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200.000 COUNSELING SERVICES GENERAL INFORMATION

201.000 Introduction

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

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

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202.000 Arkansas Medicaid Participation Requirements for Counseling Services

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

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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:

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

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B. Must be certified by the Division of Provider Services and Quality Assurance (DPSQA) as a Behavioral Health Agency, a Community Support Systems Agency- Intensive or Enhanced, be certified by the Dept. of Education as a school-based mental health provider or be independently licensed as a:

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Licensed Clinical Certified Social Worker (LCSW)

Licensed Marital and Family Therapist (LMFT)

Licensed Psychologist (LP)

Licensed Psychological Examiner – Independent (LPEI)

Licensed Professional Counselor (LPC)

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

Deleted: A provider must be certified by the Division of Provider Services and Quality Assurance (DPSQA). (See Section 202.100 for specific certification requirements.)

Deleted: A copy of the current DPSQA certification as a Behavioral Health provider must accompany the provider application and Medicaid contract

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

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

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

- A. Seriousness of the offense(s)
- B. Extent of violation(s)
- C. History of prior violation(s)
- D. Whether an indictment or information was filed against the provider or a related party as defined in DHS Policy 1088, titled DHS Participant Exclusion Rule.

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202.200 Providers with Multiple Sites

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

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

Failure by the parent organization to submit a letter of attestation by June 15 each year may result in the loss of Medicaid enrollment. The Enrollment Unit will verify the receipt of all required letters of attestation by July 1 of each year. A notice will be sent to any parent organization if a letter is not received advising of the impending loss of Medicaid enrollment.

210.000 PROGRAM COVERAGE**211.000 Coverage of Services**

3-1-19

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

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 beneficiaries 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 cultural health beliefs and practices, preferred languages, health literacy and other communication needs.

211.200 Staff Requirements

9-1-20

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.

PROVIDER TYPE	LICENSES	STATE CERTIFICATION REQUIRED	SUPERVISION
Independently Licensed Clinicians – Master's/Doctoral	Licensed <u>Certified</u> Social Worker (LCSW)	Yes, must be <u>licensed through the relevant licensing board</u> , to provide services	Not Required

Deleted: Outpatient Behavioral Health Services**Deleted:** certified**Deleted:** providers**Deleted:** behavioral health**Deleted:** All performing providers, provider groups, and business entities participating in the Medicaid Outpatient Behavioral Health Services (OBH) Program must be certified by the Division Provider Services and Quality Assurance.**Deleted:** An Outpatient Behavioral Health Services**Deleted:****Deleted:** site specific**Deleted:** that complies with the DPSQA Certification Rules for Providers of Outpatient Behavioral Health Services.**Deleted:** agency site**Deleted:** Behavioral Health**Deleted:** site.**Deleted:** Licensed performing providers as certified by DPSQA must also maintain an Emergency Service Plan that complies with the DPSQA Certification Rules for Providers of Outpatient Behavioral Health Services manual. ¶**Deleted:** Outpatient Behavioral Health Services**Deleted:** 211.100 Quality Assurance**Deleted:** Outpatient Behavioral Health Services**Deleted:** Behavioral Health**Deleted:****Deleted:** Clinical**Deleted:** certified

PROVIDER TYPE	LICENSES	STATE CERTIFICATION REQUIRED	SUPERVISION
	Licensed Marital and Family Therapist (LMFT) Licensed Psychologist (LP) Licensed Psychological Examiner – Independent (LPEI) Licensed Professional Counselor (LPC)		
Non-independently Licensed Clinicians – Master's/Doctoral	Licensed Master Social Worker (LMSW) Licensed Associate Marital and Family Therapist (LAMFT) Licensed Associate Counselor (LAC) Licensed Psychological Examiner (LPE) Provisionally Licensed Psychologist (PLP) <u>Provisionally Licensed Master Social Worker (PLMSW)</u>	Yes, must be <u>licensed through the relevant licensing board to provide services and be employed by a certified Behavioral Health Agency, Community Support System Agency, or certified by the Dept. of Education as a school-based mental health provider</u> ▼	Required
<u>Licensed Alcoholism and Drug Abuse Counselor Master's Bachelor's</u> ▼	<u>Licensed Alcoholism and Drug Abuse Counselor (LADAC) Master's Doctoral</u> <u>Licensed Associate Alcoholism and Drug Abuse Counselor (LAADAC) Bachelor</u>	Yes, must be <u>licensed through the relevant licensing board to provide services and be employed by a certified Behavioral Health Agency, or Community Support System Agency</u> ▼	
Advanced Practice Nurse (APN)	Adult Psychiatric Mental Health	<u>Must be employed by a certified Behavioral</u>	Collaborative Agreement

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 Licensed Marital and Family Therapist (LMFT)¶
 Licensed Psychologist (LP)¶
 Licensed Psychological Examiner – Independent (LPEI) ¶
 Licensed Professional Counselor (LPC)

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 Licensed Associate Counselor (LAC) ¶
 Licensed Psychological Examiner (LPE)¶
 Provisionally Licensed Psychologist (PLP)

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PROVIDER TYPE	LICENSES	STATE CERTIFICATION REQUIRED	SUPERVISION
	Clinical Nurse Specialist Child Psychiatric Mental Health Clinical Nurse Specialist Adult Psychiatric Mental Health APN Family Psychiatric Mental Health APN	<u>Health Agency, or Community Support System Agency,</u>	with Physician Required
Physician	Doctor of Medicine (MD) Doctor of Osteopathic Medicine (DO)	<u>Must be employed by a certified Behavioral Health Agency, or Community Support System Agency,</u>	Not Required

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

When an 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).

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211.300 Certification of Performing Providers

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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. The certification requirements for performing providers are located on the DPSQA website at http://humanservices.arkansas.gov/dbhs/Pages/dbhs_docs.aspx.

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211.400 Facility Requirements

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The Counseling Services provider shall be responsible for providing physical facilities that are structurally sound and meet all applicable federal, state and local regulations for adequacy of construction, safety, sanitation and health. These standards apply to buildings in which care, treatment or services are provided. In situations where Counseling Services are not provided in buildings, a safe and appropriate setting must be provided.

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211.500 Non-Refusal Requirement

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Counseling Services Program Manual

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

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212.000 Scope

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

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

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COUNSELING SERVICES

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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.

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213.000 Counseling Services Program Entry

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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 beneficiary's mental condition and, based on the beneficiary's diagnosis, determines whether treatment in the Counseling Services Program is appropriate. This documentation must be made part of the beneficiary's medical record.

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[View or print the procedure codes for OBHS services.](#)

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213.100 Independent Assessment Referral

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

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214.000 Role of Providers of Counseling Services

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Counseling Services providers provide counseling services by qualified licensed practitioners in an outpatient-based setting for the purpose of assessing and treating behavioral health conditions.

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

3-1-19

Counseling Services Providers may provide dyadic treatment of beneficiary's age 0-47 months and the parent/caregiver of the eligible beneficiary. A prior authorization will be required for all

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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 to provide those services.

Providers will diagnose children through the age of 47 months based on 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 a DMS 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.

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214.200 Medication Assisted Treatment and Opioid Use Disorder Treatment Drugs 9-1-20

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.

217.100 Primary Care Physician (PCP) Referral 6-1-22

Each beneficiary 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 beneficiary's medical record.

A beneficiary 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. No services, except Crisis Intervention, will be allowed to be provided without appropriate PCP/PCMH referral. The PCP/PCMH referral must be kept in the beneficiary's medical record.

The Patient Centered Medical Home (PCMH) will be responsible for coordinating care with a beneficiary's PCP or physician for counseling services. Medical responsibility for beneficiaries 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 beneficiary's chart as described in Section 171.410.

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

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219.110 Daily Limit of Beneficiary Services 7-1-17

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

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219.200 Telemedicine (Interactive Electronic Transactions) Services 3-1-19

See Section I for Telemedicine policy and Section III for Telemedicine billing protocol

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223.000 Exclusions

3-1-19

Services not covered under the Counseling Services Program include, but are not limited to:

- A. Room and board residential costs
- B. Educational services
- C. Telephone contacts with patient
- D. Transportation services, including time spent transporting a beneficiary for services (reimbursement for other Counseling Services is not allowed for the period of time the Medicaid beneficiary is in transport)
- E. Services to individuals with developmental disabilities that are non-behavioral health, in nature
- F. Services which are found not to be medically necessary
- G. Services provided to nursing home and ICF/IDD residents other than those specified in the applicable populations sections of the service definitions in this manual

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224.000 Physician's Role

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Counseling services providers must have relationships with a physician licensed in Arkansas in order to ensure psychiatric and medical conditions are monitored and addressed by appropriate physician oversight and that medication evaluation and prescription services are available to individuals requiring pharmacological management.

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

225.000 Diagnosis and Clinical Impression

7-1-17

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

226.000 Documentation/Record Keeping Requirements

226.100 Documentation

7-1-17

All 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. Must be individualized to the beneficiary and specific to the services provided, duplicated notes are not allowed
- B. include the date and actual time the services were provided
- C. Contain o original signature, name and credentials of the person, who authorized the services
- D. Contain o original signature, name and credentials of the person, who provided the services, if different from authorizing professional
- E. 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

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- F. Document the relationship of the services to the treatment regimen described in the Treatment Plan
- G. Contain updates describing the patient's progress
- H. Document involvement for services that require contact with anyone other than the beneficiary, evidence of compliance with HIPAA regulations, including presence in documentation of Specific Authorizations, if required

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

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

227.000 Prescription for Counseling Services

3-1-19

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 beneficiary. The prescription for the services and subsequent renewals must be documented in the beneficiary's medical record.

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Deleted: Each beneficiary that receives only Counseling Level Services can receive a limited amount of Counseling Level Services without a Primary Care Physician (PCP) referral or Patient-Centered Medical Home (PCMH) approval. Once those limits are reached, a PCP referral or PCMH approval will be necessary.

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228.000 Provider Reviews

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

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228.130 Retrospective Reviews

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The Division of Medical Services (DMS) of the Arkansas Department of Human Services has contracted with a Quality Improvement Organization (QIO) or QIO-like organization to perform retrospective (post payment) reviews of 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.

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228.131 Purpose of the Review

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The purpose of the review is to:

- A. Ensure that services are delivered in accordance with the counselors plan of care documented at intake for service delivery and conform to generally accepted professional standards.
- B. Evaluate the medical necessity of services provided to Medicaid beneficiaries.

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- C. Evaluate the clinical documentation to determine if it is sufficient to support the services billed during the requested period of authorized services.
- D. Safeguard the Arkansas Medicaid program against unnecessary or inappropriate use of services and excess payments in compliance with 42 CFR § 456.3(a).

228.132 Review Sample and the Record Request

3-1-19

On a calendar quarterly basis, the contractor will select a statistically valid random sample from an electronic data set of all Counseling Services beneficiaries whose dates of service occurred during the three (3) -month selection period. If a beneficiary was selected in any of the three (3) calendar quarters prior to the current selection period, then they will be excluded from the sample and an alternate beneficiary will be substituted. The utilization review process will be conducted in accordance with 42 CFR § 456.23.

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

All medical records must be submitted to the contractor via fax, mail or electronic medium. [View or print current contractor contact information.](#) Records will not be accepted via email.

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228.133 Review Process

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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.

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

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

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

229.000 Medicaid Beneficiary Appeal Process 7-1-17

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

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

229.100 Electronic Signatures 7-1-17

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

229.200 Recoupment Process 7-1-17

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

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

230.000 PRIOR AUTHORIZATION (PA) AND EXTENSION OF BENEFITS

231.000 Introduction to Extension of Benefits 7-1-17

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

231.100 Prior Authorization 2-1-22

Prior Authorization is required for certain Counseling Services provided to Medicaid-eligible beneficiaries under the age of four (4).

Information related to clinical management guidelines and authorization request processes is available at **current contractor's website**.

Procedure codes requiring prior authorization:

[View or print the procedure codes for OBHS services.](#)

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231.200 Extension of Benefits 7-1-17

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

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

231.300 Substance Abuse Covered Codes

2-1-22

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

[View or print the procedure codes for OBHS services.](#)

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

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240.000 REIMBURSEMENT

240.100 Reimbursement

3-1-19

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

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

A. Counseling Services

Fifteen-Minute (15) 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 beneficiary, per service.

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

All billing must reflect a daily total, per Counseling service, based on the established procedure codes. No rounding is allowed.

The sum of the days' time, in minutes, per service will determine how many units are allowed to be billed. That number must not be exceeded. The total of minutes per service must be compared to the following grid, which determines the number of units allowed.

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

60 minute Units	Timeframe
One (1) unit =	50-60 minutes

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Two (2) units =	110-120 minutes
Three (3) units =	170-180 minutes
Four (4) units =	230-240 minutes
Five (5) units =	290-300 minutes
Six (6) units =	350-360 minutes
Seven (7) units=	410-420 minutes
Eight (8) units=	470-480 minutes

In a single claim transaction, a provider may bill only for service time accumulated within a single day for a single beneficiary. There is no "carryover" of time from one day to another or from one beneficiary to another.

Documentation in the beneficiary's record must reflect exactly how the number of units is determined.

No more than four (4) units may be billed for a single hour per beneficiary or provider of the service.

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

241.000 Fee Schedule

3-1-19

Arkansas Medicaid provides fee schedules on the Arkansas Medicaid website. The fee schedule link is located at <https://medicaid.mmis.arkansas.gov/Provider/Docs/fees.aspx> under the provider manual section. The fees represent the fee-for-service reimbursement methodology.

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

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

242.000 Rate Appeal Process

7-1-17

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

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

Counseling Services Program Manual

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.

250.000 BILLING PROCEDURES

251.000 Introduction to Billing

7-1-20

Counseling Services providers use the CMS-1500 form to bill the Arkansas Medicaid Program on paper for services provided to eligible Medicaid beneficiaries. Each claim may contain charges for only one (1) beneficiary. [View a CMS-1500 sample form.](#)

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

252.000 CMS-1500 Billing Procedures

252.100 Procedure Codes for Types of Covered Services

3-1-19

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

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

252.110 Counseling Services

252.111 Individual Behavioral Health Counseling

2-1-22

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CPT®/HCPCS PROCEDURE CODE	PROCEDURE CODE DESCRIPTION
View or print the procedure codes for OBHS services.	Psychotherapy, 30 min Psychotherapy, 45 min Psychotherapy, 60 min
SERVICE DESCRIPTION	MINIMUM DOCUMENTATION REQUIREMENTS
Individual Behavioral Health Counseling is a face-to-face treatment provided to an individual in an outpatient setting for the purpose of treatment and remediation of a condition as described in the current allowable DSM. The treatment service must reduce or alleviate identified symptoms related to either (a) Mental Health or (b) Substance Abuse <u>condition</u> , and maintain or improve level of functioning, and/or prevent deterioration.	<ul style="list-style-type: none">• Date of Service• Start and stop times of face-to-face encounter with beneficiary• Place of service• Diagnosis and pertinent interval history• Brief mental status and observations

Counseling Services Program Manual

<p>Additionally, tobacco cessation counseling is a component of this service.</p>	<ul style="list-style-type: none"> • Rationale and description of the treatment used that must coincide with <u>the most recent intake assessment</u>. • Beneficiary's response to treatment that includes current progress or regression and prognosis • Any revisions indicated for the diagnosis, or medication concerns • Plan for next individual therapy session, including any homework assignments and/or advanced psychiatric directive or crisis plans • Staff signature/credentials/date of signature 	
NOTES	UNIT	BENEFIT LIMITS
<p>Services provided must be congruent with the objectives and interventions articulated on the most recent <u>intake assessment</u>. Services must be consistent with established behavioral healthcare standards. Individual Psychotherapy is not permitted with beneficiaries who do not have the cognitive ability to benefit from the service.</p> <p>This service is not for beneficiaries under four (4) years of age except in documented exceptional cases. This service will require a Prior Authorization for beneficiaries four (4) years of age.</p>	<p>30 minutes 45 minutes 60 minutes</p> <p>View or print the procedure codes for OBHS services.</p>	<p>DAILY MAXIMUM OF ENCOUNTERS THAT MAY BE BILLED:</p> <p>One (1) encounter between all three (3) codes.</p> <p>YEARLY MAXIMUM OF ENCOUNTERS THAT MAY BE BILLED (extension of benefits can be requested):</p> <p>Twelve (12) encounters between all three (3) codes</p>
APPLICABLE POPULATIONS	SPECIAL BILLING INSTRUCTIONS	
<p>Children, Youth, and Adults Residents of Long-Term Care Facilities</p>	<p>A provider may only bill one (1) Individual Behavioral Health Counseling Code per day per beneficiary. A provider cannot bill any other Individual Behavioral Health Counseling Code on the same date of service for the same beneficiary. There are twelve (12) total individual counseling encounters allowed per year regardless of code billed for Individual Behavioral Health Counseling, <u>prior to</u> an extension of benefits <u>approved</u> by the Quality Improvement Organization contracted with Arkansas Medicaid.</p>	
ALLOWED MODE(S) OF DELIVERY	TIER	
<p>Face-to-face Telemedicine (Adults, Youth, and Children)</p>	<p>Counseling</p>	
ALLOWABLE PERFORMING PROVIDERS	PLACE OF SERVICE (POS)	

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<ul style="list-style-type: none"> Independently Licensed Clinicians – Master's/Doctoral Non-independently Licensed Clinicians – Master's/Doctoral Advanced Practice Nurses Physicians Providers of services for beneficiaries under four (4) years of age must be trained and certified in specific evidence-based practices to be reimbursed for those services <ul style="list-style-type: none"> 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), 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)
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252.112

Group Behavioral Health Counseling

2-1-22

CPT®/HCPCS PROCEDURE CODE	PROCEDURE CODE DESCRIPTION
View or print the procedure codes for OBHS services.	Group psychotherapy (other than of a multiple-family group)
SERVICE DESCRIPTION	MINIMUM DOCUMENTATION REQUIREMENTS
<p>Group Behavioral Health Counseling is a face-to-face treatment provided to a group of beneficiaries. Services leverage the emotional interactions of the group's members to assist in each beneficiary's treatment process, support their rehabilitation effort, and to minimize relapse. Services pertain to a beneficiary's (a) Mental Health or (b) Substance Abuse condition, or both. Additionally, tobacco cessation counseling is a component of this service.</p> <p>Services must be congruent with the age and abilities of the beneficiary, client-centered, and strength-based; with emphasis on needs as identified by the beneficiary and provided with cultural competence.</p>	<ul style="list-style-type: none"> Date of Service Start and stop times of actual group encounter that includes identified beneficiary 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 Beneficiary's response to the group counseling that includes current progress or regression and prognosis Any revisions indicated for diagnosis, or medication concerns

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	<ul style="list-style-type: none"> 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. Beneficiaries 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 beneficiaries eighteen (18) years of age 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 beneficiaries 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 beneficiary must be <u>at least</u> 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 beneficiaries participate in group activities.	Encounter	<p>DAILY MAXIMUM OF ENCOUNTERS THAT MAY BE BILLED: One (1)</p> <p>YEARLY MAXIMUM OF ENCOUNTERS THAT MAY BE BILLED (extension of benefits can be requested):</p> <p>Twelve (12) encounters</p>
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	
<ul style="list-style-type: none"> Independently Licensed Clinicians – Master's/Doctoral Non-independently Licensed Clinicians – Master's/Doctoral Advanced Practice Nurses Physicians 	02 (Telemedicine), 03 (School), 11 (Office), 49 (Independent Clinic), 49 (Independent Clinic), 50 (Federally Qualified Health Center), 53 (Community Mental Health Center), 57 (Non-Residential Substances Abuse Treatment Facility), 71 (Public Health Clinic), 72 (Rural Health Clinic)	

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252.113 Marital/Family Behavioral Health Counseling with Beneficiary Present

2-1-22

CPT®/HCPCS PROCEDURE CODE	PROCEDURE CODE DESCRIPTION
View or print the procedure codes for OBHS services.	Family psychotherapy (conjoint psychotherapy) (with patient present)
SERVICE DESCRIPTION	MINIMUM DOCUMENTATION REQUIREMENTS
<p>Marital/Family Behavioral Health Counseling with Beneficiary Present is a face-to-face treatment provided to one (1) or more family members in the presence of a beneficiary. Services are designed to enhance insight into family interactions, facilitate inter-family emotional or practical support and to develop alternative strategies to address familial issues, problems, and needs. Services pertain to a beneficiary's (a) Mental Health or (b) Substance Abuse condition, or both. Additionally, tobacco cessation counseling is a component of this service.</p> <p>Services must be congruent with the age and abilities of the beneficiary, client-centered, and strength-based; with emphasis on needs as identified by the beneficiary and provided with cultural competence.</p> <p>*Dyadic treatment is available for parent/caregiver and child for dyadic treatment of children who are from zero through forty-seven (0-47) months of age and parent/caregiver. Dyadic treatment must be prior authorized. Dyadic Infant/Caregiver Psychotherapy is a behaviorally based therapy that involves improving the parent-child relationship by transforming the interaction between the two parties. The primary goal of Dyadic Infant/Parent Psychotherapy is to strengthen the relationship between a child and his or her parent (or caregiver) as a vehicle for restoring the child's sense of safety, attachment, and appropriate affect and improving the child's cognitive, behavioral, and social functioning. This service uses child directed interaction to promote interaction between the parent and the child in a playful manner. Providers must utilize a nationally recognized evidence-based practice. Practices include, but are not limited to, Child-Parent</p>	<ul style="list-style-type: none"> • Date of Service • Start and stop times of actual encounter with beneficiary and spouse/family • Place of service • Participants present and relationship to beneficiary • Diagnosis and pertinent interval history • Brief mental status of beneficiary and observations of beneficiary with spouse/family • Rationale, and description of treatment used must coincide with most recent intake assessment and improve the impact the beneficiary's condition has on the spouse/family or improve marital/family interactions between the beneficiary and the spouse/family, or both • Beneficiary and spouse/family's response to treatment that includes current progress or regression and prognosis • Any revisions indicated for the diagnosis, or medication concerns • Plan for next session, including any homework assignments or crisis plans, or both • Staff signature/credentials/date of signature • HIPAA compliant Release of Information, completed, signed, and dated

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<p>Psychotherapy (CPP) and Parent Child Interaction Therapy (PCIT).</p> <p>**Dyadic treatment by telemedicine must continue to assure adherence to the evidence-based protocol for the treatment being provided, i.e. PCIT would require a video component sufficient for the provider to be able to see both the parent and child, have a communication device (ear phones, ear buds, etc.) to enable the provider to communicate directly with the parent only while providing directives related to the parent/child interaction.</p>		
NOTES	UNIT	BENEFIT LIMITS
Natural supports may be included in these sessions if justified in service documentation and if supported in the documentation in the Mental Health Diagnosis. Only one (1) beneficiary per family, per therapy session, may be billed.	Encounter	<p>DAILY MAXIMUM OF ENCOUNTERS THAT MAY BE BILLED: One (1)</p> <p>YEARLY MAXIMUM OF ENCOUNTERS THAT MAY BE BILLED (extension of benefits can be requested):</p> <p>Twelve (12) encounters</p>
APPLICABLE POPULATIONS	SPECIAL BILLING INSTRUCTIONS	
Children, Youth, and Adults	<p>A provider can only bill one (1) Marital/Family Behavioral Health Counseling with (or without) Patient encounter per day. There are twelve (12) total Marital/Family Behavioral Health Counseling with Beneficiary Present encounters allowed, per year, unless an extension of benefits is allowed by the Quality Improvement Organization contracted with Arkansas Medicaid.</p> <p>The following <u>services</u> cannot be billed on the Same Date of Service:</p> <p>Multi-Family Behavioral Health Counseling</p> <p>Marital/Family Behavioral Health Counseling without Beneficiary Present</p> <p>–Psychoeducation</p> <p><u>Infant mental health providers may provide up to (four) 4 encounters of family therapy with or without beneficiary present in a single date of service.</u></p>	

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	View or print the procedure codes for OBHS services.
ALLOWED MODE(S) OF DELIVERY	TIER
Face-to-face Telemedicine (Adults, Youth, and Children)	Counseling
ALLOWABLE PERFORMING PROVIDERS	PLACE OF SERVICE
<ul style="list-style-type: none"> 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 <ul style="list-style-type: none"> 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), 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)

252.114 [Marital/Family Behavioral Health Counseling without Beneficiary Present](#)

2-1-22

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CPT®/HCPCS PROCEDURE CODE	PROCEDURE CODE DESCRIPTION
View or print the procedure codes for OBHS services.	Family psychotherapy (without the patient present)
SERVICE DESCRIPTION	MINIMUM DOCUMENTATION REQUIREMENTS
Marital/Family Behavioral Health Counseling without Beneficiary Present is a face-to-face treatment provided to one (1) or more family members outside the presence of a beneficiary. Services are designed to enhance insight into family interactions, facilitate inter-family emotional or practical support, and develop alternative strategies to address familial issues, problems, and needs. Services pertain to a beneficiary's (a) Mental Health or (b) Substance Abuse condition, or both.	<ul style="list-style-type: none"> Date of Service Start and stop times of actual encounter <u>with</u> spouse/family Place of service Participants present and relationship to beneficiary Diagnosis and pertinent interval history Brief observations with spouse/family

<p>Additionally, tobacco cessation counseling is a component of this service.</p> <p>Services must be congruent with the age and abilities of the beneficiary or family member(s), client-centered, and strength-based; with emphasis on needs as identified by the beneficiary and family and provided with cultural competence.</p>	<ul style="list-style-type: none"> • Rationale, and description of treatment used must coincide with the <u>most recent intake assessment</u> and improve the impact the beneficiary's condition has on the spouse/family, or improve marital/family interactions between the beneficiary and the spouse/family, or both • Beneficiary and spouse/family's response to treatment that includes current progress or regression and prognosis • <u>Rationale for excluding the identified beneficiary</u> • Any <u>revisions</u> indicated for the diagnosis, or medication concerns • Plan for next session, including any homework assignments or crisis plans, or both • Staff signature/credentials/date of signature • HIPAA compliant Release of Information, completed, signed, and dated
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NOTES	UNIT	BENEFIT LIMITS
<p>Natural supports may be included in these sessions, if justified in service documentation, and if supported in Mental Health Diagnosis. Only one (1) beneficiary per family per therapy session may be billed.</p>	<p>Encounter</p>	<p>DAILY MAXIMUM OF ENCOUNTERS THAT MAY BE BILLED: One (1)</p> <p>YEARLY MAXIMUM OF ENCOUNTERS THAT MAY BE BILLED (extension of benefits can be requested):</p> <p>Twelve (12) encounters</p>
APPLICABLE POPULATIONS	SPECIAL BILLING INSTRUCTIONS	
<p>Children, Youth, and Adults</p>	<p>A provider can only bill one (1) Marital/Family Behavioral Health Counseling with (or without) Beneficiary encounter per day.</p> <p>The following codes cannot be billed on the Same Date of Service:</p> <p>Multi-Family Behavioral Health Counseling</p> <p>Marital/Family Behavioral Health Counseling with Beneficiary Present</p> <p>–Psychoeducation</p>	

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	<p><u>Infant mental health providers may provide up to (four) 4 encounters of family therapy with or without beneficiary present in a single date of service.</u></p> <p>View or print the procedure codes for OBHS services.</p>
ALLOWED MODE(S) OF DELIVERY	TIER
Face-to-face Telemedicine (Adults, Youth, and Children)	Counseling
ALLOWABLE PERFORMING PROVIDERS	PLACE OF SERVICE
<ul style="list-style-type: none"> Independently Licensed Clinicians - Master's/Doctoral Non-independently Licensed Clinicians – Master's/Doctoral Advanced Practice Nurses Physicians <u>Providers of dyadic services must be trained and certified in specific evidence-based practices to be reimbursed for those services</u> <u>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</u> <u>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</u> 	02 (Telemedicine), 03 (School), 04 (Homeless Shelter), 11 (Office) 12 (Patient's Home), 49 (Independent Clinic), 50 (Federally Qualified Health Center), 53 (Community Mental Health Center), 57 (Non-Residential Substance Abuse Treatment Facility), 71 (Public Health Clinic), 72 (Rural Health Clinic)

252.115

Psychoeducation

2-1-22

CPT®/HCPCS PROCEDURE CODE	PROCEDURE CODE DESCRIPTION
View or print the procedure codes for OBHS services.	Psychoeducational service; per fifteen (15) minutes
SERVICE DESCRIPTION	MINIMUM DOCUMENTATION REQUIREMENTS
Psychoeducation provides beneficiaries and their families with pertinent information regarding mental illness, substance abuse, and tobacco cessation, and teaches problem-solving, communication, and coping skills to support recovery. Psychoeducation can be implemented in two (2) formats: multifamily	<ul style="list-style-type: none"> Date of Service Start and stop times of actual encounter with beneficiary and spouse/family Place of service Participants present

group and/or single-family group. Due to the group format, beneficiaries and their families are also able to benefit from support of peers and mutual aid. Services must be congruent with the age and abilities of the beneficiary, client-centered, and strength-based; with emphasis on needs as identified by the beneficiary and provided with cultural competence.

***Dyadic treatment is available for parent/caregiver and child for dyadic treatment of children from zero through forty-seven (0-47) months of age and parent/caregiver. Dyadic treatment must be prior authorized. Providers must utilize a national recognized evidence-based practice. Practices include, but are not limited to, Nurturing Parents and Incredible Years.**

- Nature of relationship with beneficiary
- Rationale for excluding the identified beneficiary, if applicable
- Diagnosis and pertinent interval history
- Rationale and objective used must coincide with the most recent intake assessment and improve the impact the beneficiary's condition has on the spouse/family or improve marital/family interactions between the beneficiary and the spouse/family, or both
- Beneficiary and Spouse/family response to treatment that includes current progress or regression and prognosis
- Any revisions indicated for the diagnosis, or medication concerns
- Plan for next session, including any homework assignments or crisis plans, or both
- HIPAA compliant Release of Information forms, completed, signed, and dated
- Staff signature/credentials/date of signature

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NOTES	UNIT	BENEFIT LIMITS
Information to support the appropriateness of excluding the identified beneficiary must be documented in the service note and medical record. Natural supports may be included in these sessions when the nature of the relationship with the beneficiary and that support's expected role in attaining treatment goals is documented. Only one (1) beneficiary per family per therapy session may be billed.	Fifteen (15) minutes	DAILY MAXIMUM OF UNITS THAT MAY BE BILLED: Four (4) YEARLY MAXIMUM OF UNITS THAT MAY BE BILLED (extension of benefits can be requested): forty-eight (48)
APPLICABLE POPULATIONS	SPECIAL BILLING INSTRUCTIONS	
Children, Youth, and Adults	<p>A provider can only bill a total of forty-eight (48) units of Psychoeducation</p> <p>The following <u>services</u> cannot be billed on the Same Date of Service:</p> <p>Marital/Family Behavioral Health Counseling with Beneficiary Present</p> <p>Marital/Family Behavioral Health Counseling without Beneficiary Present</p> <p>View or print the procedure codes for OBHS services.</p>	

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ALLOWED MODE(S) OF DELIVERY	TIER
Face-to-face Telemedicine (Adults, Youth, and Children)	Counseling
ALLOWABLE PERFORMING PROVIDERS	PLACE OF SERVICE
<ul style="list-style-type: none"> Independently Licensed Clinicians - Master's/Doctoral Non-independently Licensed Clinicians – Master's/Doctoral Advanced Practice Nurse Physician Providers of dyadic services must be trained and certified in specific evidence-based practices to be reimbursed for those services <ul style="list-style-type: none"> 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), 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), Group Home (14)

252.116 Multi-Family Behavioral Health Counseling

2-1-22

CPT®/HCPCS PROCEDURE CODE	PROCEDURE CODE DESCRIPTION
View or print the procedure codes for OBHS services.	Multiple-family group psychotherapy
SERVICE DESCRIPTION	MINIMUM DOCUMENTATION REQUIREMENTS
Multi-Family Behavioral Health Counseling is a group therapeutic intervention using face-to-face verbal interaction between two (2) to a maximum of nine (9) beneficiaries and their family members or significant others. Services are a more cost-effective alternative to Marital/Family Behavioral Health Counseling, designed to enhance members' insight into family interactions, facilitate inter-family emotional or practical support and to develop alternative strategies to address familial issues, problems and needs. Services may pertain to a beneficiary's (a) Mental Health or (b) Substance Abuse condition. Additionally, tobacco cessation counseling is a component	<ul style="list-style-type: none"> Date of Service Start and stop times of actual encounter with beneficiary and/or spouse/family Place of service Participants present Nature of relationship with beneficiary Diagnosis and pertinent interval history Rationale for and objective used to improve the impact the beneficiary's condition has on the spouse/family and/or improve marital/family interactions between the beneficiary and the spouse/family.

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of this service. Services must be congruent with the age and abilities of the beneficiary, client-centered and strength-based; with emphasis on needs as identified by the beneficiary and family and provided with cultural competence.			<ul style="list-style-type: none"> • Beneficiary and Spouse/Family response to treatment that includes current progress or regression and prognosis • Any revisions indicated for the diagnosis, or medication(s) • Plan for next session, including any homework assignments and/or crisis plans • HIPAA compliant Release of Information forms, completed, signed and dated • Staff signature/credentials/date of signature 		
NOTES			UNIT		
May be provided independently if patient is being treated for substance abuse diagnosis only. Comorbid substance abuse should be provided as integrated treatment utilizing Family Psychotherapy.			Encounter		
			DAILY MAXIMUM OF ENCOUNTERS THAT MAY BE BILLED: 1 YEARLY MAXIMUM OF ENCOUNTERS THAT MAY BE BILLED (extension of benefits can be requested): 12		
APPLICABLE POPULATIONS			SPECIAL BILLING INSTRUCTIONS		
Children, Youth, and Adults			There are twelve (12) total Multi-Family Behavioral Health Counseling encounters allowed per year. The following services cannot be billed on the Same Date of Service: Marital/Family Behavioral Health Counseling without Beneficiary Present Marital/Family Behavioral Health Counseling with Beneficiary Present Interpretation of Diagnosis Interpretation of Diagnosis, Telemedicine View or print the procedure codes for OBHS services.		
ALLOWED MODE(S) OF DELIVERY			TIER		
Face-to-face			Counseling		
ALLOWABLE PERFORMING PROVIDERS			PLACE OF SERVICE		
<ul style="list-style-type: none"> • Independently Licensed Clinicians - Master's/Doctoral • Non-independently Licensed Clinicians – Master's/Doctoral • Advanced Practice Nurse 			03 (School), 11 (Office), 49 (Independent Clinic), 50 (Federally Qualified Health Center), 53 (Community Mental Health Center), 57 (Non-Residential Substance Abuse Treatment Facility), 71 (Public Health Clinic), 72 (Rural Health Clinic)		

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- Physician

252.117 Mental Health Diagnosis

2-1-22

CPT®/HCPCS PROCEDURE CODE	PROCEDURE CODE DESCRIPTION	
View or print the procedure codes for OBHS services.	Psychiatric diagnostic evaluation (with no medical services)	
SERVICE DESCRIPTION	MINIMUM DOCUMENTATION REQUIREMENTS	
<p>Mental Health Diagnosis is a clinical service for the purpose of determining the existence, type, nature, and appropriate treatment of a mental illness, or related disorder, as described in the current allowable DSM. This service may include time spent for obtaining necessary information for diagnostic purposes. The 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 beneficiary, client-centered, and strength-based; with emphasis on needs as identified by the beneficiary and provided with cultural competence.</p>	<ul style="list-style-type: none"> • Date of Service • Start and stop times of the face-to-face encounter with the beneficiary and the interpretation time for diagnostic formulation • Place of service • Identifying information 	
	<ul style="list-style-type: none"> • 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
<p>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</p> <p>This service can be provided via telemedicine</p> <p>*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)</p>	Encounter	<p>DAILY MAXIMUM OF ENCOUNTERS THAT MAY BE BILLED: One (1)</p> <p>YEARLY MAXIMUM OF ENCOUNTERS THAT MAY BE BILLED (extension of benefits can be requested): One (1)</p>

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Goals and objectives to be placed in Plan of Care

<p>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:</p> <ul style="list-style-type: none"> ○ 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 caregiver-infant relationship and interactive patterns and ○ Child's affective, language, cognitive, motor, sensory, self-care, and social functioning 		
APPLICABLE POPULATIONS	SPECIAL BILLING INSTRUCTIONS	
<p>Children, Youth, and Adults Residents of Long-Term Care</p>	<p>The following codes cannot be billed on the Same Date of Service: Psychiatric Assessment View or print the procedure codes for OBHS services.</p>	
ALLOWED MODE(S) OF DELIVERY	TIER	
<p>Face-to-face Telemedicine (Adults, Youth, and Children)</p>	<p>Counseling</p>	
ALLOWABLE PERFORMING PROVIDER	PLACE OF SERVICE	
<ul style="list-style-type: none"> • 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 <ul style="list-style-type: none"> ○ Independently Licensed Clinicians – Parent/Caregiver and Child (Dyadic 	<p>02 (Telemedicine), 03 (School), 04 (Homeless Shelter), 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)</p>	

<p>treatment of Children from zero through forty-seven (0-47) months of age and Parent/Caregiver) Provider</p> <ul style="list-style-type: none"> 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 	
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252.118 Interpretation of Diagnosis

2-1-22

CPT®/HCPCS PROCEDURE CODE	PROCEDURE CODE DESCRIPTION	
View or print the procedure codes for OBHS services.	Interpretation or explanation of results of psychiatric, other medical examinations and procedures, or other accumulated data, to family or other responsible persons (or advising them how to assist patient)	
SERVICE DESCRIPTION	MINIMUM DOCUMENTATION REQUIREMENTS	
Interpretation of Diagnosis is a direct service provided for the purpose of interpreting the results of psychiatric or other medical exams, procedures, or accumulated data. Services may include diagnostic activities or advising the beneficiary and their family. Services pertain to a beneficiary's (a) Mental Health or (b) Substance Abuse condition, or both. Consent forms may be required for family or significant other involvement. Services must be congruent with the age and abilities of the beneficiary, client-centered, and strength-based; with emphasis on needs as identified by the beneficiary and provided with cultural competence.	<ul style="list-style-type: none"> _____ Date of service Start and stop times of face-to-face encounter with beneficiary and/or parent(s) or guardian(s) Place of service Participants present and relationship to beneficiary Diagnosis and pertinent interval history Rationale for and description of the treatment used that must coincide with the most recent intake assessment Participant(s) response and feedback Recommendation for additional supports including referrals, resources, and information Staff signature/credentials/date of signature(s) 	
NOTES	UNIT	BENEFIT LIMITS
For beneficiaries under eighteen (18) years of age, the time may be spent face-to-face with the beneficiary; the beneficiary and the parent(s) or guardian(s); or alone with the parent(s) or guardian(s). For beneficiaries over eighteen (18) years of age, the time may be spent face-to-face with the beneficiary and the spouse, legal guardian, or significant other. This service can be provided via telemedicine to beneficiaries eighteen (18) years of age and	Encounter	<p>DAILY MAXIMUM OF ENCOUNTERS THAT MAY BE BILLED: One (1)</p> <p>YEARLY MAXIMUM OF ENCOUNTERS THAT MAY BE BILLED (extension of</p>

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<p>above. This service can also be provided via telemedicine to beneficiaries seventeen (17) years of age and under with documentation of parental or guardian involvement during the service. This documentation must be included in the medical record.</p> <p>*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. Interpretation of Diagnosis will be required in order for all children, through forty-seven (47) months of age, to receive services. This service includes up to four (4) encounters for children through forty-seven (47) months of age and can be provided without a prior authorization. The Interpretation of Diagnosis is a direct service that includes an interpretation from a broader perspective, based on the history and information collected through the Mental Health Diagnosis. This interpretation identifies and prioritizes the infant's needs, establishes a diagnosis, and helps to determine the care and services to be provided.</p>		<p>benefits can be requested):</p> <p>One (1)</p>
APPLICABLE POPULATIONS	SPECIAL BILLING INSTRUCTIONS	
<p>Children, Youth, and Adults</p>	<p>The following codes cannot be billed on the Same Date of Service:</p> <p>Psychoeducation</p> <p>Psychiatric Assessment</p> <p>Multi-Family Behavioral Health Counseling</p> <p>Substance Abuse Assessment</p> <p>View or print the procedure codes for OBHS services.</p> <p>This service can be provided via telemedicine to beneficiaries eighteen (18) years of age and above. This service can also be provided via telemedicine to beneficiaries seventeen (17) years of age and under with documentation of parental or guardian involvement during the service. This documentation must be included in the medical record.</p>	
ALLOWED MODE(S) OF DELIVERY	TIER	
<p>Face-to-face</p> <p>Telemedicine Adults, Youth and Children</p>	<p>Counseling</p>	

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ALLOWABLE PERFORMING PROVIDERS	PLACE OF SERVICE
<ul style="list-style-type: none"> 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 <ul style="list-style-type: none"> 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), 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)

252.119

Substance Abuse Assessment

2-1-22

CPT®/HCPCS PROCEDURE CODE	PROCEDURE CODE DESCRIPTION
View or print the procedure codes for OBHS services.	Alcohol and/or drug assessment
SERVICE DESCRIPTION	MINIMUM DOCUMENTATION REQUIREMENTS
<p>Substance Abuse Assessment is a service that identifies and evaluates the nature and extent of a beneficiary's substance abuse condition using the Addiction Severity Index (ASI) or an assessment instrument approved by DAABHS and DMS. The assessment must screen for and identify any existing co-morbid conditions. The assessment should assign a diagnostic impression to the beneficiary, resulting in a treatment recommendation and referral appropriate to effectively treat the condition(s) identified.</p> <p>Services must be congruent with the age and abilities of the beneficiary, client-centered, and strength-based; with emphasis on needs, as</p>	<ul style="list-style-type: none"> Date of Service Start and stop times of the face-to-face encounter with the beneficiary and the interpretation time for diagnostic formulation Place of service Identifying information Referral reason Presenting problem(s), history of presenting problem(s) including duration, intensity, and response(s) to prior treatment Cultural and age-appropriate psychosocial history and assessment Mental status (Clinical observations and impressions)

identified by the beneficiary, and provided with cultural competence.	<ul style="list-style-type: none"> • 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, beneficiary recommendation for treatment regimen appropriate to the condition and situation presented by the beneficiary, initial plan (provisional) of care, and referral to a service appropriate to effectively treat the condition(s) identified. If indicated, the assessment process must refer the beneficiary for a psychiatric consultation.	Encounter	<p>DAILY MAXIMUM OF ENCOUNTERS THAT MAY BE BILLED: One (1)</p> <p>YEARLY MAXIMUM OF ENCOUNTERS THAT MAY BE BILLED (extension of benefits can be requested): One (1)</p>
APPLICABLE POPULATIONS	SPECIAL BILLING INSTRUCTIONS	
Children, Youth, and Adults	<p>The following codes cannot be billed on the Same Date of Service:</p> <p>Interpretation of Diagnosis</p> <p>View or print the procedure codes for OBHS services.</p>	
ALLOWED MODE(S) OF DELIVERY	TIER	
Face-to-face Telemedicine (Adults, Youth, Children)	Counseling	
ALLOWABLE PERFORMING PROVIDERS	PLACE OF SERVICE	
<ul style="list-style-type: none"> • Independently Licensed Clinicians – Master's/Doctoral • Non-independently Licensed Clinicians – Master's/Doctoral • Advanced Practice Nurses • <u>Physicians</u> • <u>Licensed Alcoholism and Drug Abuse Counselor Master's Bachelor's</u> 	02 (Telemedicine), 03 (School), 04 (Homeless Shelter), 11 (Office) 12 (Patient's Home), 49 (Independent Clinic), 50 (Federally Qualified Health Center), 53 (Community Mental Health Center), 57 (Non-Residential Substance Abuse Treatment Facility), 71 (Public Health Clinic), 72 (Rural Health Clinic)	

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252.121 Pharmacological Management

CPT®/HCPCS PROCEDURE CODE	PROCEDURE CODE DESCRIPTION
View or print the procedure codes for OBHS services.	<p>Office or other outpatient encounter for the evaluation and management of an established patient, which requires at least two (2) of these three (3) key components: A problem focused history; A problem focused examination; or straightforward medical decision making.</p> <p>Office or other outpatient encounter for the evaluation and management of an established patient, which requires at least two (2) of these three (3) key components: An expanded problem-focused history; An expanded problem-focused examination; or medical decision making of low complexity.</p> <p>Office or other outpatient encounter for the evaluation and management of an established patient, which requires at least two (2) of these three (3) key components: A detailed history, A detailed examination; or medical decision making of moderate complexity.</p> <p>View or print the procedure codes for OBHS services.</p>
SERVICE DESCRIPTION	MINIMUM DOCUMENTATION REQUIREMENTS
<p>Pharmacologic Management is a service tailored to reduce, stabilize, or eliminate psychiatric symptoms, with the goal of improving functioning, including management and reduction of symptoms. This service includes evaluation of the medication prescription, administration, monitoring, and supervision, as well as informing beneficiaries regarding potential effects and side effects of medication(s), in order to make informed decisions regarding the prescribed medications. Services must be congruent with the age, strengths, and accommodations necessary for disability and cultural framework.</p> <p>Services must be congruent with the age and abilities of the beneficiary, client-centered, and strength-based; with emphasis on needs as identified by the beneficiary and provided with cultural competence.</p>	<ul style="list-style-type: none"> • Date of Service • Start and stop times of actual encounter with beneficiary • Place of service (When ninety-nine (99) is used for telemedicine, specific locations of the beneficiary, and the physician must be included) • Diagnosis and pertinent interval history • Brief mental status and observations • Rationale for and treatment used that must coincide with the Psychiatric Assessment • Beneficiary's response to treatment that includes current progress or regression and prognosis • Revisions indicated for the diagnosis, or medication(s) • Plan for follow-up services, including any crisis plans • If provided by physician that is not a psychiatrist, then any off-label uses of medications should include documented consult with the overseeing psychiatrist

	within twenty-four (24) hours of the prescription being written • Staff signature/credentials/date of signature	
NOTES	UNIT	BENEFIT LIMITS
Applies only to medications prescribed to address targeted symptoms as identified in the Psychiatric Assessment.	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): Twelve (12)
APPLICABLE POPULATIONS	SPECIAL BILLING INSTRUCTIONS	
Children, Youth, and Adults		
ALLOWED MODE(S) OF DELIVERY	TIER	
Face-to-face Telemedicine (Adults, Youth, and Children)	Counseling	
ALLOWABLE PERFORMING PROVIDERS	PLACE OF SERVICE	
• Advanced Practice Nurse • Physician	02 (Telemedicine), 03 (School), 04 (Homeless Shelter), 11 (Office), 12 (Patient's Home), 49 (Independent Clinic), 50 (Federally Qualified Health Center), 53 (Community Mental Health Center), 57 (Non-Residential Substance Abuse Treatment Facility), 71 (Public Health Clinic), 72 (Rural Health Clinic)	

252.122

Psychiatric Assessment

2-1-22

CPT®/HCPCS PROCEDURE CODE	PROCEDURE CODE DESCRIPTION
View or print the procedure codes for OBHS services.	Psychiatric diagnostic evaluation with medical services
SERVICE DESCRIPTION	MINIMUM DOCUMENTATION REQUIREMENTS
Psychiatric Assessment is a face-to-face psychodiagnostics assessment conducted by a licensed physician or Advanced Practice Nurse (APN), preferably one with specialized training and experience in psychiatry (child and adolescent psychiatry for beneficiaries	• Date of Service • Start and stop times of the face-to-face encounter with the beneficiary and the interpretation time for diagnostic formulation

under eighteen (18) years of age). This service is provided to determine the existence, type, nature, and most appropriate treatment of a behavioral health disorder. This service is not required for beneficiaries to receive counseling services.

- Place of service
- Identifying information
- Referral reason
- The interview should obtain or verify the following:
 1. The beneficiary's understanding of the factors leading to the referral
 2. The presenting problem (including symptoms and functional impairments)
 3. Relevant life circumstances and psychological factors
 4. History of problems
 5. Treatment history
 6. Response to prior treatment interventions
 7. Medical history (and examination as indicated)
- For beneficiaries under eighteen (18) years of age
 1. an interview of a parent (preferably both), the guardian (including the responsible DCFS caseworker), and the primary caretaker (including foster parents) as applicable in order to:
 - a) Clarify the reason for the referral
 - b) Clarify the nature of the current symptoms
 - c) Obtain a detailed medical, family, and developmental history
- Culturally and age-appropriate psychosocial history and assessment
- Mental status/Clinical observations and impressions
- Current functioning and strengths in specified life domains
- DSM diagnostic impressions
- Treatment recommendations
- Staff signature/credentials/date of signature

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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	Encounter	DAILY MAXIMUM OF ENCOUNTERS THAT MAY BE BILLED: One (1)

paperwork processes (i.e. treatment plans, etc.).		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 Telemedicine (Adults, Youth, and Children)	<p>The following services cannot be billed on the Same Date of Service:</p> <p>Mental Health Diagnosis</p> <p>View or print the procedure codes for OBHS services.</p>	
ALLOWED MODE(S) OF DELIVERY	TIER	
Face-to-face	Counseling	
ALLOWABLE PERFORMING PROVIDERS	PLACE OF SERVICE	
<p>A. an Arkansas-licensed physician, preferably one (1) with specialized training and experience in psychiatry (child and adolescent psychiatry for beneficiaries under eighteen (18) years of age)</p> <p>B. an Adult Psychiatric Mental Health Advanced Nurse Practitioner/Family Psychiatric Mental Health Advanced Nurse Practitioner (PMHNP-BC)</p> <p>The PMHNP-BC must meet all of the following requirements:</p> <p>A. Licensed by the Arkansas State Board of Nursing</p> <p>B. Practicing with licensure through the American Nurses Credentialing Center</p> <p>C. Practicing under the supervision of an Arkansas-licensed psychiatrist with whom the PMHNP-BC has a collaborative agreement. The findings of the Psychiatric Assessment conducted by the PMHNP-BC, must be discussed with the supervising psychiatrist within forty-five (45) days of the beneficiary entering care. The collaborative agreement must comply with all Board of Nursing requirements and must spell out, in detail, what the</p>	<p>02 (Telemedicine), 03 (School), 04 (Homeless Shelter), 11 (Office), 12, (Patient's Home), 49 (Independent Clinic), 50 (Federally Qualified Health Center), 53 (Community Mental Health Center), 57 (Non-Residential Substance Abuse Treatment Facility), 71 (Public Health Clinic), 72 (Rural Health Clinic)</p>	

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nurse is authorized to do and what age group they may treat	
D. Practicing within the scope of practice as defined by the Arkansas Nurse Practice Act	
E. Practicing within a PMHNP-BC's experience and competency level	

Intensive Outpatient Substance Abuse Treatment

<u>PROCEDURE CODES</u>	<u>PROCEDURE CODE DESCRIPTION</u>
<u>View or print the procedure codes for OBHS services.</u>	<u>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.</u>
<u>SERVICE DESCRIPTION</u>	<u>MINIMUM DOCUMENTATION REQUIREMENTS</u>
<u>Intensive Outpatient Services provide group based, non-residential, intensive, structured interventions consisting primarily of counseling and education to improve symptoms that may significantly interfere with functioning in at least one life domain (e.g., familial, social, occupational, educational, etc.). Services are goal-oriented interactions with the individual or in group/family settings. This community-based service allows the individual to apply skills in "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) beneficiaries.</u>	<ul style="list-style-type: none"> <u>Date of service</u> <u>Start and stop times of the face-to-face encounter with the beneficiary and the interpretation time for diagnostic formulation</u> <u>Place of service</u> <u>Identifying information</u> <u>Referral reason</u> <u>Presenting problem(s), history of presenting problem(s) including duration, intensity, and response(s) to prior treatment</u> <u>Diagnostic impressions</u> <u>Rationale for service including consistency with plan of care</u> <u>Brief mental status and observations</u> <u>Current functioning and strengths in specified life domains</u> <u>Beneficiary's response to the intervention that includes current progress or regression and prognosis</u> <u>Staff signature/credentials/date of signature(s)</u>
<u>NOTES</u>	<u>UNIT</u> <u>BENEFIT LIMITS</u>

	Per Diem	YEARLY MAXIMUM OF UNITS THAT MAY BE BILLED: (extension of benefits can be requested) Twenty-four (24)
<u>APPLICABLE POPULATIONS</u>	<u>SPECIAL BILLING INSTRUCTIONS</u>	
Adults and Youth	A provider may not bill for any other service on the same date of service.	
<u>ALLOWED MODE(S) OF DELIVERY</u>	<u>TIER</u>	
Face-to-face	Counseling	
<u>ALLOWABLE PERFORMING PROVIDERS</u>	<u>PLACE OF SERVICE</u>	
Intensive Outpatient Substance Abuse Treatment must be provided in a facility that is licensed by the Division of Provider Services and Quality Assurance 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).	

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Crisis Stabilization Intervention

<u>PROCEDURE CODES</u>	<u>PROCEDURE CODE DESCRIPTION</u>
<u>View or print the procedure codes for OBHS services.</u>	Crisis Stabilization service, per fifteen (15) minutes
<u>SERVICE DESCRIPTION</u>	<u>MINIMUM DOCUMENTATION REQUIREMENTS</u>
<p>Crisis Stabilization Intervention is a scheduled face-to-face (or telemedicine) treatment activity provided to a beneficiary who has recently experienced a psychiatric or behavioral health crisis that are expected to further stabilize, prevent deterioration and serve as an alternative to 24-hour inpatient care.</p> <p>Services are to be congruent with the age, strengths, needed accommodation for any disability, and cultural framework of the beneficiary and their family.</p>	<ul style="list-style-type: none"> • <u>Date of service</u> • <u>Start and stop time of actual encounter with beneficiary and possible collateral contacts with caregivers or informed persons</u> • <u>Place of service</u> • <u>Specific persons providing pertinent information and relationship to beneficiary</u> • <u>Diagnosis and synopsis of events leading up to crisis situation</u> • <u>Brief mental status and observations</u>

	<ul style="list-style-type: none"> • <u>Utilization of previously established psychiatric advance directive or crisis plan as pertinent to current situation OR rationale for crisis intervention activities utilized</u> • <u>Beneficiary's response to the intervention that includes current progress or regression and prognosis</u> • <u>Clear resolution of the current crisis and/or plans for further services</u> • <u>Development of a clearly defined crisis plan or revision to existing plan</u> • <u>Staff signature/credentials/date of signature(s)</u> 	
<u>NOTES</u>	<u>UNIT</u>	<u>BENEFIT LIMITS</u>
<p><u>A psychiatric or behavioral crisis is defined as an acute situation in which an individual is experiencing a serious mental illness or emotional disturbance to the point that the beneficiary or others are at risk for imminent harm or in which to prevent significant deterioration of the beneficiary's functioning.</u></p> <p><u>This service is a planned intervention that MUST be on the beneficiary's treatment plan to serve as an alternative to 24-hour inpatient care.</u></p>	<u>Fifteen (15) minutes</u>	<p><u>DAILY MAXIMUM OF UNITS THAT MAY BE BILLED: Twelve (12) units</u></p> <p><u>YEARLY MAXIMUM OF UNITS THAT MAY BE BILLED (extension of benefits can be requested): Seventy-two (72) units</u></p>
<u>APPLICABLE POPULATIONS</u>	<u>SPECIAL BILLING INSTRUCTIONS</u>	
<u>Children, Youth, and Adults</u>		
<u>ALLOWED MODE(S) OF DELIVERY</u>	<u>TIER</u>	
<u>Face-to-face</u> <u>Telemedicine (Adults, Youth, and Children)</u>	<u>Crisis</u>	
<u>ALLOWABLE PERFORMING PROVIDERS</u>	<u>PLACE OF SERVICE</u>	
<ul style="list-style-type: none"> • <u>Independently Licensed Clinicians – Master's/Doctoral</u> • <u>Non-independently Licensed Clinicians – Master's/Doctoral (must be employed by Behavioral Health Agency)</u> • <u>Advanced Practice Nurses</u> • <u>Physicians (must be employed by Behavioral Health Agency)</u> 	<u>02 (Telemedicine) 03 (School), 04 (Homeless Shelter), 11 (Office) 12 (Patient's Home), 15 (Mobile Unit), 23 (Emergency Room), 33 (Custodial Care facility), 49 (Independent Clinic), 50 (Federally Qualified Health Center), 53 (Community Mental Health Center), 57(Non-Residential Substance Abuse Treatment Facility), 71 (Public Health Clinic), 72 (Rural Health Clinic), 99 (Other Location)</u>	

255.001 Crisis Intervention

CPT®/HCPCS PROCEDURE CODE	PROCEDURE CODE DESCRIPTION	
View or print the procedure codes for OBHS services.	Crisis intervention service, per fifteen (15) minutes	
SERVICE DESCRIPTION	MINIMUM DOCUMENTATION REQUIREMENTS	
<p>Crisis Intervention is unscheduled, immediate, short-term treatment activities provided to a Medicaid-eligible beneficiary who is experiencing a psychiatric or behavioral crisis. Services are to be congruent with the age, strengths, needed accommodation for any disability, and cultural framework of the beneficiary and his/her family. These services are designed to stabilize the person in crisis, prevent further deterioration and provide immediate indicated treatment in the least restrictive setting. (These activities include evaluating a Medicaid-eligible beneficiary to determine if the need for crisis services is present.)</p> <p>Services are to be congruent with the age, strengths, needed accommodation for any disability, and cultural framework of the beneficiary and their family.</p>	<ul style="list-style-type: none"> • Date of service • Start and stop time of actual encounter with beneficiary and possible collateral contacts with caregivers or informed persons • Place of service • Specific persons providing pertinent information <u>and</u> relationship to beneficiary • Diagnosis and synopsis of events leading up to crisis situation • Brief mental status and observations • Utilization of previously established psychiatric advance directive or crisis plan as pertinent to current situation OR rationale for crisis intervention activities utilized • Beneficiary's response to the intervention that includes current progress or regression and prognosis • Clear resolution of the current crisis and/or plans for further services • Development of a clearly defined crisis plan or revision to existing plan • Staff signature/credentials/date of signature(s) 	
NOTES	UNIT	BENEFIT LIMITS
<p>A psychiatric or behavioral crisis is defined as an acute situation, in which an individual is experiencing a serious mental illness or emotional disturbance to the point that the beneficiary or others are at risk for imminent harm, or in which to prevent significant deterioration of the beneficiary's functioning.</p> <p>This service can be provided to beneficiaries that have not been previously assessed or have not previously received behavioral health services.</p> <p>The provider of this service MUST complete a Mental Health Diagnosis within seven (7) days of provision of this service, if provided to a beneficiary who is not currently a client.</p>	Fifteen (15) minutes	<p>DAILY MAXIMUM OF UNITS THAT MAY BE BILLED: twelve (12)</p> <p>YEARLY MAXIMUM OF UNITS THAT MAY BE BILLED (extension of benefits can be requested): seventy-two (72)</p>

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View or print the procedure codes for OBHS services. If the beneficiary cannot be contacted or does not return for a Mental Health Diagnosis appointment, attempts to contact the beneficiary must be placed in the beneficiary's medical record. If the beneficiary needs more time to be stabilized, this must be noted in the beneficiary's medical record and the Division of Medical Services Quality Improvement Organization (QIO) must be notified.		
APPLICABLE POPULATIONS	SPECIAL BILLING INSTRUCTIONS	
Children, Youth, and Adults		
ALLOWED MODE(S) OF DELIVERY	TIER	
Face-to-face Telemedicine (Adults, Youth, and Children)	Crisis	
ALLOWABLE PERFORMING PROVIDERS	PLACE OF SERVICE	
<ul style="list-style-type: none"> Independently Licensed Clinicians – Master's/Doctoral Non-independently Licensed Clinicians – Master's/Doctoral (must be employed by Behavioral Health Agency) Advanced Practice Nurses Physicians (must be employed by Behavioral Health Agency) 	02 (Telemedicine), 03 (School), 04 (Homeless Shelter), 11 (Office) 12 (Patient's Home), 15 (Mobile Unit), 23 (Emergency Room), 33 (Custodial Care facility), 49 (Independent Clinic), 50 (Federally Qualified Health Center), 53 (Community Mental Health Center), 57 (Non-Residential Substance Abuse Treatment Facility), 71 (Public Health Clinic), 72 (Rural Health Clinic), 99 (Other Location)	

255.003

Acute Crisis Units

2-1-22

CPT®/HCPCS PROCEDURE CODE	PROCEDURE CODE DESCRIPTION
View or print the procedure codes for OBHS 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	<ul style="list-style-type: none"> <u>Date of service</u> <u>Assessment information including mental health and substance abuse psychosocial evaluation, initial discharge plan, strengths and abilities to be considered for community re-entry</u> <u>Place of service</u> <u>Specific persons providing pertinent information and relationship to beneficiary</u>

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<p>observation; crisis intervention; psychiatric, substance, and co-occurring treatment; and initiate referral mechanisms for independent assessment and care planning as needed.</p>		<ul style="list-style-type: none"> • <u>Diagnosis and synopsis of events leading up to acute crisis admission</u> • <u>Interpretive summary</u> • <u>Brief mental status and observations</u> • <u>Utilization of previously established psychiatric advance directive or crisis plan as pertinent to current situation OR rationale for crisis intervention activities utilized</u> • <u>Beneficiary's response to the intervention that includes current progress or regression and prognosis</u> • <u>Clear resolution of the current crisis and/or plans for further services</u> • <u>Development of a clearly defined crisis plan or revision to existing plan</u> • <u>Thorough discharge plan including treatment and community resources</u> <p><u>Staff signature/credentials/date of signature(s)</u></p>
NOTES	EXAMPLE ACTIVITIES	
APPLICABLE POPULATIONS	UNIT	BENEFIT LIMITS
Adults	Per Diem	<ul style="list-style-type: none"> • 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 as an Acute Crisis Unit Provider.	55 (Residential Substance Abuse Treatment Facility), 56 (Psychiatric Residential Treatment Center)	

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255.004 Substance Abuse Detoxification

2-1-22

CPT®/HCPCS PROCEDURE CODE	PROCEDURE CODE DESCRIPTION
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View or print the procedure codes for OBHS services.	Alcohol and/or drug services; detoxification	
SERVICE DESCRIPTION	MINIMUM DOCUMENTATION REQUIREMENTS	
<p>Substance Abuse Detoxification is a set of interventions aimed at managing acute intoxication and withdrawal from alcohol or other drugs. Services help stabilize beneficiaries by clearing toxins from the beneficiary's body. Services are short-term and may be provided in a crisis unit, inpatient, or outpatient setting, and may include evaluation, observation, medical monitoring, and addiction treatment. Detoxification seeks to minimize the physical harm caused by the abuse of substances and prepares the beneficiary for ongoing treatment.</p>	<ul style="list-style-type: none"> • <u>Date of service</u> • <u>Assessment information including mental health and substance abuse psychosocial evaluation, initial discharge plan, strengths and abilities to be considered for community re-entry</u> • <u>Place of service</u> • <u>Specific persons providing pertinent information and relationship to beneficiary</u> • <u>Diagnosis and synopsis of events leading up to acute crisis admission</u> • <u>Interpretive summary</u> • <u>Brief mental status and observations</u> • <u>Utilization of previously established psychiatric advance directive or crisis plan as pertinent to current situation OR rationale for crisis intervention activities utilized</u> • <u>Beneficiary's response to the intervention that includes current progress or regression and prognosis</u> • <u>Clear resolution of the current crisis and/or plans for further services</u> • <u>Development of a clearly defined crisis plan or revision to existing plan</u> • <u>Thorough discharge plan including treatment and community resources</u> <p><u>Staff signature/credentials/date of signature(s)</u></p>	
NOTES	EXAMPLE ACTIVITIES	
APPLICABLE POPULATIONS	UNIT	BENEFIT LIMITS
Youth and Adults	N/A	<ul style="list-style-type: none"> • Six (6) encounters per SFY; Extension of Benefits required for additional encounters
PROGRAM SERVICE CATEGORY		
Crisis Services		

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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 <u>licensed</u> by the Division of Provider Services and Quality Assurance as a Substance Abuse Detoxification provider.	55 (Residential Substance Abuse Treatment Facility) <u>21 (Inpatient Hospital)</u>

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256.200 Reserved

8-1-18

256.400 Place of Service Codes

8-1-18

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

Place of Service	POS Codes
Telemedicine <u>(other than client's home)</u>	02
School (Including Licensed Child Care Facility)	03
Homeless Shelter	04
<u>Telemedicine (client located in their home),</u>	<u>10</u>
Office (<u>Counseling Services</u> Provider Service Site)	11
Patient's Home	12
Group Home	14
Mobile Unit	15
Temporary Lodging	16
Inpatient Hospital	21
Nursing Facility	32
Custodial Care Facility	33
Independent Clinic	49
Federally Qualified Health Center	50
Community Mental Health Center	53
Residential Substance Abuse Treatment Facility	55
Non-Residential Substance Abuse Treatment Facility	57
Public Health Clinic	71
Rural Health Clinic	72
Other	99

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256.500 Billing Instructions – Paper Only

11-1-17

To bill for [Counseling Services](#), use the CMS-1500 form. The numbered items correspond to numbered fields on the claim form. [View a CMS-1500 sample form.](#)

When completing the CMS-1500, accuracy, completeness and clarity are important. Claims cannot be processed if applicable information is not supplied or is illegible. Claims should be typed whenever possible.

Completed claim forms should be forwarded to the Arkansas Medicaid fiscal agent. [View or print Claims contact information.](#)

NOTE: A provider rendering services without verifying eligibility for each date of service does so at the risk of not being reimbursed for the services.

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256.510

Completion of the CMS-1500 Claim Form

7-1-17

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

Field Name and Number	Instructions for Completion
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.
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.

Field Name and Number	Instructions for Completion
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 <u>Counseling Services</u> for all beneficiaries after <u>ten (10) counseling services</u> . If services are the result of a Child Health Services (EPSDT) screening/ referral, enter the referral source, including name and title.
17a. (blank)	Not required.
17b. NPI	Enter NPI of the referring physician.
18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES	When the serving/billing provider's services charged on this claim are related to a beneficiary's or participant's inpatient hospitalization, enter the individual's admission and discharge dates. Format: MM/DD/YY.
19. RESERVED FOR LOCAL USE	Not applicable to <u>Counseling Services</u> .
20. OUTSIDE LAB? \$ CHARGES	Not required. Not required.
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.

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Field Name and Number	Instructions for Completion
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	<p>The "from" and "to" dates of service for each billed service. Format: MM/DD/YY.</p> <ol style="list-style-type: none"> 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.
E. DIAGNOSIS POINTER	Enter the diagnosis code reference letter (pointer) as shown in Item Number 21 to relate to the date of service and the procedures performed to the primary diagnosis. When multiple services are performed, the primary reference letter for each service should be listed first; other applicable services should follow. The reference letter(s) should be A-L or multiple letters as applicable. The "Diagnosis Pointer" is the line letter from Item Number 21 that relates to the reason the service(s) was performed.
F. \$ CHARGES	The full charge for the service(s) totaled in the detail. This charge must be the usual charge to any client, patient, or other beneficiary of the provider's services.
G. DAYS OR UNITS	The units (in whole numbers) of service(s) provided during the period indicated in Field 24A of the detail.
H. EPSDT/Family Plan	Enter E if the services resulted from a Child Health Services (EPSDT) screening/referral.
I. ID QUAL	Not required.
J. RENDERING PROVIDER ID #	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.

Field Name and Number	Instructions for Completion
25. FEDERAL TAX I.D. NUMBER	Not required. This information is carried in the provider's Medicaid file. If it changes, please contact Provider Enrollment.
26. PATIENT'S ACCOUNT NO.	Optional entry that may be used for accounting purposes; use up to 16 numeric or alphabetic characters. This number appears on the Remittance Advice as "MRN."
27. ACCEPT ASSIGNMENT?	Not required. Assignment is automatically accepted by the provider when billing Medicaid.
28. TOTAL CHARGE	Total of Column 24F—the sum all charges on the claim.
29. AMOUNT PAID	Enter the total of payments previously received on this claim. Do not include amounts previously paid by Medicaid. Do not include in this total the automatically deducted Medicaid or ARKids First-B co-payments.
30. RESERVED	Reserved for NUCC use.
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS	The provider or designated authorized individual must sign and date the claim certifying that the services were personally rendered by the provider or under the provider's direction. "Provider's signature" is defined as the provider's actual signature, a rubber stamp of the provider's signature, an automated signature, a typewritten signature, or the signature of an individual authorized by the provider rendering the service. The name of a clinic or group is not acceptable.
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.

257.000 Special Billing Procedures

257.100 Reserved

8-1-18