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 electronic medium. **View or print current contractor contact information.** Records will not be accepted via email.

228.133 Review Process 1-1-2~~3~~4

The record will be reviewed using a review tool based upon the promulgated Medicaid Counseling 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 therapy (LP, LCSW, LMSW, LPE, LPE-I, LPC, LAC, LMFT, LAMFT, 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 client. 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 will 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~~ that 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 client. 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. D~~M~~HS will ensure that its contractor(s) is/are furnished a copy of the Act.

229.000 Medicaid Client Appeal Process 1-1-2~~3~~4

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

The appeal request must be in writing and received by the Appeals and Hearings ~~Section~~ office ~~of the~~in ~~Department of Human Services~~DHS within thirty (30) days of the date on the letter explaining the denial of services.

229.200 Recoupment Process 1-1-2~~3~~4

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

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

231.000 Introduction to Extension of Benefits 1-1-2~~3~~4

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

231.200 Extension of Benefits 1-1-2~~3~~4

Extension of benefits is required for all services when the maximum benefit for the service is exhausted. Yearly service benefits are based on the state fiscal year running from July 1 to June 30. Extension of Benefits ~~is~~ also is required whenever a client exceeds eight (8) hours of outpatient services in one 24-hour day, with the exception of any service that is paid on a per diem basis.

Extension of ~~b~~Benefit requests must be sent to the D~~M~~HS ~~-~~contracted entity to perform ~~e~~Extensions of ~~b~~Benefits for clients. **View or print current contractor contact information.** Information related to clinical management guidelines and authorization request processes is available at **current contractor's website**.

240.100 Reimbursement 1-1-2~~3~~4

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 client 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 client is eligible for Arkansas Medicaid prior to rendering services.

A. Counseling Services

Fifteen (15) -Minute Units, unless otherwise stated

Counseling Services must be billed on a per unit basis as indicated in the service definition, as reflected in a daily total, per client, per service.

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

All billing must reflect a daily total, per Counseling S~~s~~ervice, 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 client. There is no "carryover" of time from one day to another or from one client to another.

Documentation in the client'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 client or provider of the service.

241.000 Fee Schedule 1-1-234

Arkansas Medicaid provides fee schedules on the **DHMS website**. The fees represent the fee-for-service reimbursement methodology.

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

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

242.000 Rate Appeal Process 1-1-234

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

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

The request for review by the Rate Review Panel must be postmarked within fifteen (15) calendar days following the notification of the initial decision by the Assistant Director, Division of

Medical Services. The Rate Review Panel will meet to consider the question(s) within fifteen (15) calendar days after receipt of a request for such appeal. The question(s) will be heard by the panel and a recommendation will be submitted to the Director of the Division of Medical Services.

251.000 Introduction to Billing 1-1-2~~3~~4

Counseling Services providers use the CMS-1500 form to bill ~~the~~ Arkansas Medicaid ~~Program~~ on paper for services provided to eligible Medicaid clients. Each claim may contain charges for only one (1) client. **View a CMS-1500 sample form.**

Section III of this manual contains information about available options for electronic claim submission.

252.112 Group Behavioral Health Counseling 1-1-2~~3~~4

CPT®/HCPCS PROCEDURE CODE	PROCEDURE CODE DESCRIPTION
View or print the procedure codes for counseling services.	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 clients. Services leverage the emotional interactions of the group's members to assist in each client's treatment process, support their rehabilitation effort, and to minimize relapse. Services pertain to a client's (a) Mental Health or (b) Substance Abuse condition, or both. Additionally, tobacco cessation counseling is a component of this service. Services must be congruent with the age and abilities of the client, client-centered, and strength-based; with emphasis on needs as identified by the client and provided with cultural competence.	• Date of Service • Start and stop times of actual group encounter that includes identified client • Place of service • Number of participants • Diagnosis and pertinent interval history • Focus of group • Brief mental status and observations • Rationale for group counseling must coincide with the most recent intake assessment • Client's response to the group counseling that includes current progress or regression and prognosis • Any revisions indicated for diagnosis, or medication concerns • Plan for next group session, including any homework assignments or crisis plans, or both • Staff signature/credentials/date of signature

NOTES	UNIT	BENEFIT LIMITS
This does NOT include psychosocial groups. Clients eligible for Group 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 clients eighteen (18) years of age	Encounter	DAILY MAXIMUM OF ENCOUNTERS THAT MAY BE BILLED: One (1) YEARLY MAXIMUM OF ENCOUNTERS THAT MAY BE BILLED

and over, the minimum number that must be served in a specified group is two (2). The maximum that may be served in a specified group is twelve (12). For groups of clients under eighteen (18) years of age, the minimum number that must be served in a specified group is two (2). The maximum that may be served in a specified group is ten (10). A client must be at least four (4) years of age to receive group therapy. Group treatment must be age and developmentally appropriate, (i.e., sixteen (16) year-olds and four (4) year-olds must not be treated in the same group). Providers may bill for services only at times during which clients participate in group activities.		(extension of benefits can be requested): Twelve (12) encounters

APPLICABLE POPULATIONS	**SPECIAL BILLING INSTRUCTIONS**
Children, Youth, and Adults	A provider can only bill one (1) Group Behavioral Health Counseling encounter per day. There are twelve (12) total group behavioral health counseling encounters allowed per year, unless an extension of benefits is allowed by the Quality Improvement Organization contracted with Arkansas Medicaid.
ALLOWED MODE(S) OF DELIVERY	**TIER**
Face-to-face Telemedicine (Adults, eighteen (18) years of age and above)	Counseling
ALLOWABLE PERFORMING PROVIDERS	**PLACE OF SERVICE**
• Independently Licensed Clinicians – Master's/Doctoral • Non-independently Licensed Clinicians – Master's/Doctoral • Licensed Alcoholism and Drug Abuse Counselor Master's • Advanced Practice Nurses • Physicians	02 (Telemedicine), 03 (School), 10 (Telehealth Provided in Client's Home), 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)

252.117 Mental Health Diagnosis 1-1-234

CPT®/HCPCS PROCEDURE CODE	**PROCEDURE CODE DESCRIPTION**
View or print the procedure codes for counseling services.	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	• Date of Service • Start and stop times of the face-to-face encounter with the client and the interpretation time for diagnostic formulation

include time spent for obtaining necessary information for diagnostic purposes. The psychodiagnostics 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 or telemedicine 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 client, client-centered, and strength-based; with emphasis on needs as identified by the client and provided with cultural competence.	• Place of service • Identifying information • Referral reason • Presenting problem(s), history of presenting problem(s) including duration, intensity, and response(s) to prior treatment • Culturally and age-appropriate psychosocial history and assessment • Mental status (Clinical observations and impressions) • Current functioning plus strengths and needs • DSM diagnostic impressions • 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 This service can be provided via telemedicine ***Dyadic treatment is available for parent/caregiver and child for dyadic treatment of children from zero through forty-seven (0-47) months of age and parent/caregiver. A Mental Health Diagnosis will be required for all children through forty-seven (47) months of age to receive services. This service includes up to four (4) encounters for children through the age of forty-seven (47) months of age and can be provided without a prior authorization. This service must include an assessment of:** ○ **Presenting symptoms and behaviors** ○ **Developmental and medical history** ○ **Family psychosocial and medical history** ○ **Family functioning, cultural and communication patterns, and current environmental conditions and stressors** ○ **Clinical interview with the primary caregiver and observation of the**	Encounter	DAILY MAXIMUM OF ENCOUNTERS THAT MAY BE BILLED: One (1) YEARLY MAXIMUM OF ENCOUNTERS THAT MAY BE BILLED (extension of benefits can be requested): One (1)

caregiver-infant relationship and interactive patterns and ○ **Child's affective, language, cognitive, motor, sensory, self-care, and social functioning**		
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:** Psychiatric Assessment **View or print the procedure codes for counseling services.**	
ALLOWED MODE(S) OF DELIVERY	**TIER**	
Face-to-face Telemedicine (Adults, Youth, and Children)	Counseling	
ALLOWABLE PERFORMING PROVIDER	**PLACE OF SERVICE**	
• Independently Licensed Clinicians – Master's/Doctoral • Non-independently Licensed Clinicians – Master's/Doctoral • Advanced Practice Nurses • Physicians • Providers of dyadic services must be trained and certified in specific evidence-based practices to be reimbursed for those services ○ Independently Licensed Clinicians – Parent/Caregiver and Child (Dyadic treatment of Children from zero through forty-seven (0-47) months of age and Parent/Caregiver) Provider ○ Non-independently Licensed Clinicians – Parent/Caregiver and Child (Dyadic treatment of Children from zero through forty-seven (0-47) months of age and Parent/Caregiver) Provider	02 (Telemedicine), 03 (School), 04 (Homeless Shelter), 10 (Telehealth Provided in Client's Home), 11 (Office) 12 (Patient's Home), 32 (Nursing 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)	

252.119 Substance Abuse Assessment 1-1-23~~3~~4

CPT®/HCPCS PROCEDURE CODE	PROCEDURE CODE DESCRIPTION
View or print the procedure codes for counseling services.	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 client's substance abuse condition using the Addiction Severity Index (ASI) or an assessment instrument approved by DHS The assessment must screen for and identify any existing co-morbid conditions. The assessment should assign a diagnostic impression to the client, 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 client, client-centered, and strength-based; with emphasis on needs, as identified by the client, and provided with cultural competence.	• Date of Service • Start and stop times of the face-to-face encounter with the client 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 • Cultural and age-appropriate psychosocial history and assessment • Mental status (Clinical observations and impressions) • Current functioning and strengths in specified life domains • DSM diagnostic impressions • 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, client recommendation for treatment regimen appropriate to the condition and situation presented by the client, 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 client for a psychiatric consultation.	Encounter	DAILY MAXIMUM OF ENCOUNTERS THAT MAY BE BILLED: One (1) YEARLY MAXIMUM OF ENCOUNTERS THAT MAY BE BILLED (extension of benefits can be requested): One (1)
APPLICABLE POPULATIONS	**SPECIAL BILLING INSTRUCTIONS**	
Children, Youth, and Adults	**The following codes cannot be billed on the Same Date of Service:** Interpretation of Diagnosis **View or print the procedure codes for counseling services.**	
ALLOWED MODE(S) OF DELIVERY	**TIER**	
Face-to-face Telemedicine (Adults, Youth, Children)	Counseling	
ALLOWABLE PERFORMING PROVIDERS	**PLACE OF SERVICE**	
• Independently Licensed Clinicians – Master's/Doctoral	02 (Telemedicine), 03 (School), 04 (Homeless Shelter), 10 (Telehealth Provided in Client's	

• Non-independently Licensed Clinicians – Master's/Doctoral • Advanced Practice Nurses • Physicians • Licensed Alcoholism and Drug Abuse Counselor Master's	Home), 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)

252.123 Intensive Outpatient Substance Abuse Treatment 1-1-234

PROCEDURE CODES	PROCEDURE CODE DESCRIPTION
View or print the procedure codes for counseling services.	Intensive outpatient treatment for alcohol and/or substance abuse. Treatment program must operate a minimum of three (3) hours per day and at least three (3) days per week. The treatment is based on an individualized plan of care 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 (1) life domain (e.g., familial, social, occupational, educational, etc.). Services are goal-oriented interactions with the individual or in group/family settings. This community-based service allows the individual to apply skills in "real world" environments. Such treatment may be offered during the day, before or after work or school, in the evening or on a weekend. The services follow a defined set of policies and procedures or clinical protocols. The service also provides a coordinated set of individualized treatment services to persons who are able to function in a school, work, and home environment but are in need of treatment services beyond traditional outpatient programs. Treatment may appropriately be used to transition persons from higher levels of care or may be provided for persons at risk of being admitted to higher levels of care. Intensive outpatient programs provide nine (9) or more hours per week of skilled treatment, three to five (3-5) times per week in groups of no fewer than three (3) and no more than twelve (12) clients.	• Date of service • Start and stop times of the face-to-face encounter with the client 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 • Diagnostic impressions • Rationale for service including consistency with plan of care • Brief mental status and observations • Current functioning and strengths in specified life domains • Client's response to the intervention that includes current progress or regression and prognosis • Staff signature/credentials/date of signature(s)

NOTES	UNIT	BENEFIT LIMITS
	Per Diem	YEARLY MAXIMUM OF UNITS THAT MAY BE BILLED: (extension of benefits can be

		requested) Twenty-four (24)
APPLICABLE POPULATIONS	**SPECIAL BILLING INSTRUCTIONS**	
Adults and Youth	A provider may not bill for any other service on the same date of service.	
ALLOWED MODE(S) OF DELIVERY	**TIER**	
Face-to-face	Counseling	
ALLOWABLE PERFORMING PROVIDERS	**PLACE OF SERVICE**	
Intensive Outpatient Substance Abuse Treatment must be provided in a facility that is licensed by ~~the Division of Provider Services and Quality Assurance~~ DHS as an Intensive Outpatient Substance Abuse Treatment Provider.	11 (Office) 14 (Group Home), 22 (On Campus – OP Hospital), 49 (Independent Clinic), 50 (Federally Qualified Health Center), 53 (Community Mental Health Center), 57 (Non-Residential Substance Abuse Treatment Facility), 71 (Public Health Clinic),	

~~**255.000 Crisis Stabilization Intervention** 1-1-23~~

~~**PROCEDURE CODES**~~	~~**PROCEDURE CODE DESCRIPTION**~~	
~~**View or print the procedure codes for counseling services.**~~	~~Crisis Stabilization service, per fifteen (15) minutes~~	
~~**SERVICE DESCRIPTION**~~	~~**MINIMUM DOCUMENTATION REQUIREMENTS**~~	
~~Crisis Stabilization Intervention is a scheduled face-to-face (or telemedicine) treatment activity provided to a client who has recently experienced a psychiatric or behavioral health crisis that is expected to further stabilize, prevent deterioration, and serve as an alternative to twenty-four (24) -hour inpatient care.~~ ~~Services are to be congruent with the age, strengths, needed accommodation for any disability, and cultural framework of the client and their family.~~	~~• Date of service~~ ~~• Start and stop time of actual encounter with client and possible collateral contacts with caregivers or informed persons~~ ~~• Place of service~~ ~~• Specific persons providing pertinent information and relationship to client~~ ~~• 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~~ ~~• Client'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 client or others are at risk for imminent harm or in which to prevent significant deterioration of the client's functioning.~~ ~~This service is a planned intervention that MUST be on the client's treatment plan to serve as an alternative to twenty-four (24) -hour inpatient care.~~	~~Fifteen (15) minutes~~	~~DAILY MAXIMUM OF UNITS THAT MAY BE BILLED: Twelve (12) units~~ ~~YEARLY MAXIMUM OF UNITS THAT MAY BE BILLED (extension of benefits can be requested): Seventy-two (72) units~~
~~APPLICABLE POPULATIONS~~	**~~SPECIAL BILLING INSTRUCTIONS~~**	
~~Children, Youth, and Adults~~		
~~ALLOWED MODE(S) OF DELIVERY~~	**~~TIER~~**	
~~Face-to-face~~ ~~Telemedicine (Adults, Youth, and Children)~~	~~Crisis~~	
~~ALLOWABLE PERFORMING PROVIDERS~~	**~~PLACE OF SERVICE~~**	
~~• Independently Licensed Clinicians – Master's/Doctoral~~ ~~• Non-independently Licensed Clinicians – Master's/Doctoral~~ ~~• Licensed Alcoholism and Drug Abuse Counselor Master's~~ ~~• Advanced Practice Nurses~~ ~~• Physicians~~	~~02 (Telemedicine) 03 (School), 04 (Homeless Shelter), 10 (Telehealth Provided in Client's Home), 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)~~	

255.001 Crisis Intervention **1-1-2~~3~~4**

CPT®/HCPCS PROCEDURE CODE	PROCEDURE CODE DESCRIPTION
View or print the procedure codes for counseling services.	Crisis intervention service, per fifteen (15) minutes
SERVICE DESCRIPTION	**MINIMUM DOCUMENTATION REQUIREMENTS**
Crisis Intervention is unscheduled, immediate, short-term treatment activities provided to a Medicaid-eligible client 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 client 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 client to determine if the need for crisis services is present.)	• Date of service • Start and stop time of actual encounter with client and possible collateral contacts with caregivers or informed persons • Place of service • Specific persons providing pertinent information and relationship to client • Diagnosis and synopsis of events leading up to crisis situation • Brief mental status and observations • Utilization of previously established

Services are to be congruent with the age, strengths, needed accommodation for any disability, and cultural framework of the client and their family.	psychiatric advance directive or crisis plan as pertinent to current situation OR rationale for crisis intervention activities utilized • Client'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 client or others are at risk for imminent harm, or in which to prevent significant deterioration of the client's functioning. This service can be provided to clients that have not been previously assessed or have not previously received behavioral health services. ~~No PCP referral is required for crisis intervention~~ The provider of this service MUST complete a Mental Health Diagnosis within seven (7) days of provision of this service, if provided to a client who is not currently a client. **View or print the procedure codes for counseling services.** If the client cannot be contacted or does not return for a Mental Health Diagnosis appointment, attempts to contact the client must be placed in the client's medical record. If the client needs more time to be stabilized, this must be noted in the client's medical record and ~~the Division of Medical Services~~ DHS Quality Improvement Organization (QIO) must be notified.	Fifteen (15) minutes	DAILY MAXIMUM OF UNITS THAT MAY BE BILLED: twelve (12) YEARLY MAXIMUM OF UNITS THAT MAY BE BILLED (extension of benefits can be requested): seventy-two (72)
APPLICABLE POPULATIONS	**SPECIAL BILLING INSTRUCTIONS**	
Children, Youth, and Adults		
ALLOWED MODE(S) OF DELIVERY	**TIER**	
Face-to-face Telemedicine (Adults, Youth, and Children)	Crisis	
ALLOWABLE PERFORMING PROVIDERS	**PLACE OF SERVICE**	
• Independently Licensed Clinicians – Master's/Doctoral	02 (Telemedicine), 03 (School), 04 (Homeless Shelter), 10 (Telehealth Provided in Client's	

• Non-independently Licensed Clinicians – Master's/Doctoral • Advanced Practice Nurses • Physicians	Home), 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)

255.003 Acute Crisis Units 1-1-234

CPT®/HCPCS PROCEDURE CODE	PROCEDURE CODE DESCRIPTION
View or print the procedure codes for counseling services.	Behavioral Health; short-term residential
SERVICE DESCRIPTION	**MINIMUM DOCUMENTATION REQUIREMENTS**
Acute Crisis Units provide brief (96 hours or less) crisis treatment services to persons eighteen (18) years of age and over, who are experiencing a psychiatric or substance abuse-related crisis, or both, 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 substance abuse services on-site at all times, as well as on-call psychiatry available twenty-four (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. Services can be extended beyond 96 hours with approved extension of benefits.	• Date of service • Assessment information including mental health and substance abuse psychosocial evaluation, initial discharge plan, strengths and abilities to be considered for community re-entry • Place of service • Specific persons providing pertinent information and relationship to client • Diagnosis and synopsis of events leading up to acute crisis admission • Interpretive summary • 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 • Client'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 • Thorough discharge plan including treatment and community resources • Staff signature/credentials/date of signature(s)
NOTES	**EXAMPLE ACTIVITIES**

APPLICABLE POPULATIONS	UNIT	BENEFIT LIMITS

Adults	Per Diem	• Ninety-six (96) hours or less per admission; Extension of Benefits required for additional days
	PROGRAM SERVICE CATEGORY	
	Crisis Services	
ALLOWED MODE(S) OF DELIVERY	**TIER**	
Face-to-face	N/A	
ALLOWABLE PERFORMING PROVIDERS	**PLACE OF SERVICE**	
Acute Crisis Units must be certified by the ~~Division of Provider Services and Quality Assurance~~ DHS as an Acute Crisis Unit Provider.	55 (Residential Substance Abuse Treatment Facility), 56 (Psychiatric Residential Treatment Center	

255.004 Substance Abuse Detoxification 1-1-2~~3~~4

CPT®/HCPCS PROCEDURE CODE	PROCEDURE CODE DESCRIPTION
View or print the procedure codes for counseling services.	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 clients by clearing toxins from the client'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 client for ongoing treatment.	• Date of service • Assessment information including mental health and substance abuse psychosocial evaluation, initial discharge plan, strengths and abilities to be considered for community re-entry • Place of service • Specific persons providing pertinent information and relationship to client • Diagnosis and synopsis of events leading up to acute crisis admission • Interpretive summary • 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 • Client'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

	• Thorough discharge plan including treatment and community resources • Staff signature/credentials/date of signature(s)	
NOTES	**EXAMPLE ACTIVITIES**	
APPLICABLE POPULATIONS	**UNIT**	**BENEFIT LIMITS**
Youth and Adults	N/A	• Six (6) encounters per SFY; Extension of Benefits required for additional encounters
	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 licensed by ~~the Division of Provider Services and Quality Assurance~~ DHS as a Substance Abuse Detoxification provider.	21 (Inpatient Hospital), 55 (Residential Substance Abuse Treatment Facility)	

256.510 Completion of the CMS-1500 Claim Form

1-1-2~~34~~

Field Name and Number		Instructions for Completion
1.	(type of coverage)	Not required.
1a.	INSURED'S I.D. NUMBER (For Program in Item 1)	Client's or participant's 10-digit Medicaid or ARKids First-A or ARKids First-B identification number.
2.	PATIENT'S NAME (Last Name, First Name, Middle Initial)	Client's or participant's last name and first name.
3.	PATIENT'S BIRTH DATE	Client's or participant's date of birth as given on the individual's Medicaid or ARKids First-A or ARKids First-B identification card. Format: MM/DD/YY.
	SEX	Check M for male or F for female.
4.	INSURED'S NAME (Last Name, First Name, Middle Initial)	Required if insurance affects this claim. Insured's last name, first name, and middle initial.
5.	PATIENT'S ADDRESS (No., Street)	Optional. Client's or participant's complete mailing address (street address or post office box).
	CITY	Name of the city in which the client or participant resides.
	STATE	Two-letter postal code for the state in which the client or participant resides.

Field Name and Number		Instructions for Completion
	ZIP CODE	Five-digit zip code; nine digits for post office box.
	TELEPHONE (Include Area Code)	The client's or participant's telephone number or the number of a reliable message/contact/ emergency telephone
6.	PATIENT RELATIONSHIP TO INSURED	If insurance affects this claim, check the box indicating the patient's relationship to the insured.
7.	INSURED'S ADDRESS (No., Street)	Required if insured's address is different from the patient's address.
	CITY	
	STATE	
	ZIP CODE	
	TELEPHONE (Include Area Code)	
8.	PATIENT STATUS	Not required.
9.	OTHER INSURED'S NAME (Last name, First Name, Middle Initial)	If patient has other insurance coverage as indicated in Field 11d, the other insured's last name, first name, and middle initial.
	a. OTHER INSURED'S POLICY OR GROUP NUMBER	Policy and/or group number of the insured individual.
	b. OTHER INSURED'S DATE OF BIRTH	Not required.
	SEX	Not required.
	c. EMPLOYER'S NAME OR SCHOOL NAME	Required when items 9 a-d are required. Name of the insured individual's employer and/or school.
	d. INSURANCE PLAN NAME OR PROGRAM NAME	Name of the insurance company.
10.	IS PATIENT'S CONDITION RELATED TO:	
	a. EMPLOYMENT? (Current or Previous)	Check YES or NO.
	b. AUTO ACCIDENT?	Required when an auto accident is related to the services. Check YES or NO.
	PLACE (State)	If 10b is YES, the two-letter postal abbreviation for the state in which the automobile accident took place.
	c. OTHER ACCIDENT?	Required when an accident other than automobile is related to the services. Check YES or NO.
	10d. RESERVED FOR LOCAL USE	Not used.
11.	INSURED'S POLICY GROUP OR FECA NUMBER	Not required when Medicaid is the only payer.
	a. INSURED'S DATE OF BIRTH	Not required.

Field Name and Number	Instructions for Completion
SEX	Not required.
b. EMPLOYER'S NAME OR SCHOOL NAME	Not required.
c. INSURANCE PLAN NAME OR PROGRAM NAME	Not required.
d. IS THERE ANOTHER HEALTH BENEFIT PLAN?	When private or other insurance may or will cover any of the services, check YES and complete items 9a through 9d.
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE	Not required.
13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE	Not required.
14. DATE OF CURRENT: ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)	Required when services furnished are related to an accident, whether the accident is recent or in the past. Date of the accident.
15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE	Not required.
16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION	Not required.
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	~~Primary Care Physician (PCP) referral or PCMH sign-off is required for Counseling Services for all clients after ten (10) counseling services. If services are the result of a Child Health Services (EPSDT) screening/ referral, enter the referral source, including name and title.~~Not required.
17a. (blank)	Not required.
17b. NPI	~~Enter NPI of the referring physician~~Not required.
18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES	When the serving/billing provider's services charged on this claim are related to a client's or participant's inpatient hospitalization, enter the individual's admission and discharge dates. Format: MM/DD/YY.
19. RESERVED FOR LOCAL USE	Not applicable to Counseling Services.
20. OUTSIDE LAB?	Not required.
$ CHARGES	Not required.

Field Name and Number	Instructions for Completion
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY	Enter the applicable ICD indicator to identify which version of ICD codes is being reported. Use “9” for ICD-9-CM. Use “0” for ICD-10-CM. Enter the indicator between the vertical, dotted lines in the upper right-hand portion of the field. Diagnosis code for the primary medical condition for which services are being billed. Use the appropriate International Classification of Diseases (ICD). List no more than 12 diagnosis codes. Relate lines A-L to the lines of service in 24E by the letter of the line. Use the highest level of specificity.
22. MEDICAID RESUBMISSION CODE	Reserved for future use.
ORIGINAL REF. NO.	Reserved for future use.
23. PRIOR AUTHORIZATION NUMBER	The prior authorization or benefit extension control number if applicable.
24A. DATE(S) OF SERVICE	The “from” and “to” dates of service for each billed service. Format: MM/DD/YY. 1. On a single claim detail (one charge on one line), bill only for services provided within a single calendar month. 2. Providers may bill on the same claim detail for two or more sequential dates of service within the same calendar month when the provider furnished equal amounts of the service on each day of the date sequence.
B. PLACE OF SERVICE	Two-digit national standard place of service code. See Section 252.200 for codes.
C. EMG	Enter “Y” for “Yes” or leave blank if “No”. EMG identifies if the service was an emergency.
D. PROCEDURES, SERVICES, OR SUPPLIES	
CPT/HCPCS	Enter the correct CPT or HCPCS procedure codes from Sections 252.100 through 252.150.
MODIFIER	Use applicable modifier.

Field Name and Number		Instructions for Completion
E.	DIAGNOSIS POINTER	Enter the diagnosis code reference letter (pointer) as shown in Item Number 21 to relate to the date of service and the procedures performed to the primary diagnosis. When multiple services are performed, the primary reference letter for each service should be listed first; other applicable services should follow. The reference letter(s) should be A-L or multiple letters as applicable. The "Diagnosis Pointer" is the line letter from Item Number 21 that relates to the reason the service(s) was performed.
F.	$ CHARGES	The full charge for the service(s) totaled in the detail. This charge must be the usual charge to any client, patient, or other client of the provider's services.
G.	DAYS OR UNITS	The units (in whole numbers) of service(s) provided during the period indicated in Field 24A of the detail.
H.	EPSDT/Family Plan	Enter E if the services resulted from a Child Health Services (EPSDT) screening/referral.
I.	ID QUAL	Not required.
J.	RENDERING PROVIDER ID #	Enter the 9-digit Arkansas Medicaid provider ID number of the individual who furnished the services billed for in the detail or
	NPI	Enter NPI of the individual who furnished the services billed for in the detail.
25.	FEDERAL TAX I.D. NUMBER	Not required. This information is carried in the provider's Medicaid file. If it changes, please contact Provider Enrollment.
26.	PATIENT'S ACCOUNT NO.	Optional entry that may be used for accounting purposes; use up to 16 numeric or alphabetic characters. This number appears on the Remittance Advice as "MRN."
27.	ACCEPT ASSIGNMENT?	Not required. Assignment is automatically accepted by the provider when billing Medicaid.
28.	TOTAL CHARGE	Total of Column 24F—the sum all charges on the claim.
29.	AMOUNT PAID	Enter the total of payments previously received on this claim. Do not include amounts previously paid by Medicaid. Do not include in this total the automatically deducted Medicaid or ARKids First-B co-payments.
30.	RESERVED	Reserved for NUCC use.

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

TOC not required

172.100 Services not Requiring a PCP Referral

~~9-1-20~~1-1-24

The services listed in this section do not require a PCP referral:

A. Adult Developmental Day Treatment (ADDT) core services;

B. ARChoices waiver services;

C. Anesthesia services, excluding outpatient pain management;

D. Assessment (including the physician's assessment) in the emergency department of an acute care hospital to determine whether an emergency condition exists. The physician and facility assessment services do not require a PCP referral (if the Medicaid beneficiary is enrolled with a PCP);

E. Chiropractic services;

F. Dental services;

G. Developmental Disabilities Services Community and Employment Support;

H. Disease control services for communicable diseases, including testing for and treating sexually transmitted diseases such as HIV/AIDS;

I. Emergency services in an acute care hospital emergency department, including emergency physician services;

J. Family Planning services;

K. Gynecological care;

L. Inpatient hospital admissions on the effective date of PCP enrollment or on the day after the effective date of PCP enrollment;

M. Mental health services, as follows:

1. Psychiatry for services provided by a psychiatrist enrolled in Arkansas Medicaid and practicing as an individual practitioner
2. Medication Assisted Treatment for Opioid Use Disorder when rendered by an X-DEA waivered practitioner
3. Rehabilitative Services for Youth and Children (RSYC) Program
4. Outpatient counseling services

N. Obstetric (antepartum, delivery, and postpartum) services

1. Only obstetric-gynecologic services are exempt from the PCP referral requirement
2. The obstetrician or the PCP may order home health care for antepartum or postpartum complications
3. The PCP must perform non-obstetric, non-gynecologic medical services for a pregnant woman or refer her to an appropriate provider

O. Nursing facility services and intermediate care facility for individuals with intellectual disabilities (ICF/IID) services;

P. Ophthalmology services, including eye examinations, eyeglasses, and the treatment of diseases and conditions of the eye;

Q. Optometry services;

R. Pharmacy services;

S. Physician services for inpatients in an acute care hospital, including direct patient care (initial and subsequent evaluation and management services, surgery, etc.), and indirect care (pathology, interpretation of X-rays, etc.);

T. Hospital non-emergency or outpatient clinic services on the effective date of PCP enrollment or on the day after the effective date of PCP enrollment;

U. Physician visits (except consultations, which do require PCP referral) in the outpatient departments of acute care hospitals but only if the Medicaid beneficiary is enrolled with a PCP and the services are within applicable benefit limitations;

V. Professional components of diagnostic laboratory, radiology, and machine tests in the outpatient departments of acute care hospitals, but only if the Medicaid beneficiary is enrolled with a PCP and the services are within applicable benefit limitations;

W. Targeted Case Management services provided by the Division of Youth Services or the Division of Children and Family Services under an inter-agency agreement with the Division of Medical Services;

X. Transportation (emergency and non-emergency) to Medicaid-covered services; and

Y. Other services, such as sexual abuse examinations, when the Medicaid Program determines that restricting access to care would be detrimental to the patient's welfare or to program integrity or would create unnecessary hardship.