Division of Medical Services
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MEMORANDUM

TO: Interested Persons and Providers

FROM: Elizabeth Pitman, Director, Division of Medical Services

DATE: October 12, 2022

SUBJ: Proposed Filing: Rebalancing Services for Clients with IDD and BH Needs (r210)

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

Public comments must be submitted in writing at the above address or at the following email address: ORP@dhs.arkansas.gov Please note that public comments submitted in response to this notice are considered public documents. A public comment, including the commenter's name and any personal information contained within the public comment, will be made publicly available and may be seen by various people.

If you have any comments, please submit those comments in writing, no later than November 13, 2022.

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

NOTICE OF RULE MAKING

The Director of the Division of Medical Services of the Department of Human Services announces for a public comment period of thirty (30) calendar days a notice of rulemaking for the following proposed rule under one or more of the following chapters, subchapters, or sections of the Arkansas Code: §§ 20-48-1003, 20-76-201, 20-77-107, and 25-10-129.

Effective January 1, 2023:

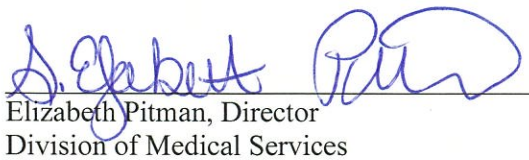
The Director of the Division of Medical Services amends ten (10) manuals and related State Plan pages. There are three (3) new manuals: Community and Employment Support (CES) Waiver Certification Manual, Home and Community-Based Services for Clients with Intellectual Disabilities and Behavioral Health Needs Manual, and the Diagnostic and Evaluation Manual. The following manuals are amended: Community Support System Provider Certification Manual, Provider-led Arkansas Shared Savings Entities (PASSE) Manual, Physician's Manual, and Outpatient Behavioral Health Services Manual. Three manuals are repealed: Independent Licensed Practitioner Certification Manual, School-Based Mental Health Manual and corresponding Medicaid State Plan pages, and Adult Behavioral Health Services for Community Independence Manual. The manual amendments, enactments, and repeals are focused on shifting away from a fee-for-service methodology for clients with Intellectual and Developmental Disabilities (IDD) and Behavioral Health (BH) needs, lessening the administrative burden on providers, supporting the workforce, and raising the quality of care with evidence-based and recognized service models. The proposed rule estimates a financial impact of $350,000 ($250,670 of which is federal funds) for state fiscal year (SYF) 2023 and $700,000 ($501,340 of which is federal funds) for SYF 2024.

The proposed rule is available for review at the Department of Human Services (DHS) Office of Rules Promulgation, 2nd floor Donaghey Plaza South Building, 7th and Main Streets, P. O. Box 1437, Slot S295, Little Rock, Arkansas 72203-1437. You may also access and download the proposed rule at https://humanservices.arkansas.gov/do-business-with-dhs/proposed-rules/. Public comments must be submitted in writing at the above address or at the following email address: ORP@dhs.arkansas.gov. All public comments must be received by DHS no later than **November 13, 2022**. Please note that public comments submitted in response to this notice are considered public documents. A public comment, including the commenter's name and any personal information contained within the public comment, will be made publicly available and may be seen by various people.

A public hearing by remote access only through a Zoom webinar will be held on October 27, 2022, at 10:30 a.m. and public comments may be submitted at the hearing. Individuals can access this public hearing at https://us02web.zoom.us/j/81309686433 . The webinar ID is 813 0968 6433. If you would like the electronic link, "one-tap" mobile information, listening only dial-in phone numbers, or international phone numbers, please contact ORP at ORP@dhs.arkansas.gov.

If you need this material in a different format, such as large print, contact the Office of Rules Promulgation at 501-534-4138.

The Arkansas Department of Human Services is in compliance with Titles VI and VII of the Civil Rights Act and is operated, managed and delivers services without regard to religion, disability, political affiliation, veteran status, age, race, color or national origin. 4502100209



Elizabeth Pitman, Director
Division of Medical Services

Rules for the Division of Developmental Disabilities Services

Community and Employment Support (CES) Waiver Providers

LAST UPDATED: January 1, 2023

Subchapter 1. General.

101. Authority.

These standards are promulgated under the authority of Ark. Code Ann. § 20-76-201, and Ark. Code Ann. §§ 20-48-101 to 1108.

102. Purpose.

The purpose of these standards is to:

(1) Serve as the minimum standards for community providers delivering services to clients enrolled in the Arkansas 1915(c) home and community-based waiver number AR.0188, which is known as the Community and Employment Support Waiver (CES Waiver); and

(2) Ensure the health and safety of clients who are enrolled in the CES Waiver.

103. Definitions.

(a) "Adverse agency action" means

(1) A denial of an application for CES Waiver Service certification; and

(2) Any enforcement action taken by DDS pursuant to Section 803 to 807.

(b) "Change of ownership" means any fifty percent (50%) or greater change in the financial interests, governing body, operational control, or other operational or ownership interests of a Provider within a twelve (12) month period.

(c) "CES Waiver" means the Arkansas 1915(c) home and community-based waiver number AR.0188, which is known as the Community and Employment Support Waiver.

(d) "CES Waiver Service" means one of the following services each as defined in section 284.000 of the Provider-Led Arkansas Shared Savings Entity (PASSE) Medicaid Manual and the CES Waiver:

(1) Respite;

(2) Supported Employment;

(3) Supportive Living;

(4) Specialized Medical Supplies;

(5) Adaptive Equipment;

(6) Community Transition Services;

(7) Consultation;

(8) Environmental Modifications; and

(9) Supplemental Support.

(e) "Chemical restraint" means the use of medication or any drug that:

(1) Is administered to manage a client's behavior;

(2) Has the temporary effect of restricting the client; and

(3) Is not a standard treatment for the client's medical or psychiatric condition.

(f) "Complex care home" means a home setting where each client residing in the home is diagnosed with an intellectually disability and a significant co-occurring deficit, which includes without limitation individuals with an intellectual disability and significant:

(1) Behavioral health needs; or

(2) Physical health needs.

(g) "DDS" means the Arkansas Department of Human Services, Division of Developmental Disabilities Services, or its delegatee.

(h) "DMS" means the Arkansas Department of Human Services, Division of Medical Services.

(i) "Directed in-service training plan" means a plan of action that:

(1) Provides training to a Provider to correct non-compliance with these standards;

(2) Establishes the topics covered and materials used in the training;

(3) Specifies the length of the training;

(4) Specifies the employees required to attend the training; and

(5) Is approved by DDS.

(j) "Employee" means an employee or other agent of a Provider who has or will have direct contact with a client or their personal property or funds, including without limitation any employee, independent contractor, sub-contractor, intern, volunteer, trainee, or agent.

(k)

(1) "Licensed professional" means a person who holds a professional certificate or license in good standing in Arkansas.

(2) "Licensed professional" includes without limitation the following independently licensed or certified professionals: general contactor, physician, psychiatrist, psychologist, social worker, psychological examiner, parent educator, communication and environmental control specialist, behavior support specialist, professional counselor, behavioral analyst, master social worker, licensed practical nurse, registered nurse, speech-language pathologist, dietician, occupational therapist, physical therapist, and recreational therapist.

(l)

(1) "Market" means the accurate and honest advertisement of a Provider that does not also constitute an attempt to solicit.

(2) "Market" includes without limitation:

(A) Advertising using traditional media;

(B) Distributing brochures or other informational materials regarding the services offered by a Provider;

(C) Conducting tours of a Provider to interested clients and their families;

(D) Mentioning services offered by a Provider in which a client or his or her family might have an interest; and

(E) Hosting informational gatherings during which the services offered by a Provider are described.

(m) "Mechanical restraint" means the use of any device attached or adjacent to a client that:

(1) Cannot be easily removed by the client; and

(2) Restricts the client's freedom of movement.

(n) "Medication error" means any one of the following:

(1) Loss of medication;

(2) Unavailability of medication;

(3) Falsification of medication logs;

(4) Theft of medication;

(5) Missed doses of medication;

(6) Incorrect medications administered;

(7) Incorrect doses of medication;

(8) Incorrect time of administration;

(9) Incorrect method of administration; and

(10) The discovery of an unlocked medication container that is always supposed to be locked.

(o) "PCSP" means a person-centered service plan, which is a written, individualized service and support plan for a client enrolled in the CES Waiver.

(p) "Plan of correction" means a plan of action that:

(1) Provides the steps a Provider must take to correct non-compliance with these standards;

(2) Establishes a timeframe for each specific action included in the plan; and

(3) Is approved by DDS.

(q) "Provider" means an individual, organization, or entity certified to provide one or more CES Waiver Services.

(r)

(1) "Restraint" means the application of force for the purpose of restraining the free movement of a client, which includes without limitation any chemical restraint and mechanical restraint.

(2) "Restraint" does not include:

(A) Briefly holding, without undue force, a client to calm or comfort him or her; or

(B) Holding a client's hand to safely escort him or her from one area to another.

(s) "Risk mitigation plan" means individualized plan developed by a client's PASSE care coordinator that outlines a client's risk factors and the action steps that must be taken to mitigate those risks.

(t) "Seclusion" means the involuntary confinement of a client in an area from which the client is physically prevented from leaving.

(u) "Serious injury" means any injury to a client that:

(1) May cause death;

(2) May result in substantial permanent impairment;

(3) Requires hospitalization; or

(4) Requires the attention of:

(A) An emergency medical technician;

(B) A paramedic; or

(C) An emergency room.

(v)

(1) "Solicit" means when a Provider intentionally initiates contact with a client (or their family) that is currently receiving services from another provider and Provider is attempting to persuade the client or their family to switch to or otherwise use the services of Provider.

(2) "Solicit" includes without limitation the following acts to induce a client or their family by:

(A) Contacting a client or the family of a client that is currently receiving services from another provider;

(B) Offering cash or gift incentives to a client or their family;

(C) Offering free goods or services not available to other similarly situated clients or their families;

(D) Making negative comments to a client or their family regarding the quality of services performed by another provider;

(E) Promising to provide services in excess of those necessary;

(F) Giving a client or his or her family the false impression, directly or indirectly, that Provider is the only provider that can perform the services desired by the client or their family; or

(G) Engaging in any activity that DDS reasonably determines to be "solicitation."

Subchapter 2. Certification.

201. Certification Required.

(a)

(1) An individual, entity, or organization must be certified by DDS to provide a CES Waiver Service.

(2) A separate DDS certification is required for each type of CES Waiver Service.

(b) A Provider that wishes to operate a complex care home must have the residence certified as a complex care home in addition to being certified to provide CES Supportive Living.

(c) A Provider must comply with all applicable requirements in these standards to maintain certification for a CES Waiver Service.

(d) An individual, entity, or organization that is on the Medicaid excluded provider list is prohibited from receiving CES Waiver Service certification.

202. Application for Certification.

(a) To apply for CES Waiver Service or complex care home certification, an applicant must submit a complete application to DDS.

(b) A complete application includes:

(1) Documentation demonstrating the applicant's entire ownership, including without limitation the applicant's governing body and all financial and business interests;

(2) Documentation of the applicant's management, including without limitation the management structure and members of the management team;

(3) Documentation of the employees and the contractors that the applicant intends to use as part of operating as a Provider;

(4) Documentation of all required state and national criminal background checks for employees and contractors;

(5) Documentation of all required drug screens, registry checks and searches for employees and contractors;

(6) Documentation demonstrating compliance with these standards; and

(7) All other documentation or other information requested by DDS.

203. Certification Process.

(a) DDS may issue CES Waiver Service or complex care home certification to an applicant if:

(1) The applicant submits a complete application under section 202;

(2) DDS determines that all employees and contractors have successfully passed all required drug screens and criminal background, maltreatment, and other registry checks and searches; and

(3) DDS determines that the applicant satisfies these standards.

(b) DDS may approve an application involving a change of ownership for an existing Provider if:

(1) The applicant submits a complete application under section 202;

(2) DDS determines that all employees and owners have successfully passed all required criminal background, maltreatment, and other required registry checks and searches; and

(3) DDS determines that the applicant satisfies these standards.

(c) Certification to perform a CES Waiver Service once issued does not expire until terminated under these standards.

Subchapter 3. Administration.

301. Organization and Ownership.

(a) A Provider must be authorized and in good standing to do business under the laws of the state of Arkansas.

(b)

(1) A Provider must appoint a single manager as the point of contact for all DDS and DMS matters and provide DDS and DMS with updated contact information for that manager.

(2) The manager must have authority over Provider and all its employees and be responsible for ensuring that requests, concerns, inquires, and enforcement actions are addressed and resolved to the satisfaction of DDS and DMS.

(c)

(1) A Provider cannot transfer CES Waiver Service certification to any other person or entity.

(2) A Provider cannot complete a change of ownership unless DDS approves the application of the new ownership pursuant to sections 202 and 203.

(3) A Provider cannot change its name or otherwise operate under a different name than the name listed on its certification without notice to DDS.

302. Employee and Staffing Requirements.

(a) A Provider must appropriately supervise all clients based on each client's needs.

(b)

(1) A Provider must meet any minimum staff-to-client ratio included in a client's treatment plan.

(2) A Provider is required to maintain at least a four-to-one (4:1) client to staff ratio in a complex care home at all times.

(c)

(1) Except as provided in subsection (c)(2) of this part, each employee must successfully pass the following:

(A) All criminal history record checks required pursuant to Ark. Code Ann. § 20-38-103, both prior to hiring and at least every five (5) years thereafter;

(B) An Arkansas Child Maltreatment Central Registry check both prior to hiring and at least every two (2) years thereafter;

(C) An Arkansas Adult and Long-term Care Facility Resident Maltreatment Central Registry check both prior to hiring and at least every two (2) years thereafter;

(D) A drug screen that tests for the use of illegal drugs prior to hiring; and

(E) An Arkansas Sex Offender Central Registry search both prior to hiring and at least every two (2) years thereafter.

(2) The drug screens, registry checks, and searches prescribed in subdivision (c)(1) are not required for any licensed professional.

(d)

(1) Employees must be eighteen (18) years of age or older.

(2) Employees must have a high school diploma or a GED.

(3) Employees performing Consultation and Environmental Modification services must be a licensed or certified professional in the appropriate field for the type of service performed.

(e) A Provider must verify an employee meets all requirements under these standards upon the request of DDS or whenever a Provider receives information after hiring that would create a reasonable belief that an employee no longer meets all requirements under these standards.

303. Employee Training and Certifications.

(a)

(1) All employees must receive training on the following topics prior to having any direct contact with clients, and at least once every twelve (12) months thereafter:

(A) Identification and prevention of adult and child abuse, exploitation, neglect, and maltreatment;

(B) Mandated reporter requirements and procedures;

(C) Incident and accident reporting;

(D) Basic health and safety practices;

(E) Infection control practices;

(F) Identification and mitigation of unsafe environmental factors;

(G) Emergency restraint procedures; and

(H) Client financial safeguards under section 308.

(2)

(A) All employees must receive at least twelve (12) hours of training prior to having any direct contact with clients, and at least once every twelve (12) months thereafter.

(B) The twelve (12) hours of training must include training on the following topics:

(i) Care planning for individuals with intellectual and developmental disabilities;

(ii) Care planning for individuals with autism spectrum disorders;

(iii) De-escalation techniques; and

(iv) Behavioral modification or prevention training.

(C) Time spent training on the topics listed in subsection (a)(1) cannot be counted towards the training prescribed in this subsection (a)(2).

(b)

(1) All employees must obtain and maintain in good standing the following credentials when performing services on behalf of Provider:

(A) CPR certification from one of the following:

(i) American Heart Association;

(ii) Medic First Aid, or

(iii) American Red Cross; and

(B) First aid certification from one of the following:

(i) American Heart Association;

(ii) Medic First Aid; or

(iii) American Red Cross.

(2) Employees who have not completed the required certifications cannot be counted towards staffing requirements.

(c)

(1) Employees assigned to a specific client or group of clients must receive client-specific training in the amount necessary to safely meet the individualized needs of those clients prior to providing services to those clients.

(2) Client-specific training must at a minimum include training on the following for each client:

(A) PCSP;

(B) CES Waiver Service treatment plans;

(C) Diagnosis and medical needs;

(D) Medication management plan, if applicable;

(E) Behavioral support needs;

(F) Behavioral prevention and intervention plan;

(G) Permitted interventions, if applicable; and

(H) Setting-specific emergency and evacuation procedures.

(3) Client-specific training pursuant to this subsection (c) may count towards the training requirements of subsection (a)(2).

(4) Client-specific training must be conducted at least once every twelve (12) months.

(d) A licensed professional is not required to receive the trainings or certifications prescribed in this section 303.

304. Employee Records.

(a) A Provider must maintain a personnel record for each employee that includes:

(1) A detailed current job description;

(2) All required criminal background checks;

(3) All required Child Maltreatment Central Registry checks;

(4) All required Adult and Long-term Care Facility Resident Maltreatment Central Registry checks;

(5) All conducted drug screens;

(6) All required sex offender registry searches;

(7) Signed statement that the employee will comply with Provider's drug screen and drug use policies;

(8) Copy of current state or federal identification;

(9) Copy of valid state-issued driver's license, if driving is required in the job description;

(10) Documentation demonstrating that the employee received all required training;

(11) Documentation demonstrating that the employee obtained and maintains in good standing all professional licensures, certifications, or credentials required for the CES Waiver Service the employee is performing.

(b) A Provider must retain all employee personnel records for five (5) years from the date an employee ceases providing services to the Provider or, if longer, the conclusion of all reviews, appeals, investigations, administrative actions, or judicial actions related to that employee that are pending at the end of the five-year period.

305. Client Service Records.

(a)

(1) A Provider must maintain a separate, updated, and complete service record for each client documenting the services provided to the client and any other documentation required under these standards.

(2) A Provider must maintain each client service record in a uniformly organized manner.

(b) A client's service record must include a summary document at the front that includes:

(1) The client's:

(A) Full name;

(B) Address and county of residence;

(C) Telephone number and email address, if available;

(D) Date of birth;

(E) Primary language;

(F) Diagnoses;

(G) Medications, dosage, and frequency, if applicable;

(H) Known allergies;

(I) Social Security Number;

(J) Medicaid number;

(K) Commercial or private health insurance information, if applicable; and

(L) Assigned Provider-Led Arkansas Shared Savings Entity (PASSE);

(2) The date client began receiving each CES Waiver Service from Provider;

(3) The date client ceased receiving each CES Waiver Service from Provider, if applicable;

(4) The name, phone number, and email address of the client's assigned PASSE care coordinator;

(5) The name, address, phone number, email address of the client's legal guardian, if available and applicable; and

(6) The name, address, and phone number of the client's primary care physician.

(c) A client's service record must include at least the following information and documentation:

(1) PSCP;

(2) All CES Waiver Service treatment plans;

(3) CES Waiver Service authorizations;

(4) Behavioral prevention and intervention plan;

(5) Daily activity logs or other documentation for each CES Waiver Service;

(6) Medication management plan, if applicable;

(7) Medication logs, if applicable;

(8) Copies of all completed client assessments and evaluations;

(9) Copies of any court orders that place the client in the custody of another person or entity; and

(10) Copies of any leases or residential agreements related to the client's care.

(d)

(1) A Provider must ensure that each client service record is kept confidential and available only to:

(A) Employees who need to know the information contained in the client's service record;

(B) DDS and any governmental entity with jurisdiction or other authority to access the client's service record;

(C) The client's legal guardian, if applicable; and

(D) Any other individual authorized in writing by the client or legal guardian of the client.

(2)

(A) A Provider must keep client service records in a file cabinet or room that is always locked.

(B)

(i) A Provider may use electronic records in addition to or in place of physical records to comply with these standards.

(ii) A Provider that uses electronic records must take reasonable steps to backup all electronic records and reconstruct a client's service record in the event of a breakdown in the Provider's electronic records system.

(e) A Provider must retain all client service records for five (5) years from the date the client exits from the Provider or, if longer, the conclusion of all reviews, appeals, investigations, administrative actions, or judicial actions related to client that are pending at the end of the five-year period.

306. Marketing and Solicitation.

(a) A Provider can market its services.

(b) A Provider cannot solicit a client or their family.

307. Third-party Service Agreements.

(a) A Provider may enter into written contracts with third-party vendors to provide services or otherwise satisfy requirements under these standards.

(b) A Provider must ensure that all third-party vendors comply with these standards and all other applicable laws, rules, and regulations.

308. Financial Safeguards.

(a)

(1) A client must have full use and access to their own funds or other assets.

(2) A Provider may not limit a client's use or access to their own funds or other assets unless the client or the client's legal guardian provides informed written consent or Provider otherwise has the legal authority.

(3) Limiting of a client's use or access to their own funds and assets includes without limitation the following:

(A) Designating the amount of funds a client may use or access;

(B) Limiting the amount of funds a client may use for a particular purpose; and

(C) Limiting the timeframes during which a client may use or access their funds or other assets.

(b)

(1) A Provider may use, manage, or access a client's funds or other assets only when:

(A) The client or client's legal guardian has provided informed written consent; or

(B) Provider otherwise has the legal authority.

(2) A Provider is deemed to be managing, using, or accessing a client's funds or other assets when:

(A) Serving as a representative payee of a client;

(B) Receiving benefits on behalf of the client; and

(C) Safeguarding funds or personal property for the client.

(3) A Provider may only use, manage, or access a client's funds or other assets for the benefit of the client.

(4) A Provider may only use, manage, or access a client's funds or other assets to the extent permitted by law.

(5) A Provider must safeguard client funds or other assets whenever a Provider manages, uses, or has access to a client's funds or other assets.

(c) A Provider must ensure that a client receives the benefit of the goods and services for which the client's funds or other assets are used.

(d)

(1) A Provider must maintain financial records that document all uses of a client's funds or other assets.

(2) Financial records for client funds must be maintained in accordance with generally accepted accounting practices.

(3) A Provider must make client financial records available to a client or a client's legal guardian upon request.

(e)

(1) A Provider must maintain separate accounts for each client whenever the Provider uses, manages, or accesses client funds or other assets.

(2) All interest derived from a client's funds or other assets shall accrue to the client's account.

309. Emergency Plans and Drills.

(a)

(1) A Provider must have a written emergency plan for all locations in which Provider performs CES Waiver Services, including without limitation client residences.

(2) A written emergency plan must address all foreseeable emergencies, including without limitation:

(A) Fire;

(B) Flood;

(C) Tornado;

(D) Utility disruption;

(E) Bomb threat;

(F) Active shooter; and

(G) Infectious disease outbreak.

(3) A Provider must evaluate and update written emergency plans at least annually.

(b)

(1) Each written emergency plan must at a minimum include:

(A) Designated relocation sites and evacuation routes;

(B) Procedures for notifying legal guardians of relocation;

(C) Procedures for ensuring each client's safe return;

(D) Procedures to address the special needs of each client;

(E) Procedures to address interruptions in the delivery of services;

(F) Procedures for reassigning employee duties in an emergency; and

(G) Procedures for annual training of employees regarding the emergency plan.

(2)

(A) A Provider must conduct emergency fire drills at least once a month at any provider owned or leased residential setting.

(B) A Provider must document all emergency drills which must include:

(i) The date and time of the emergency drill;

(ii) The type of emergency drill;

(iii) The number of clients participating in the emergency drill;

(iv) The length of time taken to complete the emergency drill; and

(v) Notes regarding any aspects of the emergency drill that need improvement.

310. Infection Control.

(a)

(1) A Provider must follow all applicable guidance from the Arkansas Department of Health related to infection control.

(2) A Provider must provide personal protective equipment for all employees and clients as may be required in the circumstances.

(b)

(1) A Provider cannot allow an employee or any other person who has an infectious disease to enter a client's residence unless the employee or other person is also a resident.

(2) A client who becomes ill must be separated from other clients to the extent possible.

(3) A Provider must notify a client's legal guardian if the client becomes ill.

311. Compliance with State and Federal Laws, Rules, and Other Standards.

(a) A Provider must comply with all applicable local, state, or federal laws, rules, codes, or regulations and violation of any applicable local, state, or federal law, rule, code, or regulation constitutes a violation of these standards.

(b)

(1) In the event of a conflict between these standards and another applicable local, state, or federal law, rule, code, or regulation the stricter requirement shall apply.

(2) In the event of an irreconcilable conflict between these standards and another applicable local, state, or federal law, rule, code, or regulation these standards shall govern to the extent not conflicting with local, state, or federal law.

Subchapter 4. Settings Requirements.

401. General Requirements.

(a) A Provider must meet the home and community-based services settings regulations as established by 42 CFR 441.301(c) (4)-(5).

(b) A Provider owned or leased complex care home is limited to no more than eight (8) unrelated adult clients.

402. Complex Care Home Specific Requirements.

(a) Complex care homes must meet the following requirements:

(1) The interior of the complex care home must:

(A) Be maintained at a comfortable temperature;

(B) Have appropriate interior lighting;

(C) Be well-ventilated;

(D) Have a running source of potable water in the kitchen and each bathroom;

(E) Be maintained in a safe, clean, and sanitary condition;

(F) Be free of:

(i) Offensive odors;

(ii) Pests;

(iii) Lead-based paint; and

(iv) Hazardous materials.

(2) The exterior of the complex care home's physical structure must be maintained in good repair, and free of holes, cracks, and leaks, including without limitation the:

(A) Roof;

(B) Foundation;

(C) Doors;

(D) Windows;

(E) Siding;

(F) Porches;

(G) Patios;

(H) Walkways; and

(I) Driveway.

(3) The surrounding grounds of the residential setting must be maintained in a safe, clean, and manicured condition free of trash and other objects.

(4) Broken furniture and appliances on or about the premises of a residential setting must immediately be either repaired or appropriately discarded off premises and replaced.

(b) A complex care home must at a minimum include:

(1) A functioning hot water heater;

(2) A functioning HVAC unit(s) able to heat and cool;

(3) An operable on-site telephone that is available at all hours and reachable with a phone number for outside callers;

(4) All emergency contacts and other necessary contact information related to a client's health, welfare, and safety in a readily available location, including without limitation:

(A) Poison control;

(B) The client's personal care physician; and

(C) Local police;

(5) One (1) or more working flashlights;

(6) A smoke detector;

(7) A carbon monoxide detector;

(8) A first aid kit that includes at least the following:

(A) Adhesive band-aids of various sizes;

(B) Sterile gauze squares;

(C) Adhesive tape;

(D) Antiseptic;

(E) Thermometer;

(F) Scissors;

(G) Disposable gloves; and

(H) Tweezers;

(9) Fire extinguishers in number and location to satisfy all applicable laws and rules, but at least one (1) functioning fire extinguisher is required at each residence;

(10) Screens for all windows and doors used for ventilation;

(11) Screens or guards attached to the floor or wall to protect floor furnaces, heaters, hot radiators, exposed water heaters, air conditioners, and electric fans;

(12) A reasonably furnished living and dining area;

(13) A kitchen with equipment, utensils, and supplies necessary to properly store, prepare, and serve three (3) meals a day;

(14) Have written instructions and diagrams noting emergency evacuation routes to be used in case of fire, severe weather, or other emergency posted at least every twenty-five (25) feet, in all stairwells, in and by all elevators, and in each room used by clients;

(15) Have lighted "exit" signs at all exit locations; and

(16) Lockable storage containers or closets for any chemicals, toxic substances, and flammable substances that must be stored at the residential setting.

(c) A complex care home must provide each client with a bedroom that has:

(1) An individual bed measuring at least thirty-six (36) inches wide with:

(1) A firm mattress that is at least four (4) inches thick and covered with moisture repellant material;

(2) Pillows; and

(3) Linens, which must be cleaned or replaced at least weekly;

(2) Bedroom furnishings, which at a minimum include:

(1) Shelf space;

(2) Storage space for personal items; and

(3) Adequate closet space for clothes and other belongings;

(3) An entrance that can be accessed without going through a bathroom or another person's bedroom;

(4) An entrance with a lockable door; and

(5) One (1) or more windows that can open and provide an outside view.

(d) A complex care home must meet the following bathroom requirements:

(1) Each bathroom must have the following:

(A) Toilet;

(B) Sink with running hot and cold water;

(C) Toilet tissue;

(D) Liquid soap; and

(E) Towels or paper towels;

(2) At least one (1) bathroom in each complex care home must have a shower or bathtub;

(3) All toilets, bathtubs, and showers must provide for individual privacy; and

(4) All toilets, bathtubs, and showers must be designed and installed in an accessible manner for the client.

(e) A complex care home that houses more than one (1) client must provide:

(1) Fifty (50) or more square feet of separate bedroom space for each client;

(2) At least one (1) bathroom with a shower/bathtub, sink, and toilet for every four (4) clients; and

(3) Each client with their own locked storage container for client valuables.

403. Setting Exceptions and Variations.

(a) Any client need or behavior that requires a variation or exception to the setting requirements set out in Sections 401 or 402 must be justified in the client's PCSP.

(b) The justification for a variation or exception to any settings requirement set out in Sections 401 or 402 must at a minimum include:

(1) The specific, individualized need or behavior that requires a variation or exception;

(2) The positive interventions and supports used prior to the implementation of the variation or exception;

(3) The less intrusive methods of meeting the need or managing the behavior that were attempted but did not work;

(4) A clear description of the applicable variation or exception;

(5) The regular data collection and reviews that will be conducted to measure the ongoing effectiveness of the variation or exception;

(6) A schedule of periodic reviews to determine if the variation or exception is still necessary or can be terminated;

(7) The informed consent of the client or legal guardian; and

(8) An assurance that interventions and supports will cause no harm to the client.

Subchapter 5. Entries and Exits.

501. Request to Change Provider.

(a) A client or legal guardian may initiate a request to change Providers at any time by contacting their assigned care coordinator.

(b) A Provider will remain responsible for the delivery of services until such time as the client's transition to the new Provider is complete.

502. Exits and Transitions.

(a) A Provider may exit a client:

(1) If the client becomes ineligible for CES Waiver;

(2) If the client chooses to use another Provider; or

(3) For any other lawful reason.

(b) A Provider must document the exit of all clients regardless of reason.

(c) A Provider must provide reasonable assistance to all exiting clients, which at a minimum includes:

(1) Assisting the client in transitioning to another Provider or other service provider, when applicable;

(2) Submitting all necessary transfer paperwork to the Social Security Administration and any other necessary agency or financial institution, when Provider is serving as the client's representative payee; and

(3)

(A) Providing copies of the client's service records to:

(i) The client;

(ii) The legal guardian; and

(iii) Any new Provider or other service provider to which the client transfers after exiting.

(B) Service records must include:

(i) A treatment summary;

(ii) Current PCSP;

(iii) Medication logs; and

(iv) Any other records requested by the client.

(C) If copies of the exiting client's service record has not been provided within thirty (30) days of a request, it is presumed to be unreasonable delay in violation of these standards.

(d)

(1) A Provider shall remain responsible for the health, safety, and welfare of an exiting client until all transitions to the new service providers are complete.

(2) A Provider shall remain responsible for providing CES Waiver Services to an exiting client until all transitions to the new service providers are complete

503. Refusal to Serve.

(a)

(1) A selected Provider shall not refuse to serve any client unless unable to ensure the client's health, safety, or welfare.

(2) When a Provider is unable to ensure the client's health, safety, or welfare, Provider must immediately notify DDS and the client's assigned PASSE care coordinator.

(b) If a Provider is unable to ensure a client's health, safety, or welfare because qualified personnel are unavailable to deliver a CES Waiver Service included on the client's PCSP, Provider must be able to demonstrate reasonable efforts to recruit and retain qualified personnel and the results of those efforts.

(c)

(1) If a Provider is unable to ensure a client's health, safety, or welfare because adequate housing is not available, Provider must propose alternative housing arrangements and locations within the client's available resources.

(2) If the client is unwilling to accept any of the proposed alternative housing arrangements, Provider shall document that the client has refused available

resources and shall immediately notify the assigned PASSE care coordinator and DDS.

(d) Whether a Provider is refusing to serve based on legitimate client health, safety, or welfare concerns is determined in the sole discretion of DDS.

Subchapter 6. Programs and Services.

601. Medications.

(a)

(1) A client, or, if applicable, legal guardian, can self-administer medication.

(2) The election to self-administer medication must:

(A) Document the medications to be self-administered; and

(B) Be signed and dated by the client, or, if applicable, the client's legal guardian.

(b)

(1) A Provider can administer medication only as:

(A) Provided in the client's PCSP; or

(B) Otherwise ordered by:

(A) A physician; or

(B) Other health care professional authorized to prescribe.

(2) A Provider can administer medication only through:

(A) Licensed nurses; or

(B) Other health care professionals authorized to administer medication.

(c)

(1) A Provider must develop a medication management plan for all clients with prescribed medication or over-the-counter medication that is routinely administered.

(2) A medication management plan must include without limitation:

(A) The name of each medication;

(B) The name of the prescribing physician or other health care professional if the medication is by prescription;

(C) A description of each medication and any symptom or symptoms to be addressed by the medication;

(D) How each medication will be administered, including without limitation times of administration, doses, delivery, and persons who may lawfully administer each medication;

(E) How each medication will be charted;

(F) A list of the potential side effects caused by each medication; and

(G) The consent to the administration of each medication by the client or legal guardian.

(d)

(1) A Provider must maintain a medication log for each client to document the administration of all prescribed and over-the-counter medications.

(2) A medication log must be available at each location a client receives CES Waiver Services and must document the following for each administration of a medication:

(A) The name and dosage of medication administered;

(B) The symptom the medication was used to address;

(C) The method the medication was administered;

(D) The date and time the medication was administered;

(E) The name of each employee who administered the medication or assisted in the administration of the medication;

(F) If an over-the-counter medication for a specific symptom, the effectiveness of the medication;

(G) Any adverse reaction or other side effect caused by the medication;

(H) Any transfer of medication from its original container into individual dosage containers by the client's legal guardian;

(I) Any error in administering the medication and the name of the supervisor to whom the error was reported; and

(J) The prescription and the name of the prescribing physician or other health care professional if the medication was not previously listed in the medication management plan.

(3) All medication errors must be:

(A) Immediately reported to a supervisor;

(B) Documented in the medication log; and

(C) Reported as required under all applicable laws and rules including without limitation the laws and rules governing controlled substances.

(4) A supervisory level employee must review and sign each medication log on at least a monthly basis.

(e) All medications stored for a client by a Provider must be:

(1) Kept in the original medication container unless the legal guardian transfers the medication into individual dosage containers;

(2) Labeled with the client's name; and

(3) Stored in an area, medication cart, or container that is always locked.

(f) If a medication stored by a Provider is no longer to be administered to the client, then the medication must be:

(1) Returned to the client's legal guardian;

(2) Destroyed; or

(3) Otherwise disposed of in accordance with applicable laws and rules.

602. Behavioral Management Plans.

(a) A Provider must develop and implement a written behavioral management plan for clients whose risk mitigation plan indicates a risk of behavioral health need.

(1) A Provider must develop a behavioral prevention and intervention plan if the risk mitigation plan identifies a client as a low risk to display behaviors that can lead to harm to self or others.

(A) A behavioral prevention and intervention plan must address behavior shaping and management to reduce inappropriate behaviors.

(B) A behavioral prevention and intervention plan must address how the client will safely remain in their community residence and avoid an acute placement.

(C) A behavioral prevention and intervention plan must be developed and implemented by an individual who has documented training on the following topics:

(i) Verbal de-escalation;

(ii) Trauma informed care; and

(iii) Verbal intervention training.

(2)

(A) A Provider must develop a positive behavioral support plan if the risk mitigation plan identifies a client as a moderate or high risk to display behaviors that can lead to harm to self or others.

(B) A positive behavior support plan must include:

(i) each behavior to be decreased or increased:

(ii) Events or other stimuli that may trigger a client's behavior to be decreased or increased;

(iii) What should be provided or avoided in a client's environment to incentivize or disincentivize behaviors to be decreased or increased;

(iv) Specific methods employees should use to manage a client's behaviors;

(v) Interventions or other actions for employees to take if a triggering event occurs; and

(vi) Interventions or other actions for employees to take if a behavior to be decreased or increased occurs.

(C) A positive behavior support plan must be developed and implemented by one of the following licensed or certified professionals:

(i) Psychologist;

(ii) Psychological examiner;

(iii) Positive behavior support specialist;

(iv) Board certified behavior analyst;

(v) Licensed clinical social worker; or

(vi) Licensed professional counselor.

(b) A Provider must reevaluate behavioral prevention and intervention plans and positive behavior support plans at least quarterly.

(c) A Provider must refer the client to an appropriately licensed professional for reevaluation if the behavioral prevention and intervention plan or positive behavior support plans is not achieving the desired results.

(1) A Provider must regularly collect and review data regarding the use and effectiveness of all behavioral prevention and intervention plans and positive behavior support plans.

(2) The collection and review of data regarding the use and effectiveness of behavioral prevention and intervention plans and positive behavior support plans must include at least:

(A) The date and time any intervention is used;

(B) The duration of each intervention;

(C) The employee(s) involved in each intervention; and

(D) The event or circumstances that triggered the need for the intervention.

(3) Behavioral prevention and intervention plans and positive behavior support plans:

(A) Must involve the fewest and shortest interventions possible; and

(B) Cannot punish or use interventions that:

(i) Are physically or emotionally painful to the client;

(ii) Frighten the client; or

(iii) Put the client at medical risk.

603. Restraints and Other Restrictive Interventions.

(a)

(1) A Provider cannot use a restraint on a client unless the restraint is required as an emergency safety intervention.

(2) An emergency safety intervention is required when:

(A) An immediate response with a restraint is required to address an unanticipated client behavior; and

(B) The client's behavior places the client or others at serious threat of harm if no intervention occurs.

(3) The use of seclusion for a client is strictly prohibited.

(4) The use of the following types of restraints on a client are strictly prohibited:

(A) Mechanical restraint; and

(B) Chemical restraint.

(b) If a Provider uses a restraint, the Provider must:

(1) Continuously monitor the client during the entire use of the restraint; and

(2) Maintain in-person visual and auditory observation of the client by an employee during the entire use of the restraint.

(c)

(1) A Provider must document each use of a restraint or seclusion whether the use was permitted or not.

(2) The documentation must include at least the following:

(A) The behavior precipitating the use of the restraint;

(B) The length of time the restraint was used;

(C) The name of the individual that authorized the use of the restraint;

(D) The names of all individuals involved in the use of the restraint; and

(E) The outcome of the use of the restraint.

604. Supportive Living.

(a) Supporting living services are individually tailored habilitative services and activities to assist a client in acquiring, retaining, or improving skills that directly enable the client to reside in their own home, with family, or in an alternative living setting.

(1) Supportive living services must be provided in an integrated community setting.

(2) Supportive living must directly relate to goals and objectives in the client's supportive living treatment plan that is included as part of the client's PCSP.

(3) Providers must ensure that a sufficient number of direct care staff are scheduled during the performance of supportive living services to guarantee the health, safety, and welfare of each client.

(4) Providers must have backup plans in place to address contingencies if direct care staff are unable, fail, or refuse to provide scheduled supportive living services.

(b) A Provider must maintain the following documentation in the client's service record for each day the client receives supportive living services:

(1) The name and sign-in/sign-out times for each direct care staff member providing supportive living services;

(2) The specific supportive living services and activities performed;

(3) The date and beginning and ending time for each supportive living service and activity performed;

(4) Name(s) of the direct care staff providing each supportive living service and activity; and

(5) The relationship of each service and activity to the goals and objectives described in the client's supportive living treatment plan that is included as part of the client's PCSP.

(6) Daily progress notes/narrative signed and dated by one of the direct care staff performing the services and activities, describing the client's progress or lack thereof with respect to each of their individualized goals and objectives.

605. Respite.

(a) Respite services are temporary, short-term services provided to relieve a client's primary caregiver(s) or because of a primary caregiver(s) emergency absence.

(1) Receipt of respite services does not preclude a client from receiving other CES Waiver services on the same day.

(2) Respite services cannot supplant the responsibility of a parent or guardian.

(b) A Provider must maintain the following documentation in the client's service record for each day a client receives respite services:

(1) The name and sign-in/sign-out times for each direct care staff member providing respite services;

(2) The specific respite activities performed;

(3) The date and beginning and ending time of each of the activities performed; and

(4) Name(s) of the staff person performing each activity.

606. Supported Employment.

(a) Supported employment services are an array of services offering ongoing support to clients in their goal of working in competitive integrated work settings for at least minimum wage.

(1) Supported employment services may include any combination of the following services:

(A) Job assessment and discovery;

(B) Person centered employment planning;

(C) Job placement;

(D) Job development;

(E) Job coaching;

(F) Transportation to and from a client's home and employment site (when no other transportation is available); and

(G) Other workplace support services not specifically related to job skill training that enable a client to successfully integrate into a job setting.

(2) Supported employment services include services utilized to support clients who are self-employed.

(b) A Provider must maintain the following supported employment services documentation in a client's service record:

(1) Job development or transition plan for job supports;

(2) Client remuneration statements or paycheck stubs; and

(3) Client's work schedule

607. Specialized Medical Supplies.

(a) Specialized medical supplies may include medically necessary:

(1) Items that address a client's physical conditions, along with any ancillary supplies and equipment necessary for the proper functioning of such items;

(2) Durable and non-durable medical equipment necessary to address a client's functional limitations;

(3) Medical Supplies;

(4) Nutritional supplements;

(5) Non-prescription medications; and

(6) Prescription drugs.

(b) Specialized medical supplies does not include:

(1) Medical equipment or medical supplies available under the Arkansas Medicaid state plan;

(2) Items that are not of a direct medical or remedial benefit to a client; and

(3) Alternative medicines that are not approved by the Federal Drug Administration.

(c) A Provider must maintain the following specialized medical supplies documentation in a client's service record:

(1) The date of the specialized medical supplies order;

(2) The name of the care coordinator placing the order;

(3) The quantity and price per item of the specialized medical supplies ordered;

(4) A written description of the client's medical need addressed or the remedial benefit provided by the specialized medical supplies;

(5) The delivery date of the specialized medical supplies; and

(6) If installation is required, the installation date and any instructions that are provided to the client or guardian regarding use of the specialized medical supplies.

608. Adaptive Equipment.

(a) Adaptive equipment is a piece of equipment or product system that is used to increase, maintain, or improve a client's functional ability to perform daily life tasks that would not otherwise be possible. Adaptive equipment specifically includes without limitation the following:

(1) Home enabling technology that allows a client to safely perform activities of daily living without assistance;

(2) The purchase, installation fee, and monthly service fee related to a personal emergency response system that enables a client to secure help in an emergency;

(3) Computer equipment and software that:

(A) Allows a client increased control of their environment;

(B) Allows a client to gain independence; or

(C) Protects a client's health and safety; and

(4) Modifications to an automobile or van to:

(A) Enable a client to integrate more fully into the community; or

(B) Ensure the client's health, safety, and welfare.

(b) A medical professional must be consulted to ensure adaptive equipment will meet the needs of a client.

(c) Adaptive equipment *does not* include adaptions and modifications to a vehicle that are of general utility and not of direct medical or habilitative benefit to the client, including without limitation:

(1) Any portion of the purchase price or down payment for a vehicle;

(2) Monthly vehicle payments; and

(3) Regular vehicle maintenance.

(d) A Provider must maintain the following documentation in a client's service record for adaptive equipment:

(1) The date of the adaptive equipment order;

(2) The name of the care coordinator placing the order;

(3) The quantity and price per item of the adaptive equipment ordered;

(4) A written description of the client's medical need addressed or the remedial benefit provided by the adaptive equipment;

(5) The delivery date of the adaptive equipment; and

(6) If installation is required, the installation date and any instructions that are provided to the client or guardian regarding use of the adaptive equipment.

609. Community Transition Services.

(a) Community transition services cover non-recurring setup expenses for clients who are transitioning from an institutional or provider-operated living arrangement, such as an intermediate care facility or group home, into a living arrangement in a private residence where the client or their guardian is directly responsible for their own living expenses. Community transition services include without limitation the following:

(1) Security deposits required to obtain a lease on an apartment or home;

(2) Essential household furnishings required to occupy and use a private residence such as:

(A) Furniture;

(B) Window coverings;

(C) Food preparation items; and

(D) Bed and bathroom linens;

(3) Set-up fees and deposits for utility access such as:

(A) Telephone;

(B) Electricity;

(C) Natural gas; and

(D) Water;

(4) Services necessary for the client's health or safety such as one-time pest eradication or cleaning prior to occupying a private residence; and

(5) Moving expenses.

(b) Community transition services do not include:

(1) Monthly rent or mortgage payments;

(2) Food expenses;

(3) Monthly utility bills;

(4) Household appliances; and

(5) Items to be used for recreational purposes.

(c) A Provider must maintain the following documentation in a client's service record for community transition services:

(1) The date the community transition service is paid, and if applicable, delivered or performed;

(2) The name of the care coordinator requesting the community transition service;

(3) The price of the community transition service;

(4) A receipt or invoice related to the community transition service; and

(5) Written description of the community transition service and what client need was met or remedial benefit accomplished.

610. Consultation.

(a) Consultation services are direct clinical or therapeutic specialty services by a professional licensed or certified in the applicable specialty, which assist a client, their parents,

responsible persons, and service providers in carrying out the client's PCSP and any associated plans included within the PCSP. Consulting services include without limitation the following:

(1) Administering psychological and adaptive behavior assessments;

(2) Screening, assessing, and developing CES Waiver Service treatment plans;

(3) Training direct service staff or client family members in carrying out service strategies listed in the client's PCSP;

(4) Participating on the interdisciplinary team;

(5) Providing consulting, training, and technical assistance to service providers, direct care staff, or client family members on carrying out the client's PCSP;

(6) Assisting direct care staff or client family members with necessary PCSP adjustments;

(7) Advising on the appropriateness and assisting with the selection, setup, and use of adaptive equipment;

(8) Training clients and their family members on self-advocacy;

(9) Training direct care staff or client family members on:

(A) Implementing behavior prevention and intervention plans;

(B) Speech-pathology, occupational therapy, and physical therapy treatment modalities;

(C) The administration of medical procedures not previously prescribed but now necessary to allow the client to remain in a private residence;

(10) Rehabilitation counseling;

(11) Screening, assessing, developing, and modifying positive behavior support plans, and assisting direct care staff in positive behavior support plans implementation and monitoring; and

(12) Training and assisting a client, client family members, and direct care staff in proper client nutrition and special dietary needs.

(b) A Provider must use professionals in the applicable specialty holding a current license or certification by the following licensing or certification boards and organizations when providing consulting services:

(1) Psychologist: a licensed psychologist in good standing with the Arkansas Psychology Board;

(2) Psychological examiner: a licensed psychological examiner in good standing with the Arkansas Psychology Board;

(3) Mastered social worker: a licensed LMSW or ACSW in good standing with the Arkansas Social Work Licensing Board;

(4) Professional counselor: a licensed counselor in good standing with the Arkansas Board of Examiners in Counseling;

(5) Speech-language pathologist: a licensed speech-language pathologist in good standing with the Arkansas Board of Audiology and Speech Language Pathology;

(6) Occupational therapist: a licensed occupational therapist in good standing with the Arkansas State Medical Board;

(7) Physical therapist: a licensed physical therapist in good standing with the Arkansas Board of Physical Therapy;

(8) Registered nurse: a licensed registered nurse in good standing with the Arkansas Board of Nursing;

(9) Certified parent educator: meets the qualifications of a Qualified Developmental Disabilities Professional as defined in 42 C.F.R. Subsection 483.430(a);

(10) Communication and environmental control adaptive equipment/aids provider: currently enrolled durable medical equipment provider with Arkansas Medicaid;

(11) Qualified Developmental Disabilities Professional: meet the qualifications defined in 42 C.F.R. Subsection 483.430(a);

(12) Dietician: a degree in nutrition;

(13) Behavior support specialist: certified through the Center of Excellence University of Arkansas Partners for Inclusive Communities;

(14) Rehabilitation counselor: a masters degree in Rehabilitation Counseling;

(15) Recreational Therapist: a degree in Recreational Therapy.

(16) Behavior Analyst: certified and in good standing with the Behavior Analyst Certification Board as defined in Arkansas Code Annotated § 23-99-418.

(c) A Provider must maintain the following documentation in a client's service record for consultation services:

(1) The date the consultation was provided;

(2) The name of the care coordinator requesting the consultation;

(3) The consultation service provided;

(4) The name and credentials of the professional providing the consultation; and

(5) A detailed narrative regarding the content of each consultation service.

611. Environmental Modifications.

(a) Environmental modification are modifications made to a client's place of residence that:

(1) Are necessary to ensure the health, welfare, and safety of the client; or

(2) Enable the client to function with greater independence and without which the client would require institutionalization.

(b) Environmental modifications include without limitation:

(1) Wheelchair ramps;

(2) Widening doorways;

(3) Modifications relating to a client's access to and use of a bathroom;

(4) Installation of specialized electrical or plumbing systems to accommodate a client's medical equipment;

(5) Installation of sidewalks or pads for clients with mobility deficits; and

(6) Fencing to prevent the elopement and wandering of clients.

(c) Environmental modifications do not include:

(1) Repairs that are of general utility and not for a client's medical or rehabilitative need;

(2) Modification that are of aesthetic value only; and

(3) Modifications that add to the total square footage of the residence.

(d) The individual performing an environmental modification must be licensed and bonded in the state of Arkansas, as required, and possess all appropriate credentials, skills, and experience to perform the job.

(e) A Provider must maintain the following documentation for environmental modifications in a client's service record:

(1) If the residence is rented or leased, the written consent of the property owner to perform the environmental modifications;

(2) An original photo of the site where environmental modifications will be done;

(3) A to-scale sketch plan of the proposed environmental modification project;

(4) Any necessary inspections, inspection reports, and permits required by federal, state and local laws either prior to commencing work or upon completion of each environmental modification to verify that the repair, modification or installation was completed;

(5) The name of the care coordinator ordering the environmental modification;

(6) The date(s) of the environmental modification installation;

(7) The name of the individual/company performing the environmental modification, and copies of their licenses and bonding information, if applicable;

(8) The care coordinator signature at job completion certifying:

(A) The environmental modifications authorized are complete;

(B) The property was left in satisfactory condition; and

(C) Any incidental damages to the property were repaired;

(9) An itemized invoice or statement of all expenses including materials and labor associated with the environmental modification.

612. Supplemental Support.

(a) Supplemental supports are services allow a client to continue living in the community when new and unforeseen problems arise that unless remedied would cause a disruption in the client's residential setting.

(b) A Provider must maintain the following documentation in the client's service record for supplemental support services:

(1) The date of the supplemental support service is paid, and if applicable, delivered or performed;

(2) The name of the care coordinator requesting the supplemental support service;

(3) The price of the supplemental support service;

(4) A receipt or invoice related to the supplemental support service; and

(5) Written description of the supplemental support service and the unforeseen problem that without the supplemental support service would cause a disruption in the client's residential setting.

Subchapter 7. Incident and Accident Reporting.

701. Incidents to be Reported.

A Provider must report all alleged, suspected, observed, or reported occurrences of any of the following events while a client is receiving a paid CES Waiver Service:

(1) Death of a client;

(2) Serious injury to a client;

(3) Maltreatment of a client;

(4) Any event where an employee threatens or strikes a client;

(5) Use of a restrictive intervention on a client, including without limitation seclusion, a restraint, a chemical restraint, or a mechanical restraint;

(6) Any situation the whereabouts of a client are unknown for more than two (2) hours;

(7) Any unscheduled situation where a client's services are interrupted for more than two (2) hours;

(8) Events involving a risk of death, serious physical or psychological injury, or serious illness to a client;

(9) Medication errors that cause or have the potential to cause death, serious injury, or serious illness to a client;

(10) Any act or omission that jeopardizes the health, safety, or quality of life of a client;

(11) Motor vehicle accidents involving a client;

(12) A client or employee testing positive for any infectious disease that is the subject of a public health emergency declared by the Governor, Arkansas Department of Health, the President of the United States, or the United States Department of Health and Human Services; and

(13) Any event that requires notification of the police, fire department, or coroner.

702. Reporting Requirements.

(a) A Provider must:

(1) Submit reports of the following events within one (1) hour of the event:

(A) Death of a client;

(B) Serious injury to a client; and

(C) Any incident that a Provider should reasonably know might be of interest to the public or media.

(2) Submit reports of all other incidents within forty-eight (48) hours of the event.

(b) A Provider must submit all reports to DDS at the following email: DHS.DDS.Central@arkansas.gov.

(c) Reporting under these standards does not relieve a Provider of complying with other applicable reporting or disclosure requirements under state or federal laws, rules, or regulations.

703. Notification to Custodians and Legal Guardians.

(a) A Provider must notify the client's legal guardian of any reportable incident involving a client.

(b) A Provider must maintain documentation evidencing notification as required in subdivision (a).

Subchapter 8. Enforcement.

801. Monitoring.

(a)

(1) DDS shall monitor a Provider to ensure compliance with these standards.

(2)

(A) A Provider must cooperate and comply with all monitoring, enforcement, and any other regulatory or law enforcement activities performed or requested by DDS or law enforcement.

(B) Cooperation required under these standards includes without limitation cooperation and compliance with respect to investigations, surveys, site visits, reviews, and other regulatory actions taken by DDS or any third-party contracted by DHS to monitor, enforce, or take other regulatory action on behalf of DHS, DDS, or its delegatee.

(b) Monitoring includes without limitation:

(1) On-site surveys and other visits including without limitation complaint surveys and initial site visits;

(2) On-site or remote file reviews;

(3) Written requests for documentation and records required under these standards;

(4) Written requests for information; and

(5) Investigations related to complaints received.

(c) DHS may contract with a third party to monitor, enforce, or take other regulatory action on behalf of DHS or DDS.

802. Written Notice of Enforcement Action.

(a) DDS shall provide written notice to a Provider of all enforcement actions taken against the Provider.

(b) DDS shall provide written notice to a Provider by mailing the enforcement action to the manager appointed by the Provider pursuant to Section 301.

803. Enforcement Actions.

(a)

(1) DDS shall not impose an enforcement action unless:

(A) Provider is given written notice pursuant to Section 802 and an opportunity to be heard pursuant to Subchapter 10; or

(B) DDS determines that public health, safety, or welfare imperatively requires emergency action.

(2) If DDS imposes a remedy as an emergency action before a Provider receives written notice and an opportunity to be heard pursuant to (a)(1), DDS shall:

(A) Provide immediate written notice to Provider of the enforcement action; and

(B) Allow Provider an opportunity to be heard pursuant to Subchapter 10.

(b) DDS may impose on a Provider any of the following enforcement actions for a failure to comply with these standards:

(1) Plan of correction;

(2) Directed in-service training plan;

(3) Moratorium on new admissions;

(4) Transfer of clients;

(5) Monetary penalties;

(6) Suspension of certification;

(7) Revocation of certification; and

(8) Any remedy authorized by law or rule including without limitation Arkansas Code § 25-15-217.

(c) DDS shall determine the imposition and severity of these enforcement actions on a case-by-case basis using the following factors:

(1) Frequency of non-compliance;

(2) Number of non-compliance issues;

(3) Impact of non-compliance on a client's health, safety, or well-being;

(4) Responsiveness in correcting non-compliance;

(5) Repeated non-compliance in the same or similar areas;

(6) Non-compliance with previously or currently imposed enforcement actions;

(7) Non-compliance involving intentional fraud or dishonesty; and

(8) Non-compliance involving violation of any law, rule, or other legal requirement.

(d)

(1) DDS shall report any noncompliance, action, or inaction by a Provider to appropriate agencies for investigation and further action.

(2) DDS shall report non-compliance involving Medicaid billing requirements to DMS, the Arkansas Attorney General's Medicaid Fraud Control Unit, and the Office of Medicaid Inspector General.

(e) These enforcement actions are not mutually exclusive and DDS may apply multiple actions simultaneously to a failure to comply with these standards.

(f) The failure to comply with an enforcement action imposed by DDS constitutes a separate violation of these standards.

804. Moratorium.

(a) DDS may prohibit a Provider from accepting new clients.

(b) A Provider prohibited from accepting new admissions may continue to provide services to existing clients.

805. Transfer of Clients.

(a) DDS may require a Provider to transfer a client to another provider if DDS finds that the Provider cannot adequately provide services to the client.

(b) If directed by DDS, a Provider must continue providing services until the client is transferred to their new service provider of choice.

(c) A transfer of a client may be permanent or for a specific term depending on the circumstances.

806. Monetary Penalties.

(a) DDS may impose on a Provider a civil monetary penalty not to exceed five hundred dollars ($500) for each violation of these standards.

(b)

(1) DDS may file suit to collect a civil monetary penalty assessed pursuant to these standards if the Provider does not pay the civil monetary penalty within sixty (60) calendar days from the date DDS provides written notice to the Provider of the imposition of the civil monetary penalty.

(2) DDS may file suit in Pulaski County Circuit Court or the circuit court of any county in which the Provider is located.

807. Suspension and Revocation of Certification.

(a)

(1) DDS may temporarily suspend a Provider's certification if Provider fails to comply with these standards.

(2) If a Provider's certification is suspended, Provider must immediately stop providing the CES Waiver Service until DDS reinstates its certification.

(b)

(1) DDS may permanently revoke a Provider's certification if Provider fails to comply with these standards.

(2) If a Provider's certification is revoked, Provider must immediately stop providing the CES Waiver Service and comply with the permanent closure requirements in Section 901(a).

Subchapter 9. Closure.

901. Closure.

(a)

(1) A CES Waiver Service certification ends if a Provider permanently closes, whether voluntarily or involuntarily, and is effective the date of the permanent closure as determined by DDS.

(2) A Provider that intends to permanently close, or does permanently close without warning, whether voluntarily or involuntarily, must immediately:

(A) Provide the client or legal guardian with written notice of the closure;

(B) Provide the client or legal guardian with written referrals to at least three (3) other appropriate service providers;

(C) Assist each client and their legal guardian in transferring services and copies of client records to any new service providers;

(D) Assist each client and their legal guardian in transitioning to new service providers; and

(E) Arrange for the storage of client service records to satisfy the requirements in Section 305.

(b)

(1) A Provider that intends to voluntarily close temporarily due to natural disaster, pandemic, completion of needed repairs or renovations, or similar circumstances may request to temporarily close while maintaining its CES Waiver Service certification for up to one (1) year from the date of the request.

(2) A Provider must comply with subdivision (a)(2)'s requirements for notice, referrals, assistance, and storage of client records if DDS grants Provider's request for a temporary closure.

(3)

(A) DDS may grant a temporary closure if Provider demonstrates that it is reasonably likely it will be able to reopen after the temporary closure.

(B) DDS shall end a Provider's temporary closure and direct Provider to permanently close if Provider fails to demonstrate that it is reasonably likely that Provider will be able to reopen after the temporary closure.

(4)

(A) DDS may end a Provider's temporary closure if Provider demonstrates that it is in full compliance with these standards.

(B) DDS shall end a Provider's temporary closure and direct Provider to permanently close if Provider fails to become fully compliant with these standards within one (1) year from the date of the request.

Subdivision 10. Appeals.

1001. Reconsideration of Adverse Regulatory Actions.

(a)

(1) A Provider may ask for reconsideration of any adverse regulatory action taken by DDS by submitting a written request for reconsideration in accordance with DDS Policy 1076.

(2) The written request for reconsideration of an adverse regulatory action taken by DDS must be submitted by Provider and received by DDS within thirty (30) calendar days of the date of the written notice of the adverse regulatory action received by Provider.

(3) The written request for reconsideration of an adverse regulatory action must include without limitation the specific adverse regulatory action taken, the date of the adverse regulatory action, the name of Provider against whom the adverse regulatory action was taken, the address and contact information for Provider, and the legal and factual basis for reconsideration of the adverse regulatory action.

(b)

(1) DDS shall review each timely received written request for reconsideration and determine whether to affirm or reverse the adverse regulatory action taken based on these standards.

(2) DDS may request, at its discretion, additional information as needed to review the adverse regulatory action and determine whether the adverse regulatory action taken should be affirmed or reversed based on these standards.

(c)

(1) DDS shall issue in writing its determination on reconsideration within thirty (30) days of receiving the written request for reconsideration or within thirty (30) days of receiving all information requested by DDS under subdivision (b)(2), whichever is later.

(2) DDS shall issue its determination to Provider using the address and contact information provided in the request for reconsideration.

(d) DDS may also decide to reconsider any adverse regulatory action on its own accord any time it determines, in its discretion, that an adverse regulatory action is not consistent with these standards.

1002. Appeal of Regulatory Actions.

(a)

(1) A Provider may administratively appeal any adverse regulatory action to the DHS Office of Appeals and Hearings except for Provider appeals related to the payment of Medicaid service claims covered by the Medicaid Fairness Act, Ark. Code Ann §§ 20-77-1701 to -1718, which shall be governed by that Act.

(2) The DHS Office of Appeals and Hearings shall conduct administrative appeals of adverse regulatory actions pursuant to DHS Policy 1098 and other applicable laws and rules.

(b) A Provider may appeal any adverse regulatory action or other agency action to circuit court as allowed by the Administrative Procedures Act, Ark. Code Ann. §§ 25-15-201 to -220.

SECTION II - HOME AND COMMUNITY-BASED SERVICES FOR CLIENTS WITH INTELLECTUAL DISABILITIES AND BEHAVIORAL HEALTH NEEDS

CONTENTS

200.000 GENERAL INFORMATION

201.000 Introduction 1-1-23

Home and Community-Based Services are person-centered care delivered in the home or community to address a functional deficit or limitation. They are designed to keep clients in their communities.

The services outlined in this manual are contained in either the 1915(i) State Plan Amendment for Adult Behavioral Health Services for Community Independence (ABHSCI), the 1915(i) State Plan Amendment for Provider-led Arkansas Shared Savings Entity (PASSE), or the 1915(c) Community and Employment Supports Waiver for Provider-led Arkansas Shared Savings Entity (PASSE).

202.000 Arkansas Medicaid Participation Requirements for Home and Community-Based Services 1-1-23

Clients may receive services contained in this manual if they have undergone an independent assessment, tiered a II or a III based on their functional deficit, and are receiving service under the ABSCI program or the PASSE program.

203.000 Provider Certification Requirements 1-1-23

Providers who perform HCBS under this manual must be certified by the Division of Provider Services and Quality Assurance (DPSQA) or the Division of Developmental Disabilities Services (DDS) as one of the following:

A. An Outpatient Behavioral Health Agency (OBHA)

B. A Community and Employment Support Waiver Provider (CES Waiver Provider)

C. A Community Support Systems Provider (CSSP)

In addition to certification, providers who perform HCBS under this manual must be enrolled in Medicaid, and in good standing.

Providers who serve PASSE members must also be credentialed as a home and community-based provider with the PASSEs.

210.000 HOME AND COMMUNITY-BASED SERVICES UNDER ABHSCI

210.100 Partial Hospitalization 1-1-23

Partial Hospitalization is an intensive nonresidential, therapeutic treatment program. It can be used as an alternative to and/or a step-down service from inpatient residential treatment or to stabilize a deteriorating condition and avert hospitalization. The program provides clinical treatment services in a stable environment on a level equal to an inpatient program, but on a less than 24-hour basis. The environment at this level of treatment is highly structured and should maintain a staff-to-patient ratio of no more than 1:5 to ensure necessary therapeutic services and professional monitoring, control, and protection. This service shall include at a minimum: intake, individual therapy, group therapy, and psychoeducation. Partial Hospitalization shall be at a minimum of (5) five hours per day, of which 90 minutes must be a documented service provided by a Mental Health Professional. If a client member receives other services during the week but also receives Partial Hospitalization, the client member must receive, at a minimum, 20 documented hours of services on no less than (4) four days in that week. Partial Hospitalization can occur in a variety of clinical settings for adults, similar to adult day cares or adult day clinics. All Partial Hospitalization sites must be certified by the Division of Provider Services and Quality

Assurance as a Partial Hospitalization Provider. All medically necessary 1905(a) services are covered for EPSDT eligible individuals in accordance with 1905(r) of the Social Security.

210.110 Adult Rehabilitative Day Service 1-1-23

A continuum of care provided to recovering individuals living in the community-based on their level of need. This service includes educating and assisting the individual with accessing supports and services needed. The service assists the recovering individual to direct their resources and support systems. Activities include training to assist the person to learn, retain, or improve specific job skills, and to successfully adapt and adjust to a particular work environment. This service includes training and assistance to live in and maintain a household of their choosing in the community. In addition, transitional services help individuals adjust after receiving a higher level of care. The goal of this service is to promote and maintain community integration.

An array of face-to-face rehabilitative day activities providing a preplanned and structured group program for identified clients that aimed at long-term recovery and maximization of self-sufficiency, as distinguished from the symptom stabilization function of acute day treatment. These rehabilitative day activities are person- and family-centered, recovery-based, culturally competent, provide needed accommodation for any disability and must have measurable outcomes. These activities assist the client with compensating for or eliminating functional deficits and interpersonal and/or environmental barriers associated with their chronic mental illness. The intent of these services is to restore the fullest possible integration of the client as an active and productive member of his/her family, social and work community and/or culture with the least amount of ongoing professional intervention. Skills addressed may include: emotional skills, such as coping with stress, anxiety or anger; behavioral skills, such as proper use of medications, appropriate social interactions and managing overt expression of symptoms like delusions or hallucinations; daily living and self-care skills, such as personal care and hygiene, money management and daily structure/use of time; cognitive skills, such as problem solving, understanding illness and symptoms and reframing; community integration skills and any similar skills required to implement a client's master treatment plan.

210.120 Supportive Employment 1-1-23

Supportive Employment is designed to help clients acquire and keep meaningful jobs in a competitive job market. The service actively facilitates job acquisition by sending staff to accompany clients on interviews and providing ongoing support and/or on-the-job training once the client is employed.

Service settings may vary depending on individual need and level of community integration, and may include the client's home. Services delivered in the home are intended to foster independence in the community setting and may include training in menu planning, food preparation, housekeeping and laundry, money management, budgeting, following a medication regimen, and interacting with the criminal justice system.

210.130 Supportive Housing 1-1-23

Supportive Housing is designed to ensure that clients have a choice of permanent, safe, and affordable housing. An emphasis is placed on the development and strengthening of natural supports in the community. This service assists clients in locating, selecting, and sustaining housing, including transitional housing and chemical free living; provides opportunities for involvement in community life; fosters independence; and facilitates the individual's recovery journey. Supportive Housing includes assessing the client's individual housing needs and presenting options, assisting in securing housing, including the completion of housing applications and securing required documentation (e.g., Social Security card, birth certificate, prior rental history), searching for housing, communicating with landlords, coordinating the move, providing training in how to be a good tenant, and establishing procedures and contacts to retain housing.

Supportive Housing can occur in the following:

- The individual's home;
- In community settings such as school, work, church, stores, or parks; and
- In a variety of clinical settings for adults, similar to adult day cares or adult day clinics.

210.140 Adult Life Skills Development 1-1-23

A service that provides support and training for youth and adults on a one-on-one or group basis. This service should be a strength-based, culturally appropriate process that integrates the member into their community as they develop their recovery plan or habilitation plan. This service is designed to assist members in acquiring the skills needed to support as independent a lifestyle as possible, enable them to reside in their community (in their own home, with family, or in an alternative living setting), and promote a strong sense of self-worth. In addition, it aims to assist members in setting and achieving goals, learning independent life skills, demonstrating accountability, and making goal-oriented decisions related to independent living.

Topics may include: educational or vocational training, employment, resource and medication management, self-care, household maintenance, health, socialization, community integration, wellness, and nutrition. For clients with developmental or intellectual disability, supportive life skills development may focus on acquiring skills to complete activities of daily living (ADLs) and instrumental activities of daily living (IADLs), such as communication, bathing, grooming, cooking, shopping, or budgeting.

210.150 Peer Support 1-1-23

Peer Support is a consumer centered service provided by individuals (ages 18 and older) who self-identify as someone who has received or is receiving behavioral health services and thus is able to provide expertise not replicated by professional training. Peer providers are trained and certified peer specialists who self-identify as being in recovery from behavioral health issues. Peer support is a service to work with clients to provide education, hope, healing, advocacy, self-responsibility, a meaningful role in life, and empowerment to reach fullest potential. Specialists will assist with navigation of multiple systems (housing, supportive employment, supplemental benefits, building/rebuilding natural supports, etc.) which impact clients' functional ability. Services are provided on an individual or group basis, and in either the client's home or community environment.

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

210.160 Treatment Plan 1-1-23

A plan that is developed in cooperation with the client to deliver specific mental health services to restore, improve, or stabilize the client's mental health condition. Treatment Plans must be updated annually or more frequently if circumstances or needs change significantly, or if the client requests.

Treatment Plans can only be developed by the following clinicians:

A. Independently Licensed Clinicians (Masters/Doctoral)

B. Non-independently Licensed Clinicians (Masters/Doctoral)

C. Advanced Practice Nurse (APN)

D. Physician

210.170 Aftercare Recovery Support (for Substance Abuse) 1-1-23

A continuum of care provided to recovering members living in the community-based on their level of need. This service includes educating and assisting the individual with accessing supports and services needed. The service assists the recovering client member to direct their resources and support systems. In addition, transitional services to assist individuals adjust after receiving a higher level of care. The goal of this service is to promote and maintain community integration. Meals and transportation are not included in the rate for Aftercare Recovery Support. Aftercare Recovery Support can occur in the following:

- The individual's home;
- In community settings such as school, work, church, stores, or parks; and
- In a variety of clinical settings for adults, similar to adult day cares or adult day clinics.

All medically necessary 1905(a) services are covered for EPSDT eligible members in accordance with 1905(r) of the Social Security Act.

210.180 Therapeutic Communities 1-1-23

Therapeutic Communities are highly structured residential environments or continuums of care in which the primary goals are the treatment of behavioral health needs and the fostering of personal growth leading to personal accountability. Services address the broad range of needs identified by the person served. Therapeutic Communities employs community-imposed consequences and earned privileges as part of the recovery and growth process. In addition to daily seminars, group counseling, and individual activities, the persons served are assigned responsibilities within the therapeutic community setting. Participants and staff members act as facilitators, emphasizing personal responsibility for one's own life and self-improvement. The service emphasizes the integration of an individual within his or her community, and progress is measured within the context of that community's expectation.

Level 1 provides the highest level of supervision, support and treatment as well as ensuring community safety in a facility of no more than sixteen (16) beds

- Clients who receive this level of care may have treatment needs that are severe enough to require inpatient care in a hospital but don't need the full resources of a hospital setting
- The emphasis in this level is intensive services delivered using a multi-disciplinary approach including physicians, licensed counselors, and highly trained paraprofessionals.

Level 2 provides supervision, support, and treatment, but at a lower level than Level 1 above and can be used as a step down from Level 1 to begin the transition back into a community setting that will not provide twenty-four-hour/seven day (24/7) supervision, service and support

- Interventions shift from clinical to addressing the clients educational or vocational needs, socially dysfunctional behavior, and the need for stable housing
- Arranging for the full array of clinical and HCBS is critical for successful discharge
- Assertive Community Treatment (ACT) would be an ideal step-down service

220.000 HOME AND COMMUNITY-BASED SERVICES UNDER PASSE

220.100 Behavioral Assistance 1-1-23

Behavioral Assistance is a specific outcome oriented intervention provided individually or in a group setting with the child/youth and/or his/her caregiver(s) that will provide the necessary support to attain the goals of the treatment plan. Services involve applying positive behavioral interventions and supports within the community to foster behaviors that are rehabilitative and restorative in nature. The intervention should result in sustainable positive behavioral changes that improve functioning, enhance the quality of life, and strengthen skills in a variety of life domains.

Behavioral Assistance is designed to support youth and their families in meeting behavioral goals in various community settings. The service is targeted for children and adolescents who are at risk of out-of-home placement or who have returned home from residential placement and need flexible wrap-around supports to ensure safety and support community integration. The service is tied to specific treatment goals and is developed in coordination with the youth and their family. Behavioral Assistance aids the family in implementing safety plans and behavioral management plans when youth are at risk for offending behaviors, aggressions, and oppositional defiance. Staff provides supports to youth and their families during periods when behaviors have been typically problematic – such as during morning preparation for school, at bedtime, after school, or other times when there is evidence of a pattern of escalation of problem difficult behaviors. The service may be provided in school classrooms or on school busses for short periods of time to help a youth's transition from hospitals or residential settings but is not intended as a permanent solution to problem difficult behaviors at school.

220.110 Crisis Stabilization 1-1-23

Crisis Stabilization Intervention is a scheduled face-to-face treatment activity provided to a client who has recently experienced a psychiatric or behavioral health crisis that is expected to further stabilize, prevent deterioration, and serve as an alternative to twenty-four (24) -hour inpatient care. Services are to be congruent with the age, strengths, needed accommodation for any disability and cultural framework of the member and his/her family. Additional needs-based criteria for receiving the service, if applicable (specify): Specify limits (if any) on the amount, duration, or scope of this service. Per 42 CFR Section 440.240, services available to any categorically needy recipient cannot be less in amount, duration, and scope than those services available to a medically needy client, and services must be equal for any individual within a group. States must also separately address standard state plan service questions related to sufficiency of services.

220.120 Assertive Community Treatment 1-1-23

Assertive Community Treatment (ACT) is an evidence-based practice provided by a multidisciplinary team providing comprehensive treatment and support services available twenty-four (24) hours a day, seven (7) days a week wherever and whenever needed. Services are provided in the most integrated community setting possible to enhance independence and positive community involvement. An individual appropriate for services through an ACT team has needs that are so pervasive and/or unpredictable that it is unlikely that they can be met effectively by other combinations of available community services, or in circumstances where other levels of outpatient care have not been successful to sustain stability in the community. Typically, this service is targeted to individuals who have serious mental illness or co-occurring disorders, multiple diagnoses, and the most complex and expensive treatment needs.

220.130 Intensive In-Home (IIH for Children) 1-1-23

Intensive In-Home service for children is a team approach that is used to address serious and chronic emotional or behavioral issues for children (youth) who are unable to remain stable in the community without intensive interventions. Services are multifaceted: counseling, skills training, interventions, or resource coordination, and are delivered in the client's home or in a community

setting. The parent or caregiver must be an active participant in the treatment and individualized services that are developed in full partnership with the family. IIH team provides a variety of interventions that are available at the time the family needs. These interventions include "first responder" crisis response, as indicated in the care plan: twenty-four (24) hours per day, seven (7) days per week, three hundred sixty-five (365) days per year. The licensed professional is responsible for monitoring and documenting the status of the client's progress and the effectiveness of the strategies and interventions outlined in the care plan. The licensed professional then consults with identified medical professionals (such as primary care and psychiatric) and non-medical providers (child welfare and juvenile justice), engages community and natural supports, and includes their input in the care planning process.

Intensive In-Home service must be a recognized model of care, clearly outline the duration and scope and be prior approved by a PASSE.

220.140 Adult Rehabilitative Day Service 1-1-23

A continuum of care provided to recovering individuals living in the community-based on their level of need. This service includes educating and assisting the individual with accessing supports and services needed. The service assists the recovering individual to direct their resources and support systems. Activities include training to assist the person to learn, retain, or improve specific job skills, and to successfully adapt and adjust to a particular work environment. This service includes training and assistance to live in and maintain a household of their choosing in the community. In addition, transitional services to assist individuals adjust after receiving a higher level of care. The goal of this service is to promote and maintain community integration.

An array of face-to-face rehabilitative day activities providing a preplanned and structured group program for identified clients that aimed at long-term recovery and maximization of self-sufficiency, as distinguished from the symptom stabilization function of acute day treatment. These rehabilitative day activities are person- and family-centered, recovery-based, culturally competent, provide needed accommodation for any disability and must have measurable outcomes. These activities assist the client with compensating for or eliminating functional deficits and interpersonal and/or environmental barriers associated with their chronic mental illness. The intent of these services is to restore the fullest possible integration of the client as an active and productive member of his/her family, social and work community and/or culture with the least amount of ongoing professional intervention. Skills addressed may include: emotional skills, such as coping with stress, anxiety or anger; behavioral skills, such as proper use of medications, appropriate social interactions and managing overt expression of symptoms like delusions or hallucinations; daily living and self-care skills, such as personal care and hygiene, money management and daily structure/use of time; cognitive skills, such as problem solving, understanding illness and symptoms and reframing; community integration skills and any similar skills required to implement a client's master treatment plan.

220.150 Peer Support 1-1-23

Peer Support is a consumer centered service provided by individuals (ages eighteen (18) and older) who self-identify as someone who has received or is receiving behavioral health services and thus is able to provide expertise not replicated by professional training. Peer providers are trained and certified peer specialists who self-identify as being in recovery from behavioral health issues. Peer support is a service to work with clients to provide education, hope, healing, advocacy, self-responsibility, a meaningful role in life, and empowerment to reach fullest potential. Specialists will assist with navigation of multiple systems (housing, supportive employment, supplemental benefits, building/rebuilding natural supports, etc.) which impact clients' functional ability. Services are provided on an individual or group basis, and in either the client's home or community environment.

Peer support may include assisting their peers in articulating their goals for recovery, learning, and practicing new skills, helping them monitor their progress, assisting them in their treatment,

modeling effective coping techniques, and self-help strategies based on the specialist's own recovery experience, and supporting them in advocating for themselves to obtain effective services.

220.160 Family Support Partners 1-1-23

A service provided by peer counselors, of Family Support Partners (FSP), who model recovery and resiliency for caregivers of children and youth with behavioral health care needs or developmental disabilities. FSP come from legacy families and use their lived experience, training, and skills to help caregivers and their families identify goals and actions that promote recovery and resiliency and maintain independence. A FSP may assist, teach, and model appropriate child-rearing strategies, techniques, and household management skills. This service provides information on child development, age-appropriate behavior, parental expectations, and childcare activities. It may also assist the member's family in securing resources and developing natural supports.

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

220.170 Pharmacologic Counseling by RN 1-1-23

A specific, time limited one-to-one intervention by a nurse with a client and/or caregivers, related to their psycho-pharmological treatment. Pharmaceutical Counseling involves providing medication information orally or in written form to the client and/or caregivers. The service should encompass all the parameters to make the client and/or family understand the diagnosis prompting the need for the medication and any lifestyle modification required.

220.180 Respite 1-1-23

Temporary direct care and supervision for a client due to the absence or need for relief of the non-paid primary caregiver. Respite can occur at medical or specialized camps, day-care programs, the member's home or place of residence, the respite care provider's home or place of residence, foster homes, or a licensed respite facility. Respite does not have to be listed in the PCSP. The primary purpose of Respite is to relieve the member's principal care giver of the member with a behavioral health need so that stressful situations are de-escalated, and the care giver and member have a therapeutic and safe outlet. Respite must be temporary in nature. Any services provided for less than fifteen (15) days will be deemed temporary. Respite provided for more than fifteen (15) days should trigger a need to review the PCSP.

220.190 Supportive Life Skills Development 1-1-23

A service that provides support and training for youth and adults on a one-on-one or group basis. This service should be a strength-based, culturally appropriate process that integrates the member into their community as they develop their recovery plan or habilitation plan. This service is designed to assist members in acquiring the skills needed to support as independent a lifestyle as possible, enable them to reside in their community (in their own home, with family, or in an alternative living setting), and promote a strong sense of self-worth. In addition, it aims to assist members in setting and achieving goals, learning independent life skills, demonstrating accountability, and making goal-oriented decisions related to independent living.

Topics may include: educational or vocational training, employment, resource and medication management, self-care, household maintenance, health, socialization, community integration, wellness, and nutrition. For clients with developmental or intellectual disability, supportive life skills development may focus on acquiring skills to complete activities of daily living (ADLs) and

instrumental activities of daily living (IADLs), such as communication, bathing, grooming, cooking, shopping, or budgeting.

220.200 Child and Youth Support Services 1-1-23

Child and Youth Support Services are clinical, time-limited services for principal caregivers designed to increase a child's positive behaviors and encourage compliance with parents at home; working with teachers/schools to modify classroom environment to increase positive behaviors in the classroom; and increase a child's social skills, including understanding of feelings, conflict management, academic engagement, school readiness, and cooperation with teachers and other school staff. This service is intended to increase parental skill development in managing their child's symptoms of their illness and training the parents in effective interventions and techniques for working with the schools.

Services might include an In-Home Case Aide. An In-Home Case Aide is an intensive, time-limited therapy for youth in the client's home or, in rare instances, a community-based setting. Youth served may be in imminent risk of out-of-home placement or have been recently reintegrated from an out of-home placement. Services may deal with family issues related to the promotion of healthy family interactions, behavior training, and feedback to the family.

220.210 Supportive Employment 1-1-23

Supportive Employment is designed to help clients acquire and keep meaningful jobs in a competitive job market. The service actively facilitates job acquisition by sending staff to accompany clients on interviews and providing ongoing support and/or on-the-job training once the client is employed.

Service settings may vary depending on individual need and level of community integration, and may include the client's home. Services delivered in the home are intended to foster independence in the community setting and may include training in menu planning, food preparation, housekeeping and laundry, money management, budgeting, following a medication regimen, and interacting with the criminal justice system.

220.220 Supportive Housing 1-1-23

Supportive Housing is designed to ensure that clients have a choice of permanent, safe, and affordable housing. An emphasis is placed on the development and strengthening of natural supports in the community. This service assists clients in locating, selecting, and sustaining housing, including transitional housing and chemical free living; provides opportunities for involvement in community life; fosters independence; and facilitates the individual's recovery journey. Supportive Housing includes assessing the client's individual housing needs and presenting options, assisting in securing housing, including the completion of housing applications and securing required documentation (e.g., Social Security card, birth certificate, prior rental history), searching for housing, communicating with landlords, coordinating the move, providing training in how to be a good tenant, and establishing procedures and contacts to retain housing.

Supportive Housing can occur in the following:

- The individual's home;
- In community settings such as school, work, church, stores, or parks; and
- In a variety of clinical settings for adults, similar to adult day cares or adult day clinics.

220.230 Partial Hospitalization 1-1-23

Partial Hospitalization is an intensive nonresidential, therapeutic treatment program. It can be used as an alternative to and/or a step-down service from inpatient residential treatment or to

stabilize a deteriorating condition and avert hospitalization. The program provides clinical treatment services in a stable environment on a level equal to an inpatient program, but on a less than twenty-four (24) hour basis. The environment at this level of treatment is highly structured and should maintain a staff-to-patient ratio of no more than one to five (1:5) to ensure necessary therapeutic services and professional monitoring, control, and protection. This service shall include at a minimum: intake, individual therapy, group therapy, and psychoeducation. Partial Hospitalization shall be at a minimum of five (5) hours per day, of which ninety (90) minutes must be a documented service provided by a Mental Health Professional. If a client member receives other services during the week but also receives Partial Hospitalization, the client member must receive, at a minimum, twenty (20) documented hours of services on no less than four (4) days in that week. Partial Hospitalization can occur in a variety of clinical settings for adults, similar to adult day cares or adult day clinics. All Partial Hospitalization sites must be certified by the Division of Provider Services and Quality Assurance as a Partial Hospitalization Provider. All medically necessary 1905(a) services are covered for EPSDT eligible individuals in accordance with 1905(r) of the Social Security

220.240 Therapeutic Host Homes 1-1-23

A home or family setting that that consists of high intensive, individualized treatment for the member whose behavioral health or developmental disability needs are severe enough that they would be at risk of placement in a restrictive residential setting.

A therapeutic host parent is trained to implement the key elements of the member's PCSP in the context of family and community life, while promoting the PCSP's overall objectives and goals. The host parent should be present at the PCSP development meetings and should act as an advocate for the member.

220.250 Aftercare Recovery Support (for Substance Abuse) 1-1-23

A continuum of care provided to recovering members living in the community-based on their level of need. This service includes educating and assisting the individual with accessing supports and services needed. The service assists the recovering client member to direct their resources and support systems. In addition, transitional services to assist individuals adjust after receiving a higher level of care. The goal of this service is to promote and maintain community integration. Meals and transportation are not included in the rate for Aftercare Recovery Support.

Aftercare Recovery Support can occur in the following:

- The individual's home;
- In community settings such as school, work, church, stores, or parks; and
- In a variety of clinical settings for adults, similar to adult day cares or adult day clinics.

All medically necessary 1905(a) services are covered for EPSDT eligible members in accordance with 1905(r) of the Social Security Act.

220.260 Substance Abuse Detox (Observational) 1-1-23

A set of interventions aimed at managing acute intoxication and withdrawal from alcohol or other drugs. Services help stabilize the member by clearing toxins from his or her body. Detoxification (detox) services are short term and may be provided in a crisis unit, inpatient, or outpatient setting. Detox services may include evaluation, observation, medical monitoring, and addiction treatment. The goal of detox is to minimize the physical harm caused by the abuse of substances and prepare the member for ongoing substance abuse treatment.

220.270 Therapeutic Communities 1-1-23

Therapeutic Communities are highly structured residential environments or continuums of care in which the primary goals are the treatment of behavioral health needs and the fostering of personal growth leading to personal accountability. Services address the broad range of needs identified by the person served. Therapeutic Communities employs community-imposed consequences and earned privileges as part of the recovery and growth process. In addition to daily seminars, group counseling, and individual activities, the persons served are assigned responsibilities within the therapeutic community setting. Participants and staff members act as facilitators, emphasizing personal responsibility for one's own life and self-improvement. The service emphasizes the integration of an individual within his or her community, and progress is measured within the context of that community's expectation.

Level 1 provides the highest level of supervision, support and treatment as well as ensuring community safety in a facility of no more than sixteen (16) beds

- Clients who receive this level of care may have treatment needs that are severe enough to require inpatient care in a hospital but don't need the full resources of a hospital setting
- The emphasis in this level is intensive services delivered using a multi-disciplinary approach include physicians, licensed counselors, and highly trained paraprofessionals.

Level 2 provides supervision, support, and treatment, but at a lower level than Level 1 above and can be used as a step down from Level 1 to begin the transition back into a community setting that will not provide twenty-four-hour/seven day (24/7) supervision, service and support

- Interventions shift from clinical to addressing the clients educational or vocational needs, socially dysfunctional behavior, and the need for stable housing
- Arranging for the full array of clinical and HCBS is critical for successful discharge
- Assertive Community Treatment (ACT) would be an ideal step-down service

220.280 Residential Community Reintegration Program 1-1-23

The Residential Community Reintegration Program is designed to serve as an intermediate level of care between Inpatient Psychiatric Facilities and home and community-based behavioral health services. The program provides twenty-four (24) hour per day intensive therapeutic care provided in a small group home setting for children and youth with emotional and/or behavior problems which cannot be remedied by less intensive treatment. The program is intended to prevent acute or sub-acute hospitalization of youth, or incarceration. The program is also offered as a step-down or transitional level of care to prepare a youth for less intensive treatment. A Residential Community Reintegration Program shall be appropriately certified by the Department of Human Services to ensure quality of care and the safety of clients and staff.

A Residential Community Reintegration Program shall ensure the provision of educational services to all clients in the program. This may include education occurring on campus of the Residential Community Reintegration Program or the option to attend a school off campus if deemed appropriate in accordance with the Arkansas Department of Education.

220.290 CES Supported Employment 1-1-23

CES Supported Employment is a tailored array of services that offers ongoing support to members with the most significant disabilities to assist in their goal of working in competitive integrated work settings for at least minimum wage. It is intended for individuals for whom competitive employment has not traditionally occurred, or has been interrupted or intermittent as a result of a significant disability, and who need ongoing supports to maintain their employment.

CES Supported Employment includes any combination of the following services:

Vocational/job related discovery and assessment, person centered employment planning, job placement, job development, negotiation with prospective employers, job analysis, job carving, training and systematic instructions, job coaching, benefits support, training and planning, transportation, asset development, and career advancement services, extended supported employment supports, and other workplace support services including services not specifically related to job skill training that enable the waiver client to be successful in integrating into the job setting. The service array may also be utilized to support individuals who are self-employed.

Transportation between the member's place of residence and the employment site is included as a component of supported employment services when there is no other resource for transportation available.

220.300 Supportive Living 1-1-23

Supportive living is an array of individually tailored services and activities to enable members to reside successfully in their own home, with family or in an alternative living setting (apartment, or provider owned group home). Supportive living services must be provided in an integrated community setting.

Supportive living includes care, supervision, and activities that directly relate to active treatment goals and objectives set forth in the member's PCSP. It excludes room and board expenses, including general maintenance, upkeep, or improvement to the home.

Supportive living supervision and activities are meant to assist the member to acquire, retain, or improve skills in a wide variety of areas that directly affect the person's ability to reside as independently as possible in the community. The habilitation objective to be served by each activity should be documented in the member's PCSP. Examples of supervision and activities that may be provided as part of supportive living include:

A. Decision making, including the identification of and response to dangerously threatening situations, making decisions and choices affecting the member's life, and initiating changes in living arrangements or life activities;

B. Money management, including training, assistance or both in handling personal finances, making purchase and meeting personal financial obligations;

C. Daily living skills, including training in accomplishing routine housekeeping tasks, meal preparation, dressing, personal hygiene, administration of medication (to the extent permitted by state law), proper use of adaptive and assistive devices and household appliances, training on home safety, first aid, and emergency procedures;

D. Socialization, including training and assistance in participating in general community activities and establishing relationships with peers. Activity training includes assisting the member to continue to participate in an ongoing basis;

E. Community integration experiences, including activities intended to instruct the member in daily living and community living in integrated settings, such as shopping, church attendance, sports, and participation sports;

F. Mobility, including training and assistance aimed at enhancing movement within the member's living arrangement, mastering the use of adaptive aids and equipment, accessing and using public transportation, independent travel or movement within the community;

G. Communication, including training in vocabulary building, use of augmentative communication devices, and receptive and expressive language;

H. Behavior shaping and management, including training and assistance in appropriate expression of emotions or desires, compliance, assertiveness, acquisition of socially appropriate behaviors or reduction of inappropriate behaviors; the supportive living

provider is responsible for developing and overseeing the Behavioral Prevention and Intervention Plan;

I. Reinforcement of therapeutic services, including conducting exercises reinforcing physical, occupational, speech, behavioral or other therapeutic programs;

J. Companion activities and therapies, or the use of animals as modalities to motivate members to meet functional goals established for the member's habilitative training, including language skills, increased range of motion, socialization, and the development of self-respect, self-esteem, responsibility, confidence, an assertiveness; and

K. Health maintenance activities, which include tasks that members would otherwise do for themselves or have a family member do, with the exception of injections and IV medication administration. It is not considered administration, with the exception of injections and IV medications, when the paid staff assist the client by getting the medication out of the bottle or blister pack. Supportive living may be provided in clinic setting (physician office, wound clinic) to facilitate appropriate care and follow-up. If health maintenance activity is performed in a hospital setting for supportive care of the individual while receiving medical care, supportive living cannot exceed fourteen (14) consecutive days nor exceed approved prior authorized rate for the service in place prior to hospitalization.

220.310 Complex Care Homes for IDD **1-1-23**

Individuals who receive supportive living and require a higher level of care to acuity may receive supportive living in congregant home settings of no more than eight (8) unrelated persons.

Each client residing in the Complex Care Home must be diagnosed with an intellectual disability and a significant co-occurring deficit, which includes without limitation individuals with an intellectual disability and significant:

A. Behavioral health needs; or

B. Physical health needs.

A Provider is required to maintain the client to staff ratio required to meet each client's needs as provided in their Person Centered Service Plan and ensure client and staff health and safety, but under no circumstances may there be less than a four-to-one (4:1) client to staff ratio in the home at any time.

220.320 Adaptive Equipment **1-1-23**

Adaptive equipment is a piece of equipment, or product system that is used to increase, maintain, or improve functional capabilities of members, whether commercially purchased, modified, or customized. The adaptive equipment services include adaptive, therapeutic, or augmentative equipment that enables a member to increase, maintain, or improve their functional capacity to perform daily life tasks that would not be possible otherwise.

Consultation by a medical professional must be conducted to ensure the adaptive equipment will meet the needs of the member.

Adaptive equipment includes enabling technology, such as safe home modifications, that empower members to gain independence through customizable technologies that allow them to safely perform activities of daily living without assistance while still providing monitoring and response for those members, as needed. Enabling technology allows members to be proactive about their daily schedule and integrates member choice.

Adaptive equipment also includes Personal Emergency Response Systems (PERS), which is a stationary or portable electronic device used in the member's place of residence and that enables the member to secure help in an emergency. The system is connected to a response

center staffed by trained professionals who respond to activation of the device. PERS services may include the assessment, purchase, installation, and monthly rental fee.

Computer equipment, including software, can be included as adaptive equipment. Specifically, computer equipment includes equipment that allows the member increased control of their environment, to gain independence, or to protect their health and safety.

Vehicle modifications are also included as adaptive equipment. Vehicle modifications are adaptions to an automobile or van to accommodate the special needs of the member. The purpose of vehicle modifications is to enable the member to integrate more fully into the community and to ensure the health, safety, and welfare of the member. Vehicle modifications exclude: adaptations or modifications to the vehicle that are of general utility and not of direct medical or habilitative benefit to the member; purchase, down payment, monthly car payment or lease payment; or regularly scheduled maintenance of the vehicle.

220.330 Community Transition Services 1-1-23

Community Transition Services are non-recurring set-up expenses for members who are transitioning from an institutional or provider-operated living arrangement, such as an ICF or group home, to a living arrangement in a private residence where the member or his or her guardian is directly responsible for his or her own living expenses.

Community Transition service activities include those necessary to enable a member to establish a basic household, not including room and board, and may include:

A. security deposits that are required to obtain a lease on an apartment or home;

B. essential household furnishings required to occupy and use a community domicile, including furniture, window coverings, food preparation items, and bed/bath linens;

C. set-up fees or deposits for utility or service access, including telephone, electricity, heating and water;

D. services necessary for the member's health and safety such as pest eradication and one-time cleaning prior to occupancy; and

E. moving expenses.

Community Transition Services should not include payment for room and board; monthly rental or mortgage expense; regular food expenses, regular utility charges; and/or household appliances, or items that are intended for purely diversional/recreational purposes.

220.340 Consultation 1-1-23

Consultation services are clinical and therapeutic services which assist the individual, parents, legally responsible persons, responsible individuals, and service providers in carrying out the member's PCSP. These services are direct in nature. The PASSE will be responsible for maintaining the necessary information to document staff qualifications. Staff, who meets the certification criteria necessary for other consultation functions, may also provide these activities.

These activities include, but are not limited to:

A. Provision of updated psychological and adaptive behavior assessments; allowable providers: psychologist, psychological examiner, speech therapist, physical therapist, occupational therapist within the scope of their practice area;

B. Screening, assessing and developing CES waiver services treatment plans; allowable providers: Qualified Developmental Disabled Professional (QDDP), psychologist, psychological examiner, speech therapist, physical therapist, occupational therapist, dietitian, positive behavior support (PBS) specialist, licensed clinical social worker,

professional counselor, registered nurse, certified communication and environmental control specialist, board certified behavior analyst (BCBA) within the scope of their practice area;

C. Training of direct services staff or family members in carrying out special community living services strategies identified in the member's PCSP as applicable to the consultation specialty;

D. Providing information and assistance to the persons responsible for developing the member's PCSP as applicable to the consultation specialty;

E. Participating on the interdisciplinary team, when appropriate to the consultant's specialty;

F. Consulting with and providing information and technical assistance with other service providers or with direct service staff or family members in carrying out the member's PCSP specific to the consultant's specialty;

G. Assisting direct services staff or family members to make necessary program adjustments in accordance with the member's PCSP and applicable to the consultant's specialty;

H. Determining the appropriateness and selection of adaptive equipment to include communication devices, computers, and software consistent with the consultant's specialty;

I. Training or assisting members, direct services staff, or family members in the set up and use of communication devices, computers, and software consistent with the consultant's specialty;

J. Training of direct services staff or family members by a professional consultant in:

1. activities to maintain specific behavioral management programs applicable to the member.

2. activities to maintain speech pathology, occupational therapy, or physical therapy program treatment modalities specific to the member.

3. The provision of medical procedures not previously prescribed but now necessary to sustain the member in the community;

K. Training or assisting by advocacy consultants to members and family members on how to self-advocate;

L. Rehabilitation counseling;

M. The PASSE is responsible for developing a Risk Mitigation Plan for each client that outlines risk factors and action steps that must be taken to mitigate the risk. CES Waiver clients who are at low risk of displaying behaviors that can lead to harm to self, and/or community members must have a Behavioral Prevention and Intervention Plan that is overseen and implemented by the client's supportive living provider. The goal is to keep the member in his or her place of residence and avoid an acute placement. Supportive living staff developing, overseeing, and implementing Behavioral Prevention and Intervention Plans must receive training in verbal de-escalation, trauma informed care, verbal intervention training. Behavioral Prevention and Intervention Plan development must be by staff who meet minimum qualification of a Positive Behavior Support Specialist in accordance with CES Waiver standards;

N. Screening, assessing, and developing positive behavior support plans, assisting staff in implementation, monitoring, reassessment, and plan modifications; A positive behavior support plan is required when high level of behavioral related risk is identified in the PASSE Risk Mitigation Plan. Allowable providers include Psychologist, Psychological Examiners, Positive Behavior Support (PBS) Specialist, Board Certified Behavior Analyst

(BCBA) within the scope of their practice area. licensed clinical social worker and licensed professional counselors;

O. Training and assisting members, direct service staff, or family members in proper nutrition and special dietary needs.

220.350 Environmental Modifications 1-1-23

Modifications made to the member's place of residence that are necessary to ensure the health, welfare, and safety of the member or that enable the member to function with greater independence and without which, the member would require institutionalization. Examples of environmental modifications include the installation of wheelchair ramps, widening doorways, modification of bathroom facilities, installation of specialized electrical and plumbing systems to accommodate medical equipment, installation of sidewalks or pads, and fencing to ensure non-elopement, wandering, or straying of members with decreased mental capacity or aberrant behaviors.

Exclusions include modifications or repairs to the home which are of general utility and not for a specific medical or habilitative benefit; modifications or improvements which are of an aesthetic value only; and modifications that add to the total square footage of the home.

Environmental modifications that are permanent fixtures to rental property require written authorization and release of current or future liability from the property owner.

220.360 Supplemental Support 1-1-23

Supplemental Support services meet the needs of the client to improve or enable the continuance of community living. Supplemental Support Services will be based upon demonstrated needs as identified in a member's PCSP as unforeseen problems arise that, unless remedied, could cause a disruption in the member's services or placement, or place the member at risk of institutionalization.

220.370 Respite 1-1-23

Respite services are provided periodically on a short term basis in accordance with the member's PCSP. They may be provided in an emergency situation due to the absence of or need for relief to the no-paid primary caregiver. Respite services may include the cost of room and board charges when allowable.

Receipt of respite does not necessarily preclude a member from receiving other services on the same day. For example, a member may receive day services, such as supported employment, on the same day as caregiver respite services.

When caregiver respite is furnished for the relief of a foster care provider, foster care services may not be billed during the period that respite is furnished. Caregiver respite should not be furnished for the purpose of compensating relief or substitute staff for supportive living services. Caregiver respite services are not to supplant the responsibility of the parent or guardian.

220.380 Specialized Medical Supplies 1-1-23

Specialized medical equipment and supplies include:

A. Items necessary for life support or to address physical conditions along with ancillary supplies and equipment necessary to the proper functioning of such items;

B. Such other durable and non-durable medical equipment not available under the State plan that is necessary to address the member's functional limitations and has been deemed medically necessary by the prescribing physician;

C. Necessary medical supplies not available under the State plan. Items reimbursed with Waiver funds are in addition to any medical equipment and supplies furnished under the State plan and exclude those items that are not of direct medical or remedial benefit to the member. All items shall meet applicable standards of manufacture, design, and installation. The most cost effective item should be considered first;

Additional supply items are covered as a Waiver service when they are considered essential and medically necessary for home and community care;

D. Nutritional supplements;

E. Non-prescription medications. Alternative medicines not Federal Drug Administration approved are excluded from coverage;

F. Prescription drugs minus the cost of drugs covered by Medicare Part D when extended benefits available under state plan are exhausted.

230.000 REIMBURSEMENT

230.100 Method of Reimbursement 1-1-23

Home and Community-Based Services outlined in this Manual for the Adult Behavioral Health Services for Community Independence program (ABSCI) are reimbursed on a fee for service basis by Medicaid. Service rates are set on a unit or daily rate basis. A full unit or day must be rendered in order to bill a unit of service.

230.200 Fee Schedules 1-1-23

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

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

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

SECTION II - DIAGNOSTIC AND EVALUATION SERVICES

CONTENTS

200.000 DIAGNOSTIC AND EVALUATION SERVICES GENERAL INFORMATION

201.000 Arkansas Medicaid Participation Requirements 1-1-23

The Division of Medical Services (DMS) is authorizing providers to become providers of diagnostic and evaluation services. Diagnostic and evaluation services will be specific to the Divisions of Developmental Disabilities (DDS) and Aging, Adult and Behavioral Health Services (DAABHS), where appropriate to determine eligibility for services (DDS) and treatment planning/diagnostic clarification (DAABHS).

202.000 Eligible Clients for this Manual 1-1-23

A. Clients who have received a mental health diagnostic assessment by an allowable licensed professional, and have begun mental health counseling services, can receive a psychological evaluation to confirm the diagnosis in order to guide continued behavioral health counseling services.

B. Clients who display symptoms of Autism Spectrum Disorder and require an adaptive behavior and/or intellectual assessment to complete one of the two clinical prongs for a diagnosis of Autism.

C. Clients who have a qualifying developmental disability and require an adaptive behavior and/or intellectual assessment to either establish or confirm that the diagnosis meets the criteria for Institutional Level of Care.

210.000 REQUIREMENTS FOR CONFIRMING BEHAVIORAL HEALTH DIAGNOSIS

210.100 Client Requirements 1-1-23

A. The client has completed a mental health diagnostic evaluation by a licensed professional enrolled as an Arkansas Medicaid behavioral health service provider;

B. The client is currently engaged in mental health counseling services through an Arkansas Medicaid behavioral health service provider;

C. The client is currently being treated to address symptoms of the diagnosed condition; and

D. The client is forty-eight (48) months or older.

210.200 Evaluator Requirements 1-1-23

A. To perform a Psychological Evaluation to Confirm a Behavioral Health Diagnosis, the clinician must be one of the following:

1. A Licensed Psychologist (LP)
2. A Licensed Psychological Examiner (LPE)
3. A Licensed Psychological Examiner-Independent (LPEI)

B. If the evaluator, through psychological testing leads to a diagnosis of Autism, the Evaluator must have a referral to the Division of Developmental Disabilities Services (DDS).

210.300 Evaluation Requirements 1-1-23

A. A Psychological Evaluation (includes psychodiagnostic assessment of emotionality, intellectual abilities, personality, and psychopathology, e.g. MMPI, Rorschach®, WAIS®) is allowed if the following criteria is met:

1. The Evaluation is conducted in person;
2. The Evaluation is necessary to establish a differential diagnosis of behavioral or psychiatric conditions;
3. The Evaluation is necessary because the client's history and symptomatology are not readily attributable to a particular psychiatric condition; and
4. The Evaluation is necessary because questions to be answered by the Evaluation could not be resolved by a psychiatric or diagnostic interview, observation in therapy, or an assessment for level of care at a mental health facility.

B. Minimum Documentation Requirements must be met and are as follows:

1. Date of Service;
2. Start and stop times of actual encounter with the client;
3. Start and stop times of scoring, interpretation, and report preparation;
4. Place of Service;
5. Identifying information;
6. Rationale for referral;
7. Presenting problem(s);
8. Culturally and age-appropriate psychosocial history and assessment;
9. Mental status and clinical observations and impressions;
10. Tests used, results, and interpretations, as indicated;
11. DSM diagnostic impressions to include in all axes, if applicable;

12. Treatment recommendations and findings related to rationale for service and guided by test results; and

13. Staff signature/credentials/date of signature(s).

C. If psychological testing leads to a diagnosis of Autism Spectrum Disorder, the treating licensed professional must document referral to appropriate autism treatment provider.

220.000 REQUIREMENTS FOR ESTABLISHING A DIAGNOSIS OF AUTISM SPECTRUM DISORDER

220.100 Client Requirements 1-1-23

A. The client is less than 21 years of age; and

B. The client is an enrolled in Arkansas Medicaid; and

C. The client has a referral from their primary care physician for testing to establish a diagnosis of Autism Spectrum Disorder.

220.200 Evaluator Requirements 1-1-23

A. To perform an adaptive behavior and/or intellectual assessment to establish an Autism Spectrum Diagnosis, the clinician must be one of the following:

1. A Licensed Physician
2. A Licensed Psychologist (LP)
3. A Licensed Speech Language Pathologist

220.300 Evaluation Requirements 1-1-23

A. An adaptive behavior and/or intellectual assessment to establish a diagnosis of Autism Spectrum Disorder is allowed if the following criteria is met:

1. The adaptive behavior and/or intellectual assessment is conducted in person; and
2. The adaptive behavior and/or intellectual assessment is necessary to establish a diagnosis of Autism Spectrum Disorder; and
3. The assessment administered is within the clinician's scope of practice and is on **the approved assessment list**.

B. Minimum Documentation Requirements must be met and are as follows:

1. Date of Service;
2. Start and stop times of actual encounter with the client;
3. Start and stop times of scoring, interpretation and report preparation;
4. Place of Service;
5. Identifying information;
6. Rationale for referral;
7. Presenting problem(s);
8. Culturally and age-appropriate psychosocial history and assessment;
9. Clinical observations and impressions;
10. Tests used, results, and interpretations, as indicated;

11. DSM diagnostic impressions to include in all axes, if applicable;
12. Treatment recommendations and findings related to rationale for service and guided by test results; and
13. Staff signature/credentials/date of signature(s).

230.000 REQUIREMENTS FOR ESTABLISHING OR CONFIRMING INSTITUTIONAL LEVEL OF CARE FOR CLIENTS WITH IDD

230.100 Client Requirements 1-1-23

A. The client has a diagnosis from a licensed physician of the following developmental disabilities:
   1. Epilepsy
   2. Cerebral Palsy
   3. Down Syndrome
   4. Spina Bifida

B. The client has been referred by a licensed physician and has a confirmed diagnosis the following developmental disabilities:
   1. Intellectual Disability or related condition
   2. Autism Spectrum Disorder

230.200 Evaluator Requirements 1-1-23

A. To perform an adaptive behavior and/or intellectual assessment to establish or confirm Institutional Level of Care, the clinician must be one of the following:
   1. A Licensed Psychologist (LP)
   2. A Licensed Psychological Examiner (LPE)
   3. A Licensed Psychological Examiner-Independent (LPEI)

230.300 Evaluation Requirements 1-1-23

A. An adaptive behavior and/or intellectual assessment to establish or confirm Institutional Level of Care is allowed if the following criteria is met:
   1. The adaptive behavior and/or intellectual assessment is conducted in person;
   2. The adaptive behavior and/or intellectual assessment is necessary to establish or confirm Institutional Level of Care; and
   3. The assessment administered is within the clinician's scope of practice and is on **the approved assessment list**.

B. Minimum Documentation Requirements must be met and are as follows:
   1. Date of Service;
   2. Start and stop times of actual encounter with the client;
   3. Start and stop times of scoring, interpretation, and report preparation;
   4. Place of Service;
   5. Identifying information;

6. Rationale for referral;
7. Presenting problem(s);
8. Culturally and age-appropriate psychosocial history and assessment;
9. Clinical observations and impressions;
10. Tests used, results, and interpretations, as indicated;
11. DSM diagnostic impressions to include in all axes, if applicable;
12. Treatment recommendations and findings related to rationale for service and guided by test results; and
13. Staff signature/credentials/date of signature(s).

240.000 REIMBURSEMENT

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

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

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

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

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

C. 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.

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

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

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

240.100 Fee Schedules 1-1-23

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

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

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

241.000 Rate Appeal Process 1-1-23

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.

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

The request for review by the Rate Review Panel must be postmarked within 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.

~~Arkansas Department of Human Services~~

~~Behavioral Health Independently Licensed Practitioners Certification Manual~~

~~www.arkansas.gov/dhs/dhs~~

~~ARKANSAS DEPARTMENT OF HUMAN SERVICES~~

~~Independently Licensed Practitioner~~

~~Provider Certification Rules~~

I. PURPOSE:

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

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

II. SCOPE:

A. Current Independently Licensed Practitioner certification under this policy is a condition of Medicaid provider enrollment.

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

III. DEFINITIONS:

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

B. "Applicant" means an Independently Licensed Practitioner that is seeking DHS certification as an Independently Licensed Practitioner.

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

D. "Client" means any person for whom an Independently Licensed Practitioner furnishes, or has agreed or undertaken to furnish, Counseling Level Outpatient Behavioral Health services.

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

F. "Compliance" means conformance with:

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

a. Titles XIX and XXI of the Social Security Act and implementing regulations;

b. Other federal laws and regulations governing the delivery of health care funded in whole or in part by federal funds, for example, 42 U.S.C. § 1320c-5;

c. All state laws and rules applicable to Medicaid generally and to an Independently Licensed Practitioner services specifically;

d. Title VI of the Civil Rights Act of 1964 as amended, and implementing regulations;

e. The Americans With Disabilities Act, as amended, and implementing regulations;

f. The Health Insurance Portability and Accountability Act ("HIPAA"), as amended and implementing regulations.

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

H. "Coordinated Management Plan" means a plan that the provider develops and carries out to assure compliance and quality improvement.

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

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

K. "DHS" means the Arkansas Department of Human Services Division of Behavioral Health Services.

L. "Deficiency" means an item or area of noncompliance.

M. "DHS" means the Arkansas Department of Human Services.

N. "Emergency an Independently Licensed Practitioner services" means nonscheduled an Independently Licensed Practitioner services delivered under circumstances where a prudent layperson with an average knowledge of behavioral health care would reasonably believe that an Independently Licensed Practitioner services are immediately necessary to prevent death or serious impairment of health.

O. "Independently Licensed Practitioner" is an individual that is licensed to engage in private/independent practice by the appropriate State Board. The following licensure can qualify as Independently Licensed Practitioners:

1. Licensed Certified Social Worker (LCSW)

2. Licensed Marital and Family Therapist (LMFT)

3. Licensed Psychologist (LP)

4. Licensed Psychological Examiner – Independent (LPEI)

5. Licensed Professional Counselor (LPC)

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

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

2. Delivered in a clinically appropriate setting; and

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

Q. "NPDB" means the United States Department of Health and Human Services, Health Resources and Services Administration National Provider Data Bank.

R. "Performing provider" means an Independently Licensed Practitioner who personally delivers a care or service directly to a client.

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

T. "Provider" means an Independently Licensed Practitioner that is certified by DHS and enrolled by DMS to provide Outpatient Behavioral Health Services.

U. "Reviewer" means a person employed or engaged by:

1. DHS or a division or office thereof;

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

V. "Site" means a distinct place of business dedicated to the delivery of Outpatient Behavioral Health Services. Each site where an Independently Licensed Practitioner performs services at must be certified by the Division of Behavioral Health Services. Colocation within an office or clinic of a physician or psychologist is allowed for an Independently Licensed Practitioner. However, an Independently Licensed Practitioner site cannot be an adjunct to a school, a day care facility, or a long-term care facility. Each site shall be a bona fide an Independently Licensed Practitioner site.

W. "Site relocation" means closing an existing site and opening a new site.

X. "Site transfer" means moving existing staff, program, and clients from one physical

location to a second location.

Y. "Supervise" as used in this rule means to direct, inspect, observe, and evaluate performance.

Z. "Supervision documentation" means written records of the time, date, subject(s), and duration of supervisory contact maintained in the provider's official records.

IV. COMPLIANCE TIMELINE:

A. All Independently Licensed Practitioner sites must receive an on-site inspection in order to obtain DHS certification as an Independently Licensed Practitioner site.

B. DHS may authorize temporary compliance exceptions for Independently Licensed Practitioners, if deemed necessary by DHS.

V. APPLICATION FOR DHS INDEPENDENTLY LICENSED PRACTITIONER CERTIFICATION:

A. Applicants must complete form DMS-633, which can be found at the following website: http://humanservices.arkansas.gov/dhs/Documents/LMHP%20Form%20633.pdf

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

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

C. Each applicant must be an Independently Licensed Practitioner:

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

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

D. Independently Licensed Practitioner certification is not transferable or assignable.

E. The privileges of an Independently Licensed Practitioners certification are limited to the certified site.

F. Providers may file Medicaid claims only for Outpatient Behavioral Health Services delivered by an Independently Licensed Practitioner.

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

H. The applicant must attach the Independently Licensed Practitioner family involvement policy to each application.

VI. APPLICATION REVIEW PROCESS:

A. Timeline:

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

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

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

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

5. Within thirty (30) calendar days after DHS approves a corrective action plan, the applicant must document implementation of the plan and correction of the deficiencies listed in the survey report. Applicants who are unable, despite the exercise of reasonable diligence, to correct deficiencies within the time permitted may obtain up to ten (10) additional days based on a showing of good cause.

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

B. Survey Components: Each site survey will ensure that the site is in compliance with facility environment requirements, location in Section <000.000> of this certification manual. The site survey will also ensure that the Independently Licensed Practitioner complies with policy requirements and record keeping requirements.

C. Determinations:

1. Application approved.

2. Application returned for additional information.

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

VII. DHS Access to Applicants/Providers:

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

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

C. Applicants/providers shall provide DHS prompt direct access to applicant/provider documents and to applicant/provider staff and contractors.

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

VIII. ADDITIONAL CERTIFICATION REQUIREMENTS:

A. Care and Services must:

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

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

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

B. Applicants and Independently Licensed Practitioners must:

1. Be a legal entity in good standing;

2. Maintain all required business licenses;

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

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

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

1. Compliance;

2. Cultural competence;

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

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

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

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

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

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

IX. REQUIREMENTS FOR CERTIFICATION

A. Independently Licensed Practitioner may not furnish Outpatient Behavioral Health Services during any time the professional's license is subject to adverse license action.

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

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

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

3. Is excluded under DHS Policy 1088; or

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

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

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

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

3. Contain a brief description of the Independently Licensed Practitioner services;

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

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

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

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

8. Offer to provide copies of Independently Licensed Practitioner and Outpatient Behavioral Health Services rules;

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

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

D. Outpatient Behavioral Health Services maintained by the Independently Licensed Practitioner must include:

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

2. Ability to provide Pharmacologic Management at the certified site or the agreement of collaboration with a physician to provide Pharmacologic Management for clients of the Independently Licensed Practitioner.

3. Ability to refer clients to other practitioners or agencies for Outpatient Behavioral Health Services.

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

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

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

1. A 24-hour emergency telephone number;

2. The applicant/provider must:

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

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

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

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

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

4. Response strategies based upon:

   a. Time and place of occurrence;

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

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

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

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

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

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

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

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

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

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

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

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

11. The above crisis response requirements can be addressed through an agreement with another provider (i.e., Behavioral Health Agency, Independently Licensed

Practitioner). Crisis response plans must be discussed with clients and must be available for review.

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

1. For assessment and individualized care planning and delivery;

2. For discharge planning integral to treatment;

3. For mobile care;

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

5. To make timely referrals to other services;

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

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

1. Evidence based practices;

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

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

X. SITE REQUIREMENTS:

A. All Independently Licensed Practitioner sites must be located inside the State of Arkansas;

B. The Independently Licensed Practitioner site shall obtain an annual fire and safety inspection from the State Fire Marshall or local authorities which documents approval for continued occupancy.

C. All Independently Licensed Practitioner site staff shall know the exact location, contents, and use of first aid supply kits and fire fighting equipment and fire detection systems. All fire fighting equipment shall be annually maintained in appropriately designated areas within the facility.

D. The Independently Licensed Practitioner site shall post written plans and diagrams noting emergency evacuation routes in case of fire, and shelter locations in case of severe weather. All exits must be clearly marked.

E. The Independently Licensed Practitioner site shall be maintained in a manner, which provides a safe environment for clients, personnel, and visitors.

F. The Independently Licensed Practitioner site telephone number(s) and actual hours of operation shall be posted at all public entrances.

G. The Independently Licensed Practitioner site shall establish policies for maintaining client records, including policies designating where the original records are stored.

H. Each Independently Licensed Practitioner site shall maintain an organized medical record keeping system to collect and document information appropriate to the treatment processes. This system shall be organized; easily retrievable, usable medical records stored under confidential conditions and with planned retention and disposition.

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

A. Planned Closings:

1. Upon deciding to close a site either temporarily or permanently, the Independently Licensed Practitioner immediately must provide written notice to clients and to the Department of Human Services, Division of Behavioral Health Services.

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

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

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

B. Unplanned Closings:

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

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

C. All Closings:

1. Independently Licensed Practitioner must assure and document continuity of care

for all clients who receive Outpatient Behavioral Health Services at the site;

2. Notice of Closure and Continuing Care Options:

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

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

c. Before closing, Independently Licensed Practitioner must post a public notice at the site entry.

3. An acceptable transition plan is described below:

Transition Plan:

1. Provide clients/families with the referral information and have them sign a transfer of records form/release of information to enable records to be transferred to the provider of their choice.

2. Transfer records to the designated provider.

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

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

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

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

A site closing Form is available at: www.arkansas.gov/dhs/dhs See appendix # 9

D. New Sites: Providers may apply for a new site by completing the new site Form available at www.arkansas.gov/dhs/dhs

See appendix # 10 DHS Form # 5 – (Adding Site)

E. Site Transfer:

1. At least forty-five (45) calendar days before a proposed transfer of a certified site, the provider must apply to DHS to transfer site certification.

2. The provider must notify clients and families at least thirty (30) calendar days before the transfer;

3. DHS requires an on-site survey prior to allowance of service at the new site. The Division of Medical Services does not require a new Medicaid provider number. The moving or transferring site form is available at: www.arkansas.gov/dhs/dhs

See appendix # 9 – DHS Form # 4 (Closing and Moving Sites)

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

XII. PROVIDER RE-CERTIFICATION:

A. The term of DHS site certification is continuous for 3 years from the date of Certification as long as the site is not transferred and the Independently Licensed Practitioner maintains appropriate Licensure. If an Independently Licensed Practitioner loses appropriate licensure, the site that they operate in will lose certification.

B. Providers must furnish DHS a copy of:

1. An application for provider and site recertification:

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

b. The Re-Certification form with required documentation is available at www.arkansas.gov/dhs/dhs

See Appendix # 11 DHS Form 3 (Re-certification)

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

XIII. MAINTAINING DHS INDEPENDENTLY LICNESED PRACTITIONER CERTIFICATION:

A. Providers must:

1. Maintain compliance;

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

3. Display the Independently Licensed Practitioner certificate for each site at a prominent public location within the site

B. Annual Reports:

1. Providers must furnish annual reports to DHS before July 1 of each year that the provider has been in operation for the preceding twelve (12) months.

1. Annual report shall be prepared by completing forms provided by DHS. The annual report form is available at www.arkansas.gov/dhs/dhs and at Appendix # 12 DHS Form # 6

XIV. NONCOMPLIANCE

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

1. Submission and implementation of an acceptable corrective action plan as a condition of retaining Independently Licensed Practitioner certification;

2. Suspension of Independently Licensed Practitioner certification for either a fixed period or until the provider meets all conditions specified in the suspension notice;

3. Termination of Independently Licensed Practitioner certification.

XV. APPEAL PROCESS

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

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

for appeal, unless a party to the appeal requests and receives a continuance for good cause.

C. DHS shall tape record each hearing.

D. The hearing official shall issue the decision within forty-five (45) calendar days of the date that the hearing record is completed and closed. The hearing official shall issue the decision in a written document that contains findings of fact, conclusions of law, and the decision. The findings, conclusions, and decision shall be mailed to the appellant except that if the appellant is represented by counsel, a copy of the findings, conclusions, and decision shall also be mailed to the appellant's counsel. The decision is the final agency determination under the Administrative Procedure Act.

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

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

SECTION II - SCHOOL-BASED MENTAL HEALTH SERVICES

CONTENTS

200.000 SCHOOL-BASED MENTAL HEALTH SERVICES GENERAL INFORMATION

201.000 Introduction 10-13-03

In order to ensure quality and continuity of care, school districts and/or Education Services Cooperatives (ESC) that are providers of School-Based Mental Health Services, approved to receive Medicaid reimbursement for services provided to the under age 21 Medicaid population, must ensure that contractors and personnel engaged as licensed school-based mental health practitioners meet specific qualifications in order for school districts and ESC providers to bill Medicaid for their services.

202.000 Arkansas Medicaid Participation Requirements for a School District or Education Services Cooperative (ESC) to Provide School-Based Mental Health Services 10-13-03

School-Based Mental Health Services providers must meet the Provider Participation and enrollment requirements contained within Section 140.000 of this manual as well as the following criteria to be eligible to participate in the Arkansas Medicaid Program:

A. Arkansas Medicaid will enroll as providers only school districts and ESCs that are located within the State of Arkansas.

B. The Arkansas Department of Education (ADE) will ensure that a school district or ESC interested in becoming a Medicaid provider of school-based mental health services meets Medicaid provider requirements. Notification of approval by the Arkansas Department of Education must be presented to the Arkansas Division of Medical Services at the time application for enrollment is made. Subsequent decisions by ADE must be provided when issued.

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

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

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

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

A. Licensed Certified Social Worker (LCSW)

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

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

B. Licensed Master Social Worker (LMSW)

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

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

C. Licensed Professional Counselor (LPC)

1. The LPC must have received a graduate (master's) degree that is primarily professional counseling in content from a regionally accredited institution of higher education. The LPC must have accumulated at least 48 graduate semester hours to meet the academic and training content standard established by the Arkansas Board of Examiners in Counseling.
2. The LPC has three (3) years of supervised full-time experience in professional counseling acceptable to the Arkansas Board of Examiners in Counseling. One (1) year of experience may be gained for each 30 graduate semester hours earned beyond the master's degree provided that the hours are clearly related to the field of counseling and are acceptable to the Board. In no case may the applicant have less than one (1) year of supervised professional experience.
3. The LPC must be licensed as a licensed professional counselor and be in good standing with the Arkansas Board of Examiners in Counseling.
4. The LPC must meet all licensure requirements as set forth in Arkansas Code Annotated § 17-27-301 for licensed Professional Counselors (LPC).
5. The LPC must provide proof to the school district or ESC of two (2) years post-licensure experience treating children and adolescents with mental illness.
6. The LPC shall not provide services beyond those for which he or she has been trained and are within his or her scope of practice and licensure.

D. Licensed Associate Counselor (LAC)

1. The LAC must be licensed as a licensed associate counselor and in good standing with the Arkansas Board of Examiners in Counseling.
2. The LAC must meet all licensure requirements as held forth in Arkansas Code Annotated § 17-27-302.
3. The LAC may practice only under direct supervision of an LPC.
4. The plan for supervision of the LAC must be approved by the Board of Examiners in Counseling prior to any actual performance of counseling on the part of the LAC.

5. The LAC must provide proof to the school district or ESC of two (2) years post-licensure experience treating children and adolescents with mental illness.

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

7. The LAC shall provide to the school district or ESC a copy of his or her supervision plan including the name and license number of his or her supervising LPC before the LAC provides any service for which he or she is required to be under the supervision of a LPC.

E. Licensed School Psychology Specialist (LSPS)

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

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

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

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

F. Licensed Psychological Examiner (LPE)

1. The LPE must have two (2) academic years of graduate training in psychology, including a master's degree from an accredited educational institution recognized by the Arkansas Board of Examiners in Psychology as maintaining satisfactory standards or, in lieu thereof, such training and experience as the Board shall consider equivalent.

2. The LPE must be licensed as a licensed psychological examiner and be in good standing with the Arkansas Board of Examiners in Psychology.

3. The LPE shall provide to the school district or ESC the name and licensure number of his or her supervising psychologist before the LPE provides any service for which he or she is required to be under the supervision of a psychologist licensed by the Arkansas Board of Examiners in Psychology.

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

G. Psychologist

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

2. The psychologist must be licensed as a psychologist by the Arkansas Board of Examiners in Psychology.

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

202.110 School-Based Mental Health Services When School is not in Session or a Child is not in School 10-13-03

School-based mental health services providers (school districts and ESCs) will provide services twelve months of each year, either directly or by arrangement with other appropriately licensed personnel.

Examples of periods of time a child is not in school but the school district or ESC is required to provide services are:

A. Summer school break;

B. Holidays;

C. Nights and weekends;

D. When a child is out of school due to disciplinary action or

E. Other times a child may be out of school but the school district or ESC is responsible for providing services to the child.

202.120 Liability Insurance 10-13-03

Each practitioner must be covered by liability insurance. The school district or ESC may have a W-4 relationship of employment with an individual practitioner, contract with an individual practitioner or contract with an organization that employs individual practitioners. The requirement regarding liability insurance must be met in one of the following ways:

A. When school-based mental health services practitioners are employed by the local school district, the school district's liability insurance covers the practitioner.

B. When the school district enters into a professional services contract with an individual who is in private practice, the individual will be responsible for carrying liability insurance.

C. When the district contracts with an organization, such as a Community Mental Health Center, which employs mental health practitioners, the organization employing the practitioner is responsible for carrying liability insurance.

210.000 PROGRAM COVERAGE

211.000 Introduction 10-13-03

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

211.100 Continuity of Care and/or Services 10-13-03

In accordance with existing ADE policy, public education agencies are required to work cooperatively with other providers of services to children and youth. Likewise, providers of mental health services other than public education agencies are also required by state policy to work collaboratively to coordinate the delivery of mental health services with other sources of similar services and care and to make appropriate disclosure consistent with privacy and confidentiality rights of the treatment plan to all parties involved with mental health services. The school counselor will be informed as to the need for services.

211.200 Non-Refusal Requirement 10-13-03

The school-based mental health services provider may not refuse services to a Medicaid-eligible beneficiary under age 21 in a school setting unless, based upon the primary mental health diagnosis, the provider does not possess the services or program to adequately treat the beneficiary's mental health needs.

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

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

A beneficiary can receive ten (10) School-Based Mental Health Services before a PCP/PCMH referral is necessary. No services will be allowed to be provided without appropriate PCP/PCMH referral. The PCP/PCMH referral must be kept in the beneficiary's medical record.

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

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

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

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

211.310 When a Child is Ineligible for Medicaid at Time of Service 7-1-05

A. When a child who is not eligible for Medicaid receives an outpatient mental health service, an application for Medicaid eligibility may be filed by the child or his or her representative.

B. If the application for Medicaid coverage is approved, a PCP referral is not required for the period prior to the Medicaid authorization date. This period is considered **retroactive** eligibility and does not require a referral.

C. A PCP referral is required no later than forty-five calendar days after the authorization date. If the PCP referral is not obtained within forty-five calendar days of the Medicaid authorization date, reimbursement will begin, if all other requirements are met, the date the PCP referral is received. To verify the authorization date, a provider may call the Arkansas Medicaid fiscal agent or the local DHS Office.

However, a PCP is given the option of providing a referral after a service is provided. If a PCP chooses to make a referral after a service has been provided, the referral must be received by the SBMH provider no later 45 calendar days after the date of authorization. The PCP has no obligation to give a retroactive referral.

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

View or print PAC contact information. View or print DHS contact information.

211.320 Renewal of PCP Referral 10-13-03

If a beneficiary continues to require outpatient mental health services for six months or more, the PCP referral must be renewed every six months.

212.000 Scope 7-1-17

The School-Based Mental Health Services program consists of a range of mental health diagnostic, therapeutic, rehabilitative or palliative services provided by the employees and

contractors described in Section 202.100 of this manual to Medicaid-eligible beneficiaries (including ARKids B) under age twenty-one (21) suffering from psychiatric conditions as described in the current allowable American Psychiatric Association Diagnostic and Statistical Manual (DSM).

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

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

B. Provided to Medicaid recipients under age 21.

C. Provided to outpatients.

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

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

F. Included in a treatment plan.

212.100 Physician Referral 4-1-07

The Medicaid beneficiary must be referred verbally or in writing for school-based mental health services by a Medicaid-enrolled physician. The referral must establish that services are medically necessary. **The referral must be renewed every six (6) months.** The written referral or documentation of the verbal referral must include:

A. The name of the referring Medicaid-enrolled physician,

B. The referring Medicaid-enrolled physician's provider identification number and

C. The date of the referral.

212.200 Comprehensive Assessment 10-13-03

Documentation of the comprehensive assessment shall include at a minimum:

A. Complete demographic information;

B. Presenting problem(s);

C. History of present problem(s);

D. Psychiatric history;

E. Substance abuse history;

F. Medical and Developmental history;

G. Family and social history;

H. Mental status examination and

I. Clinical impression and diagnosis.

212.300 Treatment Plan Requirements 10-13-03

An individualized, written treatment plan must be developed and included in the patient medical record for each beneficiary receiving mental health services. The treatment plan must include at a minimum:

A. Demographic data;

B. Presenting problem;

C. History of problem;

D. Social history;

E. Defined goals and objectives with documented input of beneficiary. The input of family, where applicable, must also be documented and

F. Date(s) of treatment plan review, with updates to occur no less than every 90 days.

A student's IEP, Behavior Intervention and Support Plan or family services plan shall be considered to meet the definition of the individualized treatment plan only when containing the information specified above.

212.400 Place of Service 10-13-03

School-Based Mental Health Services are reimbursable by Arkansas Medicaid only when provided in the following locations:

A. School: School can be defined for purposes of these services to include an area on- or off-site based on accessibility for the child.

B. Home: When the home is considered to be an educational setting for a child who is enrolled in the public school system. (The home is not considered a place of service when the parent elects to home school the child.)

213.000 Exclusions 7-1-17

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

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

B. Educational services.

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

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

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

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

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

214.000 Covered Services 4-1-18

Outpatient Services

Fifteen-minute units, unless otherwise stated.

School-Based Mental Health Services must be billed on a per-unit basis, as reflected in a daily total, per beneficiary, per service.

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

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

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

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

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

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

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

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

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

215.000 Diagnosis and Clinical Impression 9-1-14

Diagnosis and clinical impression shall be required in the terminology of ICD for billing purposes.

216.000 Record Keeping Requirements 10-13-03

All medical records that support the provision of medical services billed to Medicaid shall be completed promptly, filed and retained by the school district or ESC in which the child attends school. The records must be available for audit. Specific record keeping requirements are listed below:

A. The school district or ESC must keep all required documentation and records for a period of five (5) years from the date of service or until all audit questions, appeal hearings, investigations or court cases are resolved, whichever period is longer.

B. The school district or ESC must furnish requested records and documentation to authorized representatives of the Arkansas Division of Medical Services and the Arkansas Attorney General's Office Medicaid Fraud Unit, as well as to representatives, authorized agents or officials of the United States Department of Health and Human Services. Failure to furnish records upon request may result in sanctions being imposed.

C. All documentation must be made available to representatives of the Arkansas Division of Medical Services (DMS) at the time of an audit by the Arkansas Medicaid Field Audit Unit.

1. All documentation must be available at the provider's place of business.

2. If an audit determines that recoupment is necessary, there will be no more than thirty (30) days allowed after the date of the recoupment notice in which additional documentation will be accepted.

See Section 217.000 of this manual for a complete listing of required documentation.

217.000 Documentation 4-1-07

The documentation must be maintained in the student's medical record.

The school district or ESC must properly maintain written records for each child receiving school-based mental health services that include, at a minimum, the following:

A. A referral from a Medicaid-enrolled physician must be obtained and filed in the medical record of each child receiving school-based mental health services. The referral may be verbal or written and must contain the physician's name and provider identification number and the date of the referral. If the referral is verbal, the school district or ESC must document the referral in the child's medical record by stating the name of the physician and the date of the verbal referral. The referral must be renewed every six (6) months.

B. Comprehensive assessment. See Section 212.200 for details.

C. Written treatment plan which meets the requirements of Section 212.300.

D. Provider of services signature and title.

E. Beneficiary of service(s).

F. Date of service(s).

G. Place the service(s) were provided.

H. Actual time of services (beginning and ending time of each service).

I. Length of time over which a service was provided.

J. Specific service(s) rendered (type of activity provided).

K. Progress notes for each service provided, which include information on patient response to treatment rendered.

NOTE: Each progress note should relate to treatment plan goals and objectives and describe the student's progress toward established goals. Progress notes may be kept in narrative form or on logs, if all required components are present.

L. Discharge plan, to include input of the beneficiary, the beneficiary's family, or both as appropriate.

217.100 Electronic Signatures 10-8-10

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

218.000 Beneficiary Appeal Process 10-13-03

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

The appeal request must be in writing and received by the Appeals and Hearings Section of the Department of Human Services within thirty days of the date on the letter explaining the denial of services. Appeal requests must be submitted to the Department of Human Services, Appeals and Hearings Section. **View or print the Appeals and Hearings Section contact information**.

219.000 Utilization Review 7-1-17

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

219.100 Record Reviews 4-1-18

The Division of Medical Services (DMS) of the Arkansas Department of Human Services (DHS) has contracted with an independent contractor to perform on-site inspections of care (IOC) and retrospective reviews of outpatient mental health services provided by School-Based Mental Health Services providers. **View or print current contractor contact information**. The reviews are conducted by licensed mental health professionals and are based on applicable federal and state laws, rules and professionally recognized standards of care.

219.200 Utilization Review Section 10-13-03

If a claim is rejected due to the same service being billed by more than one provider on the same date, the provider whose claim was rejected may contact the Utilization Review (UR) Section of the Division of Medical Services to request a review for medical necessity. If medical necessity is established the UR Section will authorize payment of the claim.

Division of Medical Services Utilization Review Section may be contacted in writing. **View or print the Utilization Review Section contact information.**

228.130 Retrospective Reviews 7-1-17

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

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

228.131 Purpose of a Review 7-1-17

The purpose of a review is to:

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

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

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

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

229.000 Medicaid Beneficiary Appeal Process 7-1-17

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

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

229.200 Recoupment Process 7-1-17

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

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

260.000 REIMBURSEMENT

261.000 Method of Reimbursement 10-13-03

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

261.010 Fee Schedule 12-1-12

Arkansas Medicaid provides fee schedules on the Arkansas Medicaid website. The fee schedule link is located at **https://medicaid.mmis.arkansas.gov/** 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.

262.000 Rate Appeal Process 10-13-03

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

action to be taken by the Division within 20 calendar days of receipt of the request for review or the date of the Program/Provider conference.

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

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

270.000 BILLING PROCEDURES

271.000 Introduction to Billing 7-1-20

School-based mental health providers use the CMS-1500 form to bill the Arkansas Medicaid Program on paper for services provided to eligible Medicaid beneficiaries. Each claim should contain charges for only one (1) beneficiary.

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

272.000 CMS-1500 Billing Procedures

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

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

272.110 Mental Health Diagnosis 2-1-22

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

strength-based, with emphasis on needs as identified by the beneficiary and provided with cultural competence.	history and assessment • Mental status/clinical observations and impressions • Current functioning plus strengths and needs in specified life domains • DSM diagnostic impressions to include all axes • Treatment recommendations • Goals and objectives to be placed in Plan of Care • Staff signature/credentials/date of signature	
NOTES	**UNIT**	**BENEFIT LIMITS**
This service may be billed for face-to-face contact as well as for time spent obtaining necessary information for diagnostic purposes; however, this time may NOT be used for development or submission of required paperwork processes (i.e. treatment plans, etc.).	Encounter	DAILY MAXIMUM OF UNITS THAT MAY BE BILLED: 1 YEARLY MAXIMUM OF UNITS THAT MAY BE BILLED (extension of benefits can be requested): 1
APPLICABLE POPULATIONS	**SPECIAL BILLING INSTRUCTIONS**	
Children and Youth	**Outpatient Behavioral Health Services Providers cannot bill on same date of service** **View or print the procedure codes for SBMH services.**	
ALLOWED MODE(S) OF DELIVERY	**TIER**	
Face-to-face	School-Based Mental Health	
ALLOWABLE PERFORMING PROVIDER	**PLACE OF SERVICE**	
• Licensed Certified Social Worker (LCSW) • Licensed Master Social Worker (LMSW) • Licensed Professional Counselor (LPC) • Licensed Associate Counselor (LAC) • Licensed School Psychology Specialist (LSPS) • Licensed Psychological Examiner (LPE) • Psychologist * School-Based Mental Health Services provider employees or contractors will provide services only in those areas in which they are licensed or credentialed.	03	

272.120 Psychological Evaluation 2-1-22

CPT®/HCPCS PROCEDURE CODE	PROCEDURE CODE DESCRIPTION
View or print the procedure codes for SBMH services.	Psychological testing (includes psychodiagnostic assessment of emotionality, intellectual abilities, personality and psychopathology, e.g. MMPI, Rorschach®, WAIS®), per hour of the psychologist's or physician's time, both face-to-face time administering tests to the patient and time interpreting these test results and preparing the report.

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

NOTES	UNIT	BENEFIT LIMITS
	60 minutes	DAILY MAXIMUM OF UNITS THAT MAY BE BILLED: 4 YEARLY MAXIMUM OF UNITS THAT MAY BE BILLED (extension of benefits can be requested): 8

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

• Psychologist	

272.130 Interpretation of Diagnosis 2-1-22

CPT®/HCPCS PROCEDURE CODE	PROCEDURE CODE DESCRIPTION	
View or print the procedure codes for SBMH services.	Interpretation or explanation of results of psychiatric or other medical examinations and procedures, or other accumulated data to family or other responsible persons, or advising them how to assist patient	
SERVICE DESCRIPTION	**MINIMUM DOCUMENTATION REQUIREMENTS**	
Interpretation of Diagnosis is a direct service provided for the purpose of interpreting the results of psychiatric or other medical exams, procedures or accumulated data. Services may include diagnostic activities and/or advising the beneficiary and his/ her family. Consent forms may be required for family or significant other involvement. Services must be congruent with the age and abilities of the beneficiary, client-centered and strength-based, with emphasis on needs as identified by the beneficiary and provided with cultural competence.	• Start and stop times of face to face encounter with beneficiary and/or parents or guardian • Date of service • Place of service • Participants present and relationship to beneficiary • Diagnosis • Rationale for and objective used that must coincide with the goals and objectives placed in Plan of Care • Participant(s) response and feedback • Staff signature/credentials/date of signature(s)	
NOTES	**UNIT**	**BENEFIT LIMITS**
For beneficiaries under the age of 18, the time may be spent face-to-face with the beneficiary, the beneficiary and the parent(s) or guardian(s) or alone with the parent(s) or guardian(s). For beneficiaries over the age of 18, the time may be spent face-to-face with the beneficiary and the spouse, legal guardian or significant other.	Encounter	DAILY MAXIMUM OF UNITS THAT MAY BE BILLED: 1 YEARLY MAXIMUM OF UNITS THAT MAY BE BILLED (extension of benefits can be requested): 1
APPLICABLE POPULATIONS	**SPECIAL BILLING INSTRUCTIONS**	
Children and Youth		
ALLOWED MODE(S) OF DELIVERY	**TIER**	
Face-to-face	School-Based Mental Health	
ALLOWABLE PERFORMING PROVIDERS	**PLACE OF SERVICE**	
• Licensed Certified Social Worker (LCSW) • Licensed Master Social Worker (LMSW) • Licensed Professional Counselor (LPC) • Licensed Associate Counselor (LAC) • Licensed School Psychology Specialist (LSPS)	03	

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

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

Natural supports may be included in these sessions if justified in service documentation. Only one beneficiary per family per therapy session may be billed.	Encounter	DAILY MAXIMUM OF UNITS THAT MAY BE BILLED: 1 YEARLY MAXIMUM OF UNITS THAT MAY BE BILLED (extension of benefits can be requested): 12
APPLICABLE POPULATIONS	**SPECIAL BILLING INSTRUCTIONS**	
Children and Youth		
ALLOWED MODE(S) OF DELIVERY	**TIER**	
Face-to-face	School-Based Mental Health	
ALLOWABLE PERFORMING PROVIDERS	**PLACE OF SERVICE**	
• Licensed Certified Social Worker (LCSW) • Licensed Master Social Worker (LMSW) • Licensed Professional Counselor (LPC) • Licensed Associate Counselor (LAC) • Licensed School Psychology Specialist (LSPS) • Licensed Psychological Examiner (LPE) • Psychologist * School-Based Mental Health Services provider employees or contractors will provide services only in those areas in which they are licensed or credentialed.	03	

272.150 Crisis Intervention 2-1-22

CPT®/HCPCS PROCEDURE CODE	**PROCEDURE CODE DESCRIPTION**
View or print the procedure codes for SBMH services.	Crisis intervention service, per 15 minutes
SERVICE DESCRIPTION	**MINIMUM DOCUMENTATION REQUIREMENTS**
Crisis Intervention is unscheduled, immediate, short-term treatment activities provided to a Medicaid-eligible beneficiary who is experiencing a psychiatric or behavioral crisis. Services are to be congruent with the age, strengths, needed accommodation for any disability, and cultural framework of the beneficiary and his/her family. These services are designed to stabilize the person in crisis, prevent further deterioration and provide immediate indicated treatment in the least restrictive setting. (These activities include evaluating a Medicaid-eligible beneficiary to determine if the need for crisis services is present.)	• Date of service • Start and stop time of actual encounter with beneficiary and possible collateral contacts with caregivers or informed persons • Place of service • Specific persons providing pertinent information in relationship to beneficiary • Diagnosis and synopsis of events leading up to crisis situation • Brief mental status and observations • Utilization of previously established psychiatric advance directive or crisis plan as pertinent to

	current situation OR rationale for crisis intervention activities utilized • Beneficiary's response to the intervention that includes current progress or regression and prognosis • Clear resolution of the current crisis and/or plans for further services • Development of a clearly defined crisis plan or revision to existing plan • Staff signature/credentials/date of signature(s)	
NOTES	**UNIT**	**BENEFIT LIMITS**
A psychiatric or behavioral crisis is defined as an acute situation in which an individual is experiencing a serious mental illness or emotional disturbance to the point that the beneficiary or others are at risk for imminent harm or in which to prevent significant deterioration of the beneficiary's functioning. This service can be provided to beneficiaries that have not been previously assessed or have not previously received behavioral health services. The provider of this service MUST complete a Mental Health Diagnosis (90791) within 7 days of provision of this service. If the beneficiary needs more time to be stabilized, this must be noted in the beneficiary's medical record and the Division of Medical Services Quality Improvement Organization (QIO) must be notified.	15 minutes	DAILY MAXIMUM OF UNITS THAT MAY BE BILLED: 12 YEARLY MAXIMUM OF UNITS THAT MAY BE BILLED (extension of benefits can be requested): 72
APPLICABLE POPULATIONS	**SPECIAL BILLING INSTRUCTIONS**	
Children and Youth		
ALLOWED MODE(S) OF DELIVERY	**TIER**	
Face-to-face	School-Based Mental Health	
ALLOWABLE PERFORMING PROVIDERS	**PLACE OF SERVICE**	
• Licensed Certified Social Worker (LCSW) • Licensed Master Social Worker (LMSW) • Licensed Professional Counselor (LPC) • Licensed Associate Counselor (LAC) • Licensed School Psychology Specialist (LSPS) • Licensed Psychological Examiner (LPE) • Psychologist * School-Based Mental Health Services provider employees or contractors will provide services only in those areas in which they are licensed or credentialed.	03	

CPT®/HCPCS PROCEDURE CODE	PROCEDURE CODE DESCRIPTION
View or print the procedure codes for SBMH 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. Services must be congruent with the age and abilities of the beneficiary, client-centered and strength-based with an emphasis on needs as identified by the beneficiary and provided with cultural competence. The treatment service must reduce or alleviate identified symptoms related to either (a) Mental Health or (b) Substance Abuse and maintain or improve level of functioning, and/or prevent deterioration. Additionally, tobacco cessation counseling is a component of this service.	• Date of service • Start and stop times of face-to-face encounter with beneficiary • Place of service • Diagnosis and pertinent interval history • Brief mental status and observations • Rationale and description of the treatment used that must coincide with objectives on the master treatment plan • Beneficiary's response to treatment that includes current progress or regression and prognosis • Any revisions indicated for the master treatment plan, diagnosis or medication(s) • Plan for next individual therapy session, including any homework assignments and/or advanced psychiatric directive • Staff signature/credentials/date of signature

NOTES	UNIT	BENEFIT LIMITS
Services provided must be congruent with the objectives and interventions articulated on the most recent treatment plan. Services must be consistent with established behavioral healthcare standards. Individual psychotherapy is not permitted with beneficiaries who do not have the cognitive ability to benefit from the service.	30 minutes 45 minutes 60 minutes **View or print the procedure codes for SBMH services.**	DAILY MAXIMUM OF UNITS THAT MAY BE BILLED: 1 YEARLY MAXIMUM OF UNITS THAT MAY BE BILLED (extension of benefits can be requested): 12 units

APPLICABLE POPULATIONS	SPECIAL BILLING INSTRUCTIONS
Children and Youth	A provider may only bill one individual counseling/psychotherapy code per day per beneficiary. A provider cannot bill any other individual counseling/psychotherapy code on the same date of service for the same beneficiary.
ALLOWED MODE(S) OF DELIVERY	**TIER**
Face-to-face	School-Based Mental Health
ALLOWABLE PERFORMING PROVIDERS	**PLACE OF SERVICE (POS)**

• Licensed Certified Social Worker (LCSW) • Licensed Master Social Worker (LMSW) • Licensed Professional Counselor (LPC) • Licensed Associate Counselor (LAC) • Licensed School Psychology Specialist (LSPS) • Licensed Psychological Examiner (LPE) • Psychologist * School-Based Mental Health Services provider employees or contractors will provide services only in those areas in which they are licensed or credentialed.	03

272.170 Group Outpatient – Group Therapy 2-1-22

CPT®/HCPCS PROCEDURE CODE	PROCEDURE CODE DESCRIPTION	
View or print the procedure codes for SBMH services.	A direct service contact between a group of patients and school-based mental health services provider personnel for the purposes of treatment and remediation of psychiatric condition.	
SERVICE DESCRIPTION	**MINIMUM DOCUMENTATION REQUIREMENTS**	
Group Behavioral Health Counseling is a face-to-face treatment provided to a group of beneficiaries. Services leverage the emotional interactions of the group's members to assist in each beneficiary's treatment process, support his/her rehabilitation effort, and to minimize relapse. Services must be congruent with the age and abilities of the beneficiary, client-centered and strength-based; with emphasis on needs as identified by the beneficiary and provided with cultural competence. Services pertain to a beneficiary's (a) Mental Health and/or (b) Substance Abuse condition. Additionally, tobacco cessation counseling is a component of this service.	• Date of Service • Start and stop times of actual group encounter that includes identified beneficiary • Place of service • Number of participants • Diagnosis • Focus of group • Brief mental status and observations • Rationale for group counseling must coincide with master treatment plan • Beneficiary's response to the group counseling that includes current progress or regression and prognosis • Any changes indicated for the master treatment plan, diagnosis, or medication(s) • Plan for next group session, including any homework assignments • Staff signature/credentials/date of signature	
NOTES	**UNIT**	**BENEFIT LIMITS**
This does NOT include psychosocial groups. Beneficiaries eligible for Group Outpatient – Group Psychotherapy must demonstrate the ability to benefit from experiences shared by	Encounter	DAILY MAXIMUM OF UNITS THAT MAY BE BILLED: 1

others, the ability to participate in a group dynamic process while respecting the others' rights to confidentiality, and must be able to integrate feedback received from other group members. For groups of beneficiaries aged 18 and over, the minimum number that must be served in a specified group is 2. The maximum that may be served in a specified group is 12. For groups of beneficiaries under 18 years of age, the minimum number that must be served in a specified group is 2. The maximum that may be served in a specified group is 10. A beneficiary must be 4 years of age to receive group therapy. Group treatment must be age and developmentally appropriate, (i.e., 16 year olds and 4 year olds must not be treated in the same group). Providers may bill for services only at times during which beneficiaries participate in group activities.		YEARLY MAXIMUM OF UNITS THAT MAY BE BILLED (extension of benefits can be requested): Counseling Level Beneficiary: 12 units Rehabilitative/Intensive Level Beneficiary: 104 units
APPLICABLE POPULATIONS	**SPECIAL BILLING INSTRUCTIONS**	
Children, Youth, and Adults	A provider can only bill one Group Behavioral Health Counseling / Community Group Psychotherapy encounter per day. For Counseling Level Beneficiaries, there are 12 total group behavioral health counseling visits allowed per year unless an extension of benefits is allowed by the Quality Improvement Organization contracted with Arkansas Medicaid. For Rehabilitative/Intensive Level Beneficiaries, there are 104 total group behavioral health counseling visits allowed per year unless an extension of benefits is allow by the Quality Improvement Organization contracted with Arkansas Medicaid.	
ALLOWED MODE(S) OF DELIVERY	**TIER**	
Face-to-face	Counseling	
ALLOWABLE PERFORMING PROVIDERS	**PLACE OF SERVICE**	
• Independently Licensed Clinicians – Master's/Doctoral • Non-independently Licensed Clinicians – Master's/Doctoral • Advanced Practice Nurse • Physician	03, 11, 49, 50, 53, 57, 71, 72	

272.200 National Place of Service Code 7-1-07

The national place of service (POS) code is used for both electronic and paper billing.

National Place of Service	National POS Code
Public School	03

272.300 Billing Instructions—Paper Only 11-1-17

Bill Medicaid for professional services with form CMS-1500. The numbered items in the following instructions correspond to the numbered fields on the claim form. **View a sample form CMS-1500.**

Carefully follow these instructions to help the Arkansas Medicaid fiscal agent efficiently process claims. Accuracy, completeness, and clarity are essential. Claims cannot be processed if necessary information is omitted.

Forward completed claim forms to the Arkansas Medicaid fiscal agent Claims Department. **View or print the Claims Department contact information.**

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

272.310 Completion of the CMS-1500 Claim Form 9-1-14

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	

Field Name and Number	Instructions for Completion
ZIP CODE	
TELEPHONE (Include Area Code)	
8. RESERVED	Reserved for NUCC use.
9. OTHER INSURED'S NAME (Last name, First Name, Middle Initial)	If beneficiary 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. RESERVED	Reserved for NUCC use.
SEX	Not required.
c. EMPLOYER'S NAME OR SCHOOL NAME	Required when items 9a and 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.
d. CLAIM CODES	The "Claim Codes" identify additional information about the beneficiary's condition or the claim. When applicable, use the Claim Code to report appropriate claim codes as designated by the NUCC. When required to provide the subset of Condition Codes, enter the condition code in this field. The subset of approved Condition Codes is found at **www.nucc.org** under Code Sets.
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. OTHER CLAIM ID NUMBER	Not required.
c. INSURANCE PLAN NAME OR PROGRAM NAME	Not required.

Field Name and Number	Instructions for Completion
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 9, 9a, 9c and 9d. Only one box can be marked.
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE	Enter "Signature on File," "SOF" or legal signature.
13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE	Enter "Signature on File," "SOF" or legal signature.
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. Enter the qualifier to the right of the vertical dotted line. Use Qualifier 431 Onset of Current Symptoms or Illness; 484 Last Menstrual Period.
15. OTHER DATE	Enter another date related to the beneficiary's condition or treatment. Enter the qualifier between the left-hand set of vertical, dotted lines. The "Other Date" identifies additional date information about the beneficiary's condition or treatment. Use qualifiers: 454 Initial Treatment 304 Latest Visit or Consultation 453 Acute Manifestation of a Chronic Condition 439 Accident 455 Last X-Ray 471 Prescription 090 Report Start (Assumed Care Date) 091 Report End (Relinquished Care Date) 444 First Visit or Consultation
16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION	Not required.
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	Enter the name of the referring physician. 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.

Field Name and Number	Instructions for Completion
19. Local Educational Agency (LEA) Number	Insert LEA number.
20. OUTSIDE LAB?	Not required.
$ CHARGES	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. RESUBMISSION CODE	Reserved for future use.
ORIGINAL REF. NO.	Any data or other information listed in this field does not/will not adjust, void or otherwise modify any previous payment or denial of a claim. Claim payment adjustments, voids, and refunds must follow previously established processes in policy.
23. PRIOR AUTHORIZATION NUMBER	The prior authorization or benefit extension control number if applicable.
24A. DATE(S) OF SERVICE	The "from" and "to" dates of service for each billed service. Format: MM/DD/YY. 1. On a single claim detail (one charge on one line), bill only for services provided within a single calendar month. 2. Providers may bill on the same claim detail for two or more sequential dates of service within the same calendar month when the provider furnished equal amounts of the service on each day of the date sequence.
B. PLACE OF SERVICE	Two-digit national standard place of service code. See Section 272.200 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	One CPT or HCPCS procedure code for each detail.
MODIFIER	Modifier(s) if applicable.

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

Field Name and Number	Instructions for Completion
32. SERVICE FACILITY LOCATION INFORMATION	If other than home or office, enter the name and street, city, state, and zip code of the facility where services were performed.
a. (blank)	Not required.
b. (blank)	Not required.
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.

272.400 Special Billing Procedures 10-13-03

Not applicable to this program.

AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED

Revised: ~~July 1, 2017~~January 1, 2023

CATEGORICALLY NEEDY

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

~~18. Rehabilitative Services (42 CFR 440.130(d)) (continued)~~

~~1. School-Based Mental Health Services (continued)~~

~~f. Covered Services (continued)~~

~~1. Individual Behavioral Health Counseling - A face-to-face treatment provided to an individual in an outpatient setting for the purpose of treatment and remediation of a condition, including tobacco cessation. Services must be congruent with the age and abilities of the beneficiary, client-centered and strength-based; with emphasis on needs as identified by the beneficiary and provided with cultural competence. The treatment service must reduce or alleviate identified symptoms related to either (a) Mental Health or (b) Substance Abuse, and maintain or improve level of functioning, and/or prevent deterioration.~~

~~2. Mental Health Diagnosis - 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 DSM-IV or subsequent revisions. This service may include time spent for obtaining necessary information for diagnostic purposes. The psychodiagnostic process may include, but is not limited to: a psychosocial and medical history, diagnostic findings, and recommendations. This service must include a face-to-face component and will serve as the basis for documentation of modality and issues to be addressed (plan of care). Services must be congruent with the age and abilities of the beneficiary, client-centered and strength-based; with emphasis on needs as identified by the beneficiary and provided with cultural competence.~~

~~3. Psychological Evaluation - Psychological Evaluation for personality assessment includes psychodiagnostic assessment of a beneficiary's emotional, personality, and psychopathology. This service may reflect the mental abilities, aptitudes, interests, attitudes, motivation, emotional and personality characteristics of the beneficiary.~~

(Reserved for future use).

AMOUNT, DURATION AND SCOPE OF
SERVICES PROVIDED

Revised: ~~July 1, 2017~~January 1, 2023

CATEGORICALLY NEEDY

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

~~18. Rehabilitative Services (42 CFR 440.130(d)) (continued)~~

~~School-Based Mental Health Services (continued)~~

~~f. Covered Services (continued)~~

~~**4. Interpretation of Diagnosis - A direct service provided for the purpose of interpreting the results of psychiatric or other medical exams, procedures, or accumulated data. Services may include diagnostic activities and/or advising the beneficiary and his/ her family. Consent forms may be required for family or significant other involvement. Services must be congruent with the age and abilities of the beneficiary, client-centered and strength-based; with emphasis on needs as identified by the beneficiary and provided with cultural competence. The time may be spent face-to-face with the beneficiary; the beneficiary and the parent(s) or guardian(s); or alone with the parent(s) or guardian(s). For beneficiaries over the age of 18, the time may be spent face-to-face with the beneficiary and the spouse, legal guardian or significant other.**~~

~~**5. Marital/Family Behavioral Health Counseling with Beneficiary Present - A face-to-face treatment provided to one or more family members in the presence of a beneficiary for the benefit of the beneficiary, including tobacco cessation. Services must be congruent with the age and abilities of the beneficiary, client-centered and strength-based; with emphasis on needs as identified by the beneficiary and provided with cultural competence. Services are designed to enhance insight into family interactions, facilitate inter-family emotional or practical support and to develop alternative strategies to address familial issues, problems and needs. Services pertain to a beneficiary's (a) Mental Health and/or (b) Substance Abuse condition.**~~

~~**6. Crisis Intervention - An unscheduled, immediate, short-term treatment activity 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, which can include interventions, stabilization activities, coping strategies and other various activities to assist the beneficiary in crisis, are designed to stabilize the person in crisis, prevent further deterioration and provide immediate indicated treatment in the least restrictive setting. The services provided are expected to reduce or eliminate the risk of harm to the person or others in order to stabilize the beneficiary. (These activities include evaluating a Medicaid-eligible beneficiary to determine if the need for crisis services is present.)**~~

(Reserved for future use).

CATEGORICALLY NEEDY

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

~~18. Rehabilitative Services (continued)~~

~~1. School-Based Mental Health Services (42 CFR 440.130(d)) (continued)~~

~~f. Covered Services (continued)~~

~~**7. Group Behavioral Health Counseling - Face-to-face treatment provided to a group of beneficiaries, including tobacco cessation. Services leverage the emotional interactions of the group's members to assist in each beneficiary's treatment process, support his/her rehabilitation effort, and to minimize relapse. Services must be congruent with the age and abilities of the beneficiary, client-centered and strength-based; with emphasis on needs as identified by the beneficiary and provided with cultural competence. Services pertain to a beneficiary's (a) Mental Health and/or (b) Substance Abuse condition.**~~

(Reserved for future use).

MEDICALLY NEEDY

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

~~18. Rehabilitative Services (42 CFR 440.130(d)) (continued)~~

~~1. School-Based Mental Health Services (continued)~~

~~f. Covered Services (continued)~~

~~1. Individual Behavioral Health Counseling - A face-to-face treatment provided to an individual in an outpatient setting for the purpose of treatment and remediation of a condition, including tobacco cessation. Services must be congruent with the age and abilities of the beneficiary, client-centered and strength-based; with emphasis on needs as identified by the beneficiary and provided with cultural competence. The treatment service must reduce or alleviate identified symptoms related to either (a) Mental Health or (b) Substance Abuse, and maintain or improve level of functioning, and/or prevent deterioration.~~

~~2. Mental Health Diagnosis - 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 DSM-IV or subsequent revisions. This service may include time spent for obtaining necessary information for diagnostic purposes. The psychodiagnostic process may include, but is not limited to: a psychosocial and medical history, diagnostic findings, and recommendations. This service must include a face-to-face component and will serve as the basis for documentation of modality and issues to be addressed (plan of care). Services must be congruent with the age and abilities of the beneficiary, client-centered and strength-based; with emphasis on needs as identified by the beneficiary and provided with cultural competence.~~

~~3. Psychological Evaluation - Psychological Evaluation for personality assessment includes psychodiagnostic assessment of a beneficiary's emotional, personality, and psychopathology. This service may reflect the mental abilities, aptitudes, interests, attitudes, motivation, emotional and personality characteristics of the beneficiary.~~

(Reserved for future use).

MEDICALLY NEEDY

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

~~18. Rehabilitative Services (42 CFR 440.130(d)) (continued)~~

~~1. School-Based Mental Health Services (continued)~~

~~f. Covered Services (continued)~~

~~4. Interpretation of Diagnosis – A direct service provided for the purpose of interpreting the results of psychiatric or other medical exams, procedures, or accumulated data. Services may include diagnostic activities and/or advising the beneficiary and his/ her family. Consent forms may be required for family or significant other involvement. Services must be congruent with the age and abilities of the beneficiary, client-centered and strength-based; with emphasis on needs as identified by the beneficiary and provided with cultural competence. The time may be spent face-to-face with the beneficiary; the beneficiary and the parent(s) or guardian(s); or alone with the parent(s) or guardian(s). For beneficiaries over the age of 18, the time may be spent face-to-face with the beneficiary and the spouse, legal guardian or significant other.~~

~~5. Marital/Family Behavioral Health Counseling with Beneficiary Present – A face-to-face treatment provided to one or more family members in the presence of a beneficiary for the benefit of the beneficiary, including tobacco cessation. Services must be congruent with the age and abilities of the beneficiary, client-centered and strength-based; with emphasis on needs as identified by the beneficiary and provided with cultural competence. Services are designed to enhance insight into family interactions, facilitate inter-family emotional or practical support and to develop alternative strategies to address familial issues, problems and needs. Services pertain to a beneficiary's (a) Mental Health and/or (b) Substance Abuse condition.~~

~~6. Crisis Intervention – An unscheduled, immediate, short-term treatment activity 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, which can include interventions, stabilization activities, evaluation, coping strategies and other various activities to assist the beneficiary in crisis, are designed to stabilize the person in crisis, prevent further deterioration and provide immediate indicated treatment in the least restrictive setting. The services provided are expected to reduce or eliminate the risk of harm to the person or others in order to stabilize the beneficiary.~~

~~*Allowable Performing Provider – Independently Licensed Clinician – Master's/Doctoral; Non-Independently Licensed Clinicians – Master's/Doctoral; Advanced Practice Nurse; Physician*~~

(Reserved for future use).

MEDICALLY NEEDY

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

~~18. Rehabilitative Services~~ (42 CFR 440.130(d)) ~~(continued)~~

~~1. School-Based Mental Health Services (continued)~~

~~f. Covered Services (continued)~~

~~**7. Group Behavioral Health Counseling – Face-to-face treatment provided to a group of beneficiaries, including tobacco cessation. Services leverage the emotional interactions of the group's members to assist in each beneficiary's treatment process, support his/her rehabilitation effort, and to minimize relapse. Services must be congruent with the age and abilities of the beneficiary, client-centered and strength-based; with emphasis on needs as identified by the beneficiary and provided with cultural competence. Services pertain to a beneficiary's (a) Mental Health and/or (b) Substance Abuse condition.**~~

(Reserved for future use).

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES - OTHER TYPES OF CARE

Revised: ~~July 1, 2017~~January 1, 2023

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

~~21. Rehabilitative Services~~

~~1. School-Based Mental Health Services~~

~~Reimbursement is based on the lesser of the amount billed or the Title XIX (Medicaid) Maximum charge allowed. The Title XIX Maximum is 80% of the psychologist fee schedule for school-based mental health services provided by school-based mental health services provider personnel except for services provided by a psychologist.~~

~~The Title XIX Medicaid Maximum for school-based mental health services provided by a psychologist is located on Attachment 4.19-B, Page 1o, Item 4.b.(17).~~

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

(Reserved for future use).

SECTION – ADULT BEHAVIORAL HEALTH SERVICES FOR COMMUNITY INDEPENDENCE

CONTENTS

200.000 ADULT BEHAVIORAL HEALTH SERVICES FOR COMMUNITY INDEPENDENCE GENERAL INFORMATION

201.000 Introduction 3-1-19

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

Outpatient Behavioral Health Services may be provided to eligible Medicaid beneficiaries at provider certified/enrolled sites. Allowable places of service are found in the service definitions located in the Reimbursement section of this manual.

202.000 Arkansas Medicaid Participation Requirements for Adult Behavioral Health Services for Community Independence 3-1-19

All Behavioral Health Agencies that provide Adult Behavioral Health Services for Community Independence must meet specified qualifications for their services and for their staff. Providers with multiple service sites must enroll each site separately and reflect the actual service site on billing claims.

Behavioral Health Agencies that provide Adult Behavioral Health Services for Community Independence must meet the Provider Participation and enrollment requirements contained within Section 140.000 of this manual as well as the following criteria to be eligible to participate in the Arkansas Medicaid Program:

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

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

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

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

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

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

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

A. Seriousness of the offense(s)

B. Extent of violation(s)

C. History of prior violation(s)

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

202.100 Certification Requirements by the Division of Provider Services and Quality Assurance (DPSQA) 3-1-19

A Behavioral Health Agency must be certified by DPSQA in order to enroll into the Medicaid program as a Behavioral Health Agency participating in the Medicaid Adult Behavioral Health Services for Community Independence Program must be certified by the DPSQA. The DPSQA Certification Rules for Providers of Outpatient Behavioral Health Services is located at **http://humanservices.arkansas.gov/dbhs/Pages/dbhs_docs.aspx**.

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

210.000 PROGRAM COVERAGE

211.000 Coverage of Services 3-1-19

Adult Behavioral Health Services for Community Independence are limited to certified providers who offer Home and Community Based (HCBS) behavioral health services for the treatment of behavioral disorders. All Behavioral Health Agencies participating in the Adult Behavioral Health Services for Community Independence program must be certified by the Division Provider Services and Quality Assurance.

An Adult Behavioral Health Services for Community Independence provider must establish a site specific emergency response plan that complies with the DPSQA Certification Rules for Behavioral Health Agencies. Each agency site must have 24-hour emergency response capability to meet the emergency treatment needs of the beneficiaries served by the site. 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 Adult Behavioral Health Services for Community Independence providers must demonstrate the capacity to provide effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy and other communication needs.

211.100 Staff Requirements 3-1-19

In order to be certified to provide Adult Behavioral Health Services for Community Independence, each Behavioral Health Agency must ensure that they employ staff who are able and available to provide Adult Behavioral Health Services for Community Independence. In order to provide Adult Behavioral Health Services for Community Independence to be reimbursed on a fee-for-service basis by Arkansas Medicaid, the Behavioral Health Agency must meet all applicable staff requirements as required in the Behavioral Health Agency Certification manual.

Each Adult Behavioral Health Services for Community Independence service has specific provider types that are to be employed by the Behavioral Health Agency which can provide specific services. In order to provide and be reimbursed on a fee-for-services basis by Arkansas Medicaid, the Behavioral Health Agency must adhere to all service specific provider type requirements.

Registered Nursing (RNs) 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. Supervision for all Adult Behavioral Health Services for Community Independence service is required as outlined in the Behavioral Health Agency Certification manual.

PROVIDER TYPE	LICENSES	STATE CERTIFICATION REQUIRED	SUPERVISION
Qualified Behavioral Health Provider – non-degreed	N/A	Yes, to provide services within a certified behavioral health agency	Required
Qualified Behavioral Health Provider – Bachelors	N/A	Yes, to provide services within a certified behavioral health agency	Required
Registered Nurse	Registered Nurse (RN)	No, must be a part of a certified agency	Required

When a Behavioral Health Agency which provides Adult Behavioral Health Services for Community Independence files a claim with Arkansas Medicaid, the staff member who actually performed the service must be identified on the claim as the rendering provider. This action is taken in compliance with the federal Improper Payments Information Act of 2002 (IPIA), Public Law 107-300 and the resulting Payment Error Rate Measurement (PERM) program initiated by the Centers for Medicare and Medicaid Services (CMS).

211.200 Certification of Performing Providers 3-1-19

As illustrated in the chart in § 211.200, certain Outpatient Behavioral Health performing providers are required to be certified by the Division 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** .

211.300 Non-Refusal Requirement 3-1-19

A Behavioral Health Agency may not refuse to provide an Adult Behavioral Health Services for Community Independence service to a Medicaid-eligible beneficiary who meets the requirements for Adult Behavioral Health Services for Community Independence 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 beneficiary so that appropriate provisions can be made.

212.000 Scope 3-1-19

Adult Behavioral Health Services for Community Independence are home and community-based treatment and services which are provided by a Certified Behavioral Health Agency to individuals eligible for Medicaid based upon the following criteria:

1. Beneficiaries receiving Arkansas Medicaid healthcare benefits on a medical Spenddown basis; and

2. Beneficiaries who are eligible for Arkansas Medicaid healthcare benefits under the 06, Medically Frail, Aid Category.

Adult Behavioral Health Services for Community Independence are provided to eligible beneficiaries that have a Behavioral Health diagnosis as described in the American Psychiatric Association Diagnostic and Statistical Manual (DSM-5 and subsequent revisions).

Eligibility for services depends on the needs of the beneficiary. Beneficiaries will be deemed eligible for Adult Behavioral Health Services for Community Independence Rehabilitative Level

Services and Intensive Level Services based upon the results of an Independent Assessment performed by an independent entity. The goal of the Independent Assessment is to determine the care, treatment, or services that will best meet the needs of the beneficiary initially and over time. Please refer to the Independent Assessment Manual for the Independent Assessment Referral Process.

REHABILITATIVE LEVEL SERVICES

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

INTENSIVE LEVEL SERVICES

- The most intensive behavioral health services for the purpose of treating mental health and substance abuse conditions. Services shall be rendered and coordinated through a team based approach. Eligibility for Intensive Level services will be determined by a standardized Independent Assessment. Intensive level Adult Behavioral Health Services for Community Independence treatment services are available—if deemed medically necessary and eligibility is determined by way of the standardized Independent Assessment.

213.000 Treatment Plan **3-1-19**

A Treatment Plan is required for eligible beneficiaries who are determined to be qualified for Adult Behavioral Health Services for Community Independence through the standardized Independent Assessment. The Treatment Plan should build upon the information from any Behavioral Health provider and information obtained during the standardized Independent Assessment.

The Treatment Plan must be included in the beneficiary's medical record and contain a written description of the treatment objectives for that beneficiary. It also must describe:

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

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

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

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

The Treatment Plan for a beneficiary that is eligible for Adult Behavioral Health Services for Community Independence must be completed by a mental health professional within 14 calendar days of the beneficiary entering care (first billable service) or within 14 days of an eligibility determination for beneficiaries receiving Arkansas Medicaid healthcare benefits on a medical Spenddown basis at a certified Behavioral Health Agency and must be signed and dated by a physician licensed in Arkansas. Subsequent revisions in the master treatment plan will be approved in writing (signed and dated) by the mental health professional as well as signed and dated by a physician licensed in Arkansas. Revisions to the Treatment Plan for Adult Behavioral Health Services for Community Independence must occur at least annually, in conjunction with the results from the Independent Assessment. Reimbursement for Treatment Plan revisions more frequently than once per year is not allowed unless there is a documented clinical change in circumstance of the beneficiary or if a beneficiary is re-assessed by the Independent Assessment vendor which results in a change of Tier.

213.100 Beneficiary Participation in the Development of the Treatment Plan 3-1-19

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

214.000 Covered Outpatient Services 3-1-19

Covered outpatient services include home and community-based services to Medicaid-eligible beneficiaries. Beneficiaries eligible for Adult Behavioral Health Services for Community Independence shall be served with an array of treatment services outlined on their Treatment Plan in an amount and duration designed to meet their medical needs.

215.000 Exclusions 3-1-19

Services not covered under the Adult Behavioral Health Services for Community Independence benefit 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 Adult Behavioral Health Services for Community Independence is not allowed for the period of time the Medicaid beneficiary is in transport);**

E. Services to individuals with developmental disabilities which are non-psychiatric in nature;

F. Services which are found not to be medically necessary; and

G. Services provided to nursing home and ICF/IDD residents

216.000 Physician's Role 3-1-19

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

A. Beneficiaries receiving Adult Behavioral Health Services for Community Independence will receive those services through a Behavioral Health Agency, which is required to employ a Medical Director. A physician must review and sign the beneficiary's Treatment Plan, including any subsequent revisions. Medical responsibility will be vested in a physician licensed in Arkansas who signs the Treatment Plan of the beneficiary. If medical responsibility is not vested in a psychiatrist for a Behavioral Health Agency, then psychiatric consultation must be available, in accordance with DPSQA certification requirements.

B. Approval of all updated or revised Treatment Plans must be documented by the physician's dated signature on the revised document and should be completed in conjunction with the beneficiary's Independent Assessment.

217.000 Prescription for Adult Behavioral Health Services for Community Independence 3-1-19

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

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

Beneficiaries determined through an Independent Assessment to be eligible to receive Rehabilitative Level Services (Tier 2) or Intensive Level Services (Tier 3) do not require a Primary Care Physician (PCP referral).

218.000 Authorization for Services 2-1-22

All Adult Behavioral Health Services for Community Independence receiving Arkansas Medicaid healthcare benefits on a medical Spenddown basis are retrospectively reviewed for medical necessity.

View or print the procedure codes requiring retrospective review for authorization and for ABHSCI services.

240.000 REIMBURSEMENT

240.100 Reimbursement 2-1-22

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

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

A. Outpatient Services

Fifteen-Minute Units, unless otherwise stated

Adult Behavioral Health Services for Community Independence 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 Adult Behavioral Health Services for Community Independence service. Providers are not allowed to accumulatively bill for spanning dates of service.

- All billing must reflect a daily total, per Adult Behavioral Health Services for Community Independence service, based on the established procedure codes. No rounding is allowed.

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

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

60 minute Units	Timeframe
One (1) unit =	50-60 minutes
Two (2) units =	110-120 minutes
Three (3) units =	170-180 minutes
Four (4) units =	230-240 minutes
Five (5) units =	290-300 minutes
Six (6) units =	350-360 minutes
Seven (7) units=	410-420 minutes
Eight (8) units=	470-480 minutes

30 Minute Units	Timeframe
One (1) unit =	25-49 minutes
Two (2) units =	50-60 minutes

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

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

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

NOTE: For services provided by a Qualified Behavioral Health Provider (QBHP), the accumulated time for the Adult Behavioral Health Services for Community Independence program service, per date of service, is one total, regardless of the number of QBHPs seeing the beneficiary on that day. For example, two (2) QBHPs see the same beneficiary on the same date of service and provides Adult Life Skills Development. The first QBHP spends a total of 10 minutes with the beneficiary. Later in the day, another QBHP provides Adult Life Skills Development to the same beneficiary and spends a total of 15 minutes. A total of 25 minutes of Behavioral Assistance was provided,

which equals (two) 2 allowable units of service. Only one QBHP may be shown on the claim as the performing provider.

View or print the procedure codes for ABHSCI services.

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.

250.000 BILLING PROCEDURES

251.000 Introduction to Billing 3-1-19

Adult Behavioral Health Services for Community Independence providers use the CMS-1500 form to bill the Arkansas Medicaid Program on paper for services provided to eligible Medicaid beneficiaries. Each claim may contain charges for only one beneficiary. **View a CMS-1500 sample form.**

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

252.000 CMS-1500 Billing Procedures

252.100 Procedure Codes for Types of Covered Services 3-1-19

Adult Behavioral Health Services for Community Independence are billed on a per unit or per encounter basis as listed. All services must be provided by at least the minimum staff within the licensed or certified scope of practice to provide the service.

Benefits are separated by Level of Service.

Prior to reimbursement for Rehabilitative Level Services or Intensive Level Services, a standardized Independent Assessment will determine eligibility and need for Rehabilitative Level Services or Intensive Level Services. The standardized Independent Assessment will be performed by an independent entity as indicated in the Arkansas Medicaid Independent Assessment Manual.

253.000 Rehabilitative Level Services

253.001 Partial Hospitalization 2-1-22

CPT®/HCPCS PROCEDURE CODE	PROCEDURE CODE DESCRIPTION
View or print the procedure codes for ABHSCI services.	Mental health partial hospitalization treatment, less than 24 hours
SERVICE DESCRIPTION	**MINIMUM DOCUMENTATION REQUIREMENTS**

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

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

APPLICABLE POPULATIONS	SPECIAL BILLING INSTRUCTIONS
Adults – Ages 18 and Above	A provider may not bill for any other services on the same date of service.
ALLOWED MODE(S) OF DELIVERY	**TIER**
Face-to-face	Rehabilitative
ALLOWABLE PERFORMING PROVIDERS	**PLACE OF SERVICE**
Partial Hospitalization must be provided in a facility that is certified by the Division of Behavioral Health Services as a Partial Hospitalization provider	11, 49, 52, 53

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

253.002 Adult Rehabilitative Day Service 2-1-22

CPT®/HCPCS PROCEDURE CODE	PROCEDURE CODE DESCRIPTION
QBHP Bachelors or RN QBHP Non-Degreed View or print the procedure codes for ABHSCI services.	Psychosocial rehabilitation services
SERVICE DESCRIPTION	**MINIMUM DOCUMENTATION REQUIREMENTS**
A continuum of care provided to recovering individuals living in the community based on their level of need. This service includes educating and assisting the individual with accessing supports and services needed. The service assists the recovering individual to direct their resources and support systems. Activities include training to assist the person to learn, retain, or improve specific job skills, and to successfully adapt and adjust to a particular work environment. This service includes training and assistance to live in and maintain a household of their choosing in the community. In addition, transitional services to assist individuals adjust after receiving a higher level of care. The goal of this service is to promote and maintain community integration. An array of face-to-face rehabilitative day activities providing a preplanned and structured group program for identified beneficiaries that aimed at long-term recovery and maximization of self-sufficiency, as distinguished from the symptom stabilization function of acute day treatment. These rehabilitative day activities are person- and family-centered, recovery-based, culturally competent, provide needed accommodation for any disability and must have measurable outcomes. These activities assist the beneficiary with compensating for or eliminating functional deficits and interpersonal and/or environmental barriers associated with their chronic mental illness. The intent of these services is to restore the fullest possible integration of the beneficiary as an active and productive member of his/her family, social and work community and/or culture with the least amount of ongoing professional intervention. Skills addressed may include: emotional skills, such as coping with stress, anxiety or anger; behavioral skills, such as proper use of medications, appropriate social interactions and managing overt expression of symptoms like delusions or hallucinations; daily living and self-care skills, such as personal care and hygiene, money management and daily structure/use of	• Date of Service • Names and relationship to the beneficiary of all persons involved • Start and stop times of actual encounter • Place of Service (When 99 is used, specific location and rationale for location must be included) • Client diagnosis necessitating service • Document how treatment used address goals and objectives from the master treatment plan • Information gained from contact and how it relates to master treatment plan objectives • Impact of information received/given on the beneficiary's treatment • Any changes indicated for the master treatment plan which must be documented and communicated to the supervising MHP for consideration • Plan for next contact, if any • Staff signature/credentials/date of signature

time; cognitive skills, such as problem solving, understanding illness and symptoms and reframing; community integration skills and any similar skills required to implement a beneficiary's master treatment plan.		
NOTES	**UNIT**	**BENEFIT LIMITS**
Staff to Client Ratio – 1:15 ratio maximum with the provision that client ratio must be reduced when necessary to accommodate significant issues related to acuity, developmental status and clinical needs.	60 minutes	DAILY MAXIMUM OF UNITS THAT MAY BE BILLED (extension of benefits can be requested): 6 units QUARTERLY MAXIMUM OF UNITS THAT MAY BE BILLED (extension of benefits can be requested): 90 units
APPLICABLE POPULATIONS	**SPECIAL BILLING INSTRUCTIONS**	
Adult – Ages 18 and Above		
ALLOWED MODE(S) OF DELIVERY	**TIER**	
Face-to-face	Rehabilitative	
ALLOWABLE PERFORMING PROVIDERS	**PLACE OF SERVICE**	
• Qualified Behavioral Health Provider – Bachelors • Qualified Behavioral Health Provider – Non-Degreed • Registered Nurse	04, 11, 12, 13, 14, 22, 23, 31, 32, 33, 49, 50, 52, 53, 57, 71, 72, 99	

253.003 Supportive Employment **2-1-22**

CPT®/HCPCS PROCEDURE CODE	**PROCEDURE CODE DESCRIPTION**
View or print the procedure codes for ABHSCI services.	Supportive Employment
SERVICE DESCRIPTION	**MINIMUM DOCUMENTATION REQUIREMENTS**
Supportive Employment is designed to help beneficiaries acquire and keep meaningful jobs in a competitive job market. The service actively facilitates job acquisition by sending staff to accompany beneficiaries on interviews and providing ongoing support and/or on-the-job training once the beneficiary is employed. This service replaces traditional vocational approaches that provide intermediate work experiences (prevocational work units, transitional employment, or sheltered workshops), which tend to isolate beneficiaries	• Date of Service • Names and relationship to the beneficiary of all persons involved • Start and stop times of actual encounter with beneficiary • Place of Service (If 99 is used, specific location and rationale for location must be included) • Client diagnosis necessitating intervention

from mainstream society. Service settings may vary depending on individual need and level of community integration, and may include the beneficiary's home.	• Document how interventions used address goals and objectives from the master treatment plan • Impact of information received/given on the beneficiary's treatment • Any changes indicated for the master treatment plan which must be documented and communicated to the supervising MHP for consideration • Plan for next contact, if any • Staff signature/credentials/date of signature	
NOTES	**UNIT**	**BENEFIT LIMITS**
	60 Minutes	QUARTERLY MAXIMUM OF UNITS THAT MAY BE BILLED (extension of benefits can be requested): 60
APPLICABLE POPULATIONS	**SPECIAL BILLING INSTRUCTIONS**	
Adults – Ages 18 and Above	A provider can bill up to 60 units per quarter (Quarters are defined as January-March, April-June, July-September, October-December) prior to an extension of benefits. A provider cannot bill any H2017 code on the same date of service.	
ALLOWED MODE(S) OF DELIVERY	**TIER**	
Face-to-face	Rehabilitative	
ALLOWABLE PERFORMING PROVIDERS	**PLACE OF SERVICE**	
• Qualified Behavioral Health Provider – Bachelors • Qualified Behavioral Health Provider – Non-Degreed • Registered Nurse	04, 11, 12, 16, 49, 53, 57, 99	

253.004 Supportive Housing **2-1-22**

CPT®/HCPCS PROCEDURE CODE	**PROCEDURE CODE DESCRIPTION**
View or print the procedure codes for ABHSCI services.	Supportive Housing
SERVICE DESCRIPTION	**MINIMUM DOCUMENTATION REQUIREMENTS**
Supportive Housing is designed to ensure that beneficiaries have a choice of permanent, safe, and affordable housing. An emphasis is placed on the development and strengthening of natural supports in the community. This service assists beneficiaries in locating, selecting, and sustaining housing, including transitional	• Date of Service • Names and relationship to the beneficiary of all persons involved • Start and stop times of actual encounter with beneficiary

housing and chemical free living; provides opportunities for involvement in community life; and facilitates the individual's recovery journey. Service settings may vary depending on individual need and level of community integration, and may include the beneficiary's home. Services delivered in the home are intended to foster independence in the community setting and may include training in menu planning, food preparation, housekeeping and laundry, money management, budgeting, following a medication regimen, and interacting with the criminal justice system.	• Place of Service (If 99 is used, specific location and rationale for location must be included) • Client diagnosis necessitating intervention • Document how interventions used address goals and objectives from the master treatment plan • Impact of information received/given on the beneficiary's treatment • Any changes indicated for the master treatment plan which must be documented and communicated to the supervising MHP for consideration • Plan for next contact, if any • Staff signature/credentials/date of signature

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

APPLICABLE POPULATIONS	SPECIAL BILLING INSTRUCTIONS
Adults – Ages 18 and Above	A provider can bill up to 60 units per quarter (Quarters are defined as January-March, April-June, July-September, October-December) prior to an extension of benefits. A provider cannot bill any H2017 code on the same date of service.

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

ALLOWABLE PERFORMING PROVIDERS	PLACE OF SERVICE
• Qualified Behavioral Health Provider – Bachelors • Qualified Behavioral Health Provider – Non-Degreed • Registered Nurse	04, 11, 12, 16, 49, 53, 57, 99

253.005 Adult Life Skills Development 2-1-22

CPT®/HCPCS PROCEDURE CODE	PROCEDURE CODE DESCRIPTION
QBHP Bachelors or RN QBHP Non-degreed View or print the procedure codes for ABHSCI services.	Comprehensive community support services

SERVICE DESCRIPTION	MINIMUM DOCUMENTATION REQUIREMENTS	
Life Skills Development services are designed to assist beneficiaries in acquiring the skills needed to support an independent lifestyle and promote an improved sense of self-worth. Life skills training is designed to assist in setting and achieving goals, learning independent living skills, demonstrate accountability, and making goal-directed decisions related to independent living (i.e., educational/vocational training, employment, resource and medication management, self-care, household maintenance, health, wellness and nutrition). Service settings may vary depending on individual need and level of community integration, and may include the beneficiary's home. Services delivered in the home are intended to foster independence in the community setting and may include training in menu planning, food preparation, housekeeping and laundry, money management, budgeting, following a medication regimen, and interacting with the criminal justice system.	• Date of Service • Names and relationship to the beneficiary of all persons involved • Start and stop times of actual encounter with beneficiary • Place of Service (If 99 is used, specific location and rationale for location must be included) • Client diagnosis necessitating intervention • Document how interventions used address goals and objectives from the master treatment plan • Impact of information received/given on the beneficiary's treatment • Any changes indicated for the master treatment plan which must be documented and communicated to the supervising MHP for consideration • Plan for next contact, if any • Staff signature/credentials/date of signature	
NOTES	**UNIT**	**BENEFIT LIMITS**
	15 Minutes	DAILY MAXIMUM OF UNITS THAT MAY BE BILLED: 8 YEARLY MAXIMUM OF UNITS THAT MAY BE BILLED (extension of benefits can be requested): 292
APPLICABLE POPULATIONS	**SPECIAL BILLING INSTRUCTIONS**	
Adults – Ages 18 and Above		
ALLOWED MODE(S) OF DELIVERY	**TIER**	
Face-to-face	Rehabilitative	
ALLOWABLE PERFORMING PROVIDERS	**PLACE OF SERVICE**	
• Qualified Behavioral Health Provider – Bachelors • Qualified Behavioral Health Provider – Non-Degreed • Registered Nurse	04, 11, 12, 16, 49, 53, 57, 99	

253.006 Peer Support **2-1-22**

CPT®/HCPCS PROCEDURE CODE	PROCEDURE CODE DESCRIPTION

<table>
<tr><td>View or print the procedure codes for ABHSCI services.</td><td colspan="2">Self-help/peer services, per 15 minutes</td></tr>
<tr><td>SERVICE DESCRIPTION</td><td colspan="2">MINIMUM DOCUMENTATION REQUIREMENTS</td></tr>
<tr><td>Peer Support is a consumer centered service provided by individuals (ages 18 and older) who self-identify as someone who has received or is receiving behavioral health services and thus is able to provide expertise not replicated by professional training. Peer providers are trained and certified peer specialists who self-identify as being in recovery from behavioral health issues. Peer support is a service to work with beneficiaries to provide education, hope, healing, advocacy, self-responsibility, a meaningful role in life, and empowerment to reach fullest potential. Specialists will assist with navigation of multiple systems (housing, supportive employment, supplemental benefits, building/rebuilding natural supports, etc.) which impact beneficiaries' functional ability. Services are provided on an individual or group basis, and in either the beneficiary's home or community environment.</td><td colspan="2">• Date of Service
• Names and relationship to the beneficiary of all persons involved
• Start and stop times of actual contact
• Place of Service (When 99 is used, specific location and rationale for location must be included)
• Client diagnosis necessitating service
• Document how treatment used address goals and objectives from the master treatment plan
• Information gained from contact and how it relates to master treatment plan objectives
• Impact of information received/given on the beneficiary's treatment
• Any changes indicated for the master treatment plan which must be documented and communicated to the supervising MHP for consideration
• Plan for next contact, if any
• Staff signature/credentials/date of signature</td></tr>
<tr><td>NOTES</td><td>UNIT</td><td>BENEFIT LIMITS</td></tr>
<tr><td></td><td>15 minutes</td><td>YEARLY MAXIMUM OF UNITS THAT MAY BE BILLED (extension of benefits can be requested): 120</td></tr>
<tr><td>APPLICABLE POPULATIONS</td><td colspan="2">SPECIAL BILLING INSTRUCTIONS</td></tr>
<tr><td>Adults – Ages 18 and Above</td><td colspan="2">Provider can only bill for 120 units (combined between H0038 and H0038, U8) per SFY</td></tr>
<tr><td>ALLOWED MODE(S) OF DELIVERY</td><td colspan="2">TIER</td></tr>
<tr><td>Face-to-face</td><td colspan="2">Rehabilitative</td></tr>
<tr><td>ALLOWABLE PERFORMING PROVIDERS</td><td colspan="2">PLACE OF SERVICE</td></tr>
<tr><td>• Certified Peer Support Specialist
• Certified Youth Support Specialist</td><td colspan="2">03, 04, 11, 12, 13, 14, 15, 16, 22, 23, 31, 32, 33, 34, 49, 50, 52, 53, 57, 71, 72, 99</td></tr>
<tr><td colspan="3">EXAMPLE ACTIVITIES</td></tr>
<tr><td colspan="3">Peer support may include assisting their peers in articulating their goals for recovery, learning and practicing new skills, helping them monitor their progress, assisting them in their treatment, modeling effective coping techniques and self-help strategies based on the specialist's own recovery experience, and supporting them in advocating for themselves to obtain effective services.</td></tr>
</table>

253.007 Treatment Plan 2-1-22

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

NOTES	UNIT	BENEFIT LIMITS
This service may be billed when the beneficiary is determined to be eligible for services. Revisions to the Treatment Plan for Adult Behavioral Health Services for Community Independence must occur at least annually, in conjunction with the results from the Independent Assessment. Reimbursement for Treatment Plan revisions more frequently than once per year is not allowed unless there is a documented clinical change in circumstance of the beneficiary or if a beneficiary is re-assessed by the Independent Assessment vendor which	30 minutes	DAILY MAXIMUM OF UNITS THAT MAY BE BILLED: 2 YEARLY MAXIMUM OF UNITS THAT MAY BE BILLED (extension of benefits can be requested): 4

results in a change of Tier. It is the responsibility of the primary mental health professional to insure that all individuals working with the client have a clear understanding and work toward the goals and objectives stated on the treatment plan.		
APPLICABLE POPULATIONS	**SPECIAL BILLING INSTRUCTIONS**	
Adults – Ages 18 and Above	Must be reviewed annually	
ALLOWED MODE(S) OF DELIVERY	**TIER**	
Face-to-face	Rehabilitative	
ALLOWABLE PERFORMING PROVIDERS	**PLACE OF SERVICE**	
• Independently Licensed Clinicians – Master's/Doctoral • Non-independently Licensed Clinicians – Master's/Doctoral • Advanced Practice Nurse • Physician	03, 04, 11, 12, 14, 33, 49, 50, 53, 57, 71, 72	

253.008 Aftercare Recovery Services **2-1-22**

CPT®/HCPCS PROCEDURE CODE	**PROCEDURE CODE DESCRIPTION**
QBHP Bachelors or RN QBHP Non-Degreed **View or print the procedure codes for ABHSCI services.**	Psychosocial rehabilitation services, per 15 minutes
SERVICE DESCRIPTION	**MINIMUM DOCUMENTATION REQUIREMENTS**
A continuum of care provided to recovering individuals living in the community based on their level of need. This service includes educating and assisting the individual with accessing supports and services needed. The service assists the recovering individual to direct their resources and support systems. Activities include training to assist the person to learn, retain, or improve specific job skills, and to successfully adapt and adjust to a particular work environment. This service includes training and assistance to live in and maintain a household of their choosing in the community. In addition, transitional services to assist individuals adjust after receiving a higher level of care. The goal of this service is to promote and maintain community integration.	• Date of Service • Names and relationship to the beneficiary of all persons involved • Start and stop times of actual encounter • Place of Service (When 99 is used, specific location and rationale for location must be included) • Client diagnosis necessitating service • Document how treatment used address goals and objectives from the master treatment plan • Information gained from contact and how it relates to master treatment plan objectives • Impact of information received/given on the beneficiary's treatment

	• Any changes indicated for the master treatment plan which must be documented and communicated to the supervising MHP for consideration • Plan for next contact, if any • Staff signature/credentials/Date of signature	
NOTES	**UNIT**	**BENEFIT LIMITS**
	15 minutes	YEARLY MAXIMUM OF UNITS THAT MAY BE BILLED (extension of benefits can be requested): 292
APPLICABLE POPULATIONS	**SPECIAL BILLING INSTRUCTIONS**	
Adults – Ages 18 and Above		
ALLOWED MODE(S) OF DELIVERY	**TIER**	
Face-to-face	2	
ALLOWABLE PERFORMING PROVIDERS	**PLACE OF SERVICE**	
• Qualified Behavioral Health Provider – Bachelors • Qualified Behavioral Health Provider – Non-Degreed	03, 04, 11, 12, 13, 14, 15, 16, 22, 23, 31, 32, 33, 34, 49, 50, 52, 53, 57, 71, 72, 99	

254.000 Intensive Level Services 3-1-19

Eligibility for intensive level services is determined by the Intensive Level Services standardized Independent Assessment.

Prior to reimbursement for any intensive level service, a beneficiary must be deemed Tier III by the Behavioral Health Independent Assessment.

Eligibility for entry into a residential setting requires adherence to appropriate Medicaid rules regarding that residential setting. Eligibility for Therapeutic Communities requires that an Individualized Treatment Plan be developed for the beneficiary.

254.001 Therapeutic Communities 2-1-22

CPT®/HCPCS PROCEDURE CODE	**PROCEDURE CODE DESCRIPTION**
Level 1 Level 2 **View or print the procedure codes for ABHSCI services.**	Behavioral health; long-term residential (nonmedical, non-acute care in a residential treatment program where stay is typically longer than 30 days), without room and board, per diem.
SERVICE DESCRIPTION	**MINIMUM DOCUMENTATION REQUIREMENTS**
Therapeutic Communities are highly structured residential environments or continuums of care in which the primary goals are the treatment of behavioral health needs and the fostering of personal growth leading to personal	• Date of Service • Names and relationship to the beneficiary of all persons involved • Place of Service

accountability. Services address the broad range of needs identified by the person served. Therapeutic Communities employs community-imposed consequences and earned privileges as part of the recovery and growth process. In addition to daily seminars, group counseling, and individual activities, the persons served are assigned responsibilities within the therapeutic community setting. Participants and staff members act as facilitators, emphasizing personal responsibility for one's own life and self-improvement. The service emphasizes the integration of an individual within his or her community, and progress is measured within the context of that community's expectation.	• Document how interventions used address goals and objectives from the master treatment plan • Information gained from contact and how it relates to master treatment plan objectives • Impact of information received/given on the beneficiary's treatment • Staff signature/credentials/date of signature	
NOTES	**UNIT**	**BENEFIT LIMITS**
Therapeutic Communities Level will be determined by the following: • Functionality based upon the Independent Assessment Score • Outpatient Treatment History and Response • Medication • Compliance with Medication/Treatment Eligibility for this service is determined by the Intensive Level Services standardized Independent Assessment. Prior to reimbursement for Therapeutic Communities in Intensive Level Services, a beneficiary must be eligible for Rehabilitative Level Services as determined by the standardized Independent Assessment. The beneficiary must then also be determined by an Intensive Level Services Independent Assessment to be eligible for Therapeutic Communities.	Per Diem	DAILY MAXIMUM OF UNITS THAT MAY BE BILLED: 1 YEARLY MAXIMUM OF UNITS THAT MAY BE BILLED (extension of benefits can be requested): 180 185 **View or print the procedure codes for ABHSCI services.**
APPLICABLE POPULATIONS	**SPECIAL BILLING INSTRUCTIONS**	
Adults – Ages 18 and Above	A provider cannot bill any other services on the same date of service.	
	PROGRAM SERVICE CATEGORY	
	Intensive	
ALLOWED MODE(S) OF DELIVERY	**TIER**	
Face-to-face	N/A	
ALLOWABLE PERFORMING PROVIDERS	**PLACE OF SERVICE**	
Therapeutic Communities must be provided in a facility that is certified by the Division of Behavioral Health Services as a Therapeutic Communities provider	14, 21, 51, 55	

255.000 Place of Service Codes 3-1-19

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

Place of Service	POS Codes
Homeless Shelter	04
Office (Behavioral Health Agency Facility Service Site)	11
Patient's Home	12
Assisted Living Facility	13
Group Home	14
Mobile Unit	15
Temporary Lodging	16
Inpatient Hospital	21
Custodial Care Facility	33
Independent Clinic	49
Federally Qualified Health Center	50
Psychiatric Facility – Partial Hospitalization	52
Community Mental Health Center	53
Non-Residential Substance Abuse Treatment Facility	57
Public Health Clinic	71
Rural Health Clinic	72
Other	99

Rules for the Division of Medical Services

Licensure Manual for Community Support System Providers

LAST UPDATED: January 1, ~~2021~~2023

Subchapter 1. General.

101. Authority.

(a) These standards are promulgated under the authority of Ark. Code Ann. §§ 20-38-101 to -113, Ark. Code Ann. §§ 20-48-101 to 1108, Ark. Code Ann. § 25-10-102, and Ark. Code Ann. § 25-15-217.

(b) The Division of Provider Services and Quality Assurance (DPSQA) shall perform all regulatory functions regarding the licensure and monitoring of Community Support System Providers.

102. Purpose.

The purpose of these standards is to:

(1) Serve as the minimum standards for ~~home~~ home and community-based services and facilities;

(2) Ensure there are providers of ~~home~~ home and community-based services that serve the needs of ~~beneficiaries~~clients, including ~~beneficiaries~~clients with ~~complex~~ behavioral health, intellectual disability, and developmental disability service needs; and

(3) Allow a ~~beneficiary~~client to receive from one provider all ~~home~~ home and community-based services identified in the ~~beneficiary~~client's individualized ~~treatment plan~~plan of care.

103. Definitions.

~~(a) "Adult day rehabilitation services" means an array of face-to-face rehabilitative day activities providing a preplanned and structured group program for identified beneficiaries~~clients ~~that aimed at long-term recovery and maximization of self-sufficiency, as distinguished from the symptom stabilization function of acute day treatment. These rehabilitative day activities are person- and family-centered, recovery-based, culturally competent, provide needed accommodation for any disability and must have measurable outcomes.~~

(a) "Adverse agency action" means a denial of a CSSP ~~licensure~~ Agency Certification and any enforcement action taken by DPSQA pursuant to Section 803 to 807.

(b) "Applicant" means an applicant for a CSSP Agency Certification.

~~(c) "Applicant" means an applicant for a CSSP license or CSSP license enhancement.~~

~~(d)~~

(1) "Change of ownership" means any change in greater than fifty percent (50%) of the financial interests, governing body, operational control, or other operational or ownership interests of the CSSP Agency.

(2) "Change in ownership" does not include a change of less than fifty percent (50%) in the membership of the CSSP Agency's 's board of directors, board of trustees, or other governing body.

(c) "Approved accrediting organization" means the Commission on Accreditation of Rehabilitation Facilities (CARF), the Joint Commission, the Council on Accreditation (COA), and the Council on Quality and Leadership (CQL).

(d) "Certification" means a written designation, issued by DHS, declaring that the provider has demonstrated compliance as declared within and defined by this rule.

(e) "Client" means any person for whom a CSSP Agency furnishes, or has agreed or undertaken to furnish, CSSP Agency services.

(f) "Compliance" means conformance with:

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

a. Titles XIX and XXI of the Social Security Act and implementing regulations;

b. Other federal laws and regulations governing the delivery of health care funded in whole or in part by federal funds, for example, 42 U.S.C. § 1320c-5;

c. All state laws and rules applicable to Medicaid generally and to CSSP services specifically;

d. Title VI of the Civil Rights Act of 1964 as amended, and implementing regulations;

e. The Americans With Disabilities Act, as amended, and implementing regulations;

f. The Health Insurance Portability and Accountability Act ("HIPAA"), as amended and implementing regulations.

g. Accreditation standards and requirements

~~(e)~~(g) "Chemical restraint" means the use of medication or any drug that:

(1) Is administered to manage a ~~beneficiary~~client's behavior in a way to reduce the safety risk to the ~~beneficiary~~client or others;

(2) Has the temporary effect of restricting the ~~beneficiary~~client; and

(3) Is not a standard treatment for the resident's medical or psychiatric condition.

~~(f)~~(h) "Community support staff" means an employee who provides direct care services or assistance to ~~beneficiaries~~clients~~, including drivers and attendants.~~ ~~.~~

~~(g)~~(i) "CSSP ~~-~~Agency Certification~~license~~" means a community support system provider that has been certified by DPSQA to provide services included within these standards~~a non-transferable license issued by DPQSA~~.

(j) "CSSP Agency Base Certification" means a CSSP Agency certified by DPSQA to perform CSSP Agency Base Services;

(k) "CSSP Agency ~~license enhancement~~Base Services" means one of the following services each as defined in section 280.000 of the Provider-Led Arkansas Shared Savings Entity (PASSE) Medicaid Manual: ~~an enhancement to a CSSP license that meets additional requirements necessary for a CSSP to offer Adult Day Rehabilitation, Community Reintegration, Therapeutic Communities, or other home- and community-based services at a location operated by the CSSP~~

(A) Adult life skills development;

(B) Supportive Housing;

(C) Supportive Employment

(D) Supportive Life Skills Development (individual and group);

(E) Respite;

(F) Supported Employment;

(G) Supportive Living;

(H) Specialized Medical Supplies;

(I) Adaptive Equipment;

(J) Community Transition Services;

(K) Consultation;

(L) Environmental Modifications; and

(M) Supplemental Support.

(N) Pharmacological Counseling

(O) Therapeutic Host Homes

(l) "CSSP Agency Enhanced Certification" means a CSSP Agency certified by DPSQA to perform:

(1) CSSP Base Services;

(2) CSSP Intensive Services; and

(3) CSSP Enhanced Services.

(4) Services set out in the Counseling Services Medicaid Manual

(m) "CSSP Agency Enhanced Services" means one of the following services each as defined in section 280.000 of the Provider-Led Arkansas Shared Savings Entity (PASSE) Medicaid Manual:

(1) Therapeutic Communities;

(2) Residential Community Reintegration Program;

(3) Adult Rehabilitation Day Treatment;

(4) Substance Abuse Detox (Observational);

(5) Partial Hospitalization;

~~Outpatient Acute Crisis Units; and~~

(6) ~~Residential~~ Complex Care Homes for IDD that house up to eight (8) unrelated ~~setting~~Facilities ~~housing more than four (4)~~ CES Waiver clients diagnosed with an intellectually disability and a significant co-occurring deficit.

(n) "CSSP Agency Intensive Certification" means a CSSP Agency certified by DPSQA to perform:

(1) CSSP Base Services; and

(2) CSSP Intensive Services.

(3) Service set out in the Counseling Services Medicaid Manual

(o) "CSSP Agency Intensive Services" means:

(1) One of the following services each as defined in section 280.000 of the Provider-Led Arkansas Shared Savings Entity (PASSE) Medicaid Manual:

(A) Assertive Community Treatment;

(B) Peer Support;

(C) Aftercare Recovery Support (Substance Abuse);

(D) Intensive In Home Services;

(E) Behavioral Assistance;

(F) Child and Youth Support;

(G) Family Support Partners; ~~and~~

(H) Crisis Stabilization Intervention; ~~or~~

~~One of the services set out in the Counseling Services Medicaid Manual.~~

~~(h)~~

~~(i) "CSSP" means a provider with a CSSP license to provide home- and community-based services.~~

~~(j)~~

~~(1) "CSSP location" means:~~

~~(A) A residential location operated by the CSSP and at which the CSSP offers one or more of the following services to any residents of the residential location:~~

~~(i) Community Reintegration; or~~

~~(ii) Therapeutic Communities; or~~

~~(B) A non-residential location operated by the CSSP and at which the CSSP offers any home- and community-based services.~~

~~(2) "CSSP location" does not include group homes, apartments, or similar locations where residents receive adult day rehabilitation services at another service location.~~

~~(k)~~(p) "Directed in-service training plan" means a plan of action that:

(1) Provides training to assist a CSSP Agency in complying with these standards and correcting deficiencies;

(2) Includes the topics covered in the training and materials used in the training;

(3) Specifies the length of the training;

(4) Specifies the employees required to attend the training; and

(5) Is approved by DPSQA.

(q) "Employee" means an employee, owner, independent contractor, or other agent of a CSSP Agency and includes without limitation full-time employees, part-time employees, transportation contractors, and any other person who acts on behalf of a CSSP Agency or has an ownership, financial, or voting interest in the CSSP Agency.~~:~~ Employee does not mean an independent contractor if:

(1) The independent contractor does not assist in the date to day operations of the CSSP Agency: and

~~(l)~~(2) The independent contractor has no client contact.

~~(m)~~

~~(1) "Enrichment activities" means activities offered to beneficiariesclients that support one or more beneficiaryclient's treatment objectives and needs, but do not constitute home- and community-based services.~~

~~(2) "Enrichment activities" include without limitation yoga, exercise classes, community outings, community events, cooking classes, and support groups.~~

~~(n)~~ "~~Home-~~Home- and community-based services" means services that are available under the Provider-led Arkansas Shared Savings Entity (PASSE) program manual for Medicaid clients who have behavioral health, intellectual disability, or developmental disability service needs ~~:~~

(r)

~~(1) Adult Behavioral Health Services for Community Independence (ABHSCI) program for Medicaid beneficiariesclients who have complex behavioral health needs; and~~

~~(2) The Provider-led Arkansas Shared Savings Entity (PASSE) program for Medicaid beneficiariesclients who have complex behavioral health, intellectual disability, or developmental disability service needs.~~

~~(o) "ITP" means a beneficiaryclient's individualized treatment plan, which is a written, individualized service plan for a CSSP beneficiaryclient to improve or maintain the beneficiaryclient's condition.~~

~~(p)~~

(s) "Licensed professional" means a person who holds possesses a ~~a~~ professional license in good standing in Arkansas.

~~(1)~~(t) "Mental Health Professional (MHP)" means a person who possesses an Arkansas license to provide clinical behavioral health care. The license must be in good standing and not subject to any adverse license action.

~~(2) "Licensed professional" includes independently licensed professionals such as a physician, licensed psychologist, licensed certified social worker (LCSW), independent licensed psychological examiner (LPE-I), licensed professional counselor (LPC), licensed marriage and family therapist (LMFT), advanced practice nurse (APN) with a specialty in psychiatry or mental health, or a clinical nurse specialist (CNS) with a specialty in psychiatry or mental health.~~

~~(3)~~

~~(A) "Licensed professional" includes non-independently licensed professional such as licensed master social worker (LMSW), licensed psychological examiner (LPE), licensed associate counselor (LAC), licensed associate marriage and family therapist (LAMFT), and a provisionally licensed psychologist.~~

~~(B) Non-independently licensed professionals must be clinically supervised by an independently licensed professional.~~

~~(q)~~

~~(1)~~(u) "Marketing" means the accurate and honest advertisement of a CSSP Agency that does not also constitute solicitation.

~~(2)~~(1) "Marketing" includes without limitation:

(A) Advertising using traditional media;

(B) Distributing brochures or other informational materials regarding the services offered by the CSSP Agency;

(C) Conducting tours of the CSSP Agency to interested ~~beneficiaries~~clients and their families;

(D) Mentioning services offered by the CSSP Agency in which the ~~beneficiary~~client or his or her family might have an interest;

(E) Hosting informational gatherings during which the services offered by the CSSP Agency are described.

~~(r)~~(v) "Mechanical restraint" means the use of any device attached or adjacent to the ~~beneficiary~~client's body that the ~~beneficiary~~client cannot easily remove that restricts the ~~beneficiary~~client's freedom of movement or normal access to the ~~beneficiary~~client's body.

~~(s)~~(w) "Medical service encounter" means a medical or psychiatric service to be performed by a licensed professional or other professional allowed to perform the medical or psychiatric service and acting within the scope of his or her practice.

~~(t)~~(x) "Medication error" means the loss of medication, unavailability of medication, falsification of medication logs, theft of medication, missed doses of medication, incorrect medications administered, incorrect doses of medication, incorrect time of administration, incorrect method of administration, and the discovery of an unlocked medication container that is always supposed to be locked.

~~(u)~~

~~(1) "Mobile crisis service" means a short term, on site, face to face therapeutic response to beneficiaries~~clients ~~experiencing a behavioral health crisis for the purpose of assessing, treating, and stabilizing a beneficiary~~client ~~and reducing the immediate risk of danger to the beneficiary~~client ~~or others.~~

~~(2) "Mobile crisis service" includes without limitation:~~

~~(A) Assessment;~~

~~(B) Interventions as needed, including psychiatric consultation and psycho-pharmacological interventions; and~~

~~Referrals and other linkages to all medically necessary services, including home- and community-based services and behavioral health services.~~

(y) "Multidisciplinary team" means a team of individuals lead by a licensed professional who monitors and supervises the delivery of services contained in the individualized plan of care (IPOC) . The licensed professional provides direct supervision of Qualified Community Support Staff and Certified Peer Specialist delivering services in the IPOC

~~(C)~~

~~(v)~~(z) "Plan of correction" means a plan of action that:

(1) Provides the steps a CSSP must take to correct noncompliance with these standards;

(2) Sets a timeframe for each specific action provided in the plan; and

(3) Is approved by DPSQA.

(aa) "Performing provider" means the individual who personally delivers care or service directly to a client.

~~(3)~~

(bb) "Professional service encounter" means any ~~home- and community-based~~professional service to be performed by a licensed professional or other professional allowed to perform the home- and community-based service and acting within the scope of his or her practice.

(cc) "Provider" means an entity that is certified by DHS and enrolled by DMS as a CSSP Agency.

(dd) "Qualified Community Support Provider" means a person who:

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

2. Works under the direct supervision of a mental health professional or as part of a multidisciplinary team under the direct supervision of a licensed professional qualified to treat client's assessed needs;

3. Works as an Arkansas Certified Peer Support under the direct supervision of a mental health professional or as part of a multidisciplinary team under the direct supervision of a licensed professional qualified to treat client's assessed needs;

4. Has successfully completed prescribed and documented courses of initial and annual training sufficient to perform all tasks assigned through the IPOC;

~~(w)~~5. Acknowledges in writing that all qualified community support provider services are controlled by the client's individualized plan of care and provided under the direct supervision of a licensed professional.

~~(x)~~(ee) "Residence" means the address ~~county~~ where a ~~beneficiary~~client is listed as residing in the Arkansas Medicaid Management Information System.

~~(y)~~

~~(1)~~(ff) "Restraint" means the application of physical force for the purpose of restraining the free movement of a resident's body.

(1) "Restraint" does not include:
~~(2)~~

(A) Briefly holding, without undue force, a ~~beneficiary~~client in order to calm or comfort the ~~beneficiary~~client; or

(B) Holding a ~~beneficiary~~client's hand to safely escort a resident from one area to another.

~~(z)~~(gg) "Seclusion" means the involuntary confinement of a resident alone or in a room or an area from which the resident is physically prevented from leaving.

~~(aa)~~(hh) "Serious injury" means any injury to a ~~beneficiary~~client that:

(1) May cause death;

(2) May result in substantial permanent impairment;

(3) Requires the attention of an emergency medical technician, a paramedic, or a doctor; or

(4) Requires hospitalization.

~~(bb)~~

~~(1)~~(ii) "Solicitation" means the initiation of contact with a ~~beneficiary~~client or his or her family by a CSSP when the ~~beneficiary~~client is currently receiving services from another provider and the CSSP is attempting to convince the ~~beneficiary~~client or his or her family to switch to or otherwise use the soliciting CSSP's services.

~~(2)~~(1) "Solicitation" includes without limitation the following acts to induce a ~~beneficiary~~client or his or her family by:

(A) Contacting a ~~beneficiary~~client or the family of a ~~beneficiary~~client that is currently receiving services from another provider;

(B) Offering cash or gift incentives to a ~~beneficiary~~client or his or her family;

(C) Offering free goods or services not available to other similarly situated ~~beneficiaries~~clients or their families;

(D) Making negative comments to a ~~beneficiary~~client or his or her family regarding the quality of services performed by another service provider;

(E) Promising to provide services in excess of those necessary;

(F) Giving a ~~beneficiary~~client or his or her family the false impression, directly or indirectly, that the CSSP is the only service provider that can perform the services desired by the ~~beneficiary~~client or his or her family; or

(G) Engaging in any activity that DPSQA reasonably determines to be "solicitation."

Subchapter 2. ~~Licensing~~Certification.

201. ~~License~~ Certification Require~~d~~ments.

~~(a)~~

~~(1)~~

(a) A CSSP must have ~~a CSSP license~~ one of the following certifications issued by DPSQA pursuant to these standards:

(1) CSSP Agency Base Certification;

(2) CSSP Agency Intensive Certification; or

~~(A)~~(3) CSSP Agency Enhanced Certification.

~~(b)~~ A CSSP Agency cannot provide services outside of the authority provided through ~~a~~its CSSP Agency ~~license~~certification without obtaining a separate credential to provide such services independent of the CSSP Agency ~~license~~certification.

(b)

(c) A CSSP Agency must comply with all requirements of these standards for all home and community-based services provided by the CSSP Agency.

~~(1) A CSSP that offers home- and community-based services at a CSSP location must have a CSSP license enhancement issued by DPSQA pursuant to these standards for the CSSP location.~~

~~(A) A CSSP license enhancement is specific to a single location.~~

~~(B) A separate CSSP license enhancement is required for each location even if the same person or entity has a CSSP license enhancement at other locations.~~

~~(C) A location may only have one CSSP license enhancement attributed to it at any one time.~~

~~(2) A CSSP must comply with all requirements of these standards for all home- and community-based services provided by the CSSP.~~

(d) A CSSP Agency must comply with all requirements of these standards for all home and community-based services provided by the CSSP Agency.

(e) A CSSP Agency must be accredited by an approved accrediting organization for all home and community-based services offered or intended to be offered by the CSSP Agency before DPSQA may issue any CSSP Agency certification.

~~(c)~~

~~(1) A CSSP must be accredited by an approved accrediting organization for all home- and community-based services offered or intended to be offered by the CSSP before DPSQA may issue any CSSP certification license or CSSP license enhancement.~~

~~(2)~~(f) A CSSP Agency must demonstrate its accreditation or accreditations cover each ~~home~~ Home and community-based service the CSSP offers or intends to offer.

~~(3)~~(g) A CSSP Agency must comply with all requirements of its accreditations.

~~(4)~~(h) A loss of a CSSP Agency's ~~'s~~ accreditation constitutes a violation of these standards.

~~(d)~~

~~(1)~~(i) In the event of a conflict between these standards and the requirements of a CSSP~~'s~~ Agency's accreditations, the stricter requirement shall apply.

~~(2)~~(j) In the event of an irreconcilable conflict between these standards and the requirements of a CSSP~~'s~~ Agency's accreditations, these standards shall govern.

202. ~~Licensure~~ Application for Certification.

~~(a)~~

~~(1)~~ (a) To apply for a CSSP Agency ~~license~~certification, an applicant must submit a complete application to DPSQA.

~~(2)~~ (b) A complete application includes:

(1) Documentation demonstrating the applicant's entire ownership, including without limitation all the applicant's financial, governing body, and business interests;

(2) Documentation of the applicant's management, including without limitation the management structure and members of the management team;

(3) Documentation of the ~~applicant's current contractors and the~~employees and contractors that the applicant intends to use as part of operating the CSSP Agency;

(4) Documentation of all required state and national criminal background checks for employees and ~~operators~~contractors;

(5) Documentation of all required ~~C~~drug screens, ~~hild Maltreatment R~~registry checks, and searches ~~Adult Maltreatment Registry checks~~ for employees and ~~operators~~contractors;

(6) Documentation demonstrating compliance with these standards ~~for a CSSP license~~; and

(7) All other documentation or other information requested by DPSQA.

~~(b)~~

~~(1) To apply for a CSSP license enhancement, the applicant must submit:~~

~~(1) A complete application for a CSSP license enhancement;~~

~~(2) Documentation demonstrating compliance with the standards for a CSSP license enhancement; and~~

~~(3) All other documentation or other information requested by DPSQA.~~

~~(2) An applicant may apply for a CSSP license enhancement at the same time the applicant applies for a CSSP license.~~

~~(c) To apply to change the ownership of an existing CSSP, the CSSP must submit a complete application described in section 202(a)(2) regarding the requested new ownership of the CSSP license and CSSP license enhancement, if any.~~

203. ~~Licensure~~ Certification P~~P~~rocess.

(a) DPSQA may approve an application for ~~a~~ CSSP Agency ~~license~~ certification and issue a CSSP Agency ~~license~~ certification if:

(1) The applicant submits a complete application under Section 202(a);

(2) DPSQA determines that all employees and operators have successfully passed all required criminal background and maltreatment checks; and

(3) DPSQA determines that the applicant satisfies these standards.

~~(b) DPSQA may approve an application for a CSSP license enhancement and issue a CSSP license enhancement if:~~

~~(1) The applicant has a CSSP license;~~

~~(2) The applicant submits a complete application under Section 202(b); and~~

~~(3) DPSQA determines that the applicant satisfies the standards for a CSSP license enhancement.~~

~~(c)~~(b) DPSQA may approve an application to change the ownership of an existing CSSP Agency and change the ownership of an existing CSSP ~~license~~ Agency certification ~~and any CSSP license enhancement~~ if:

(1) The applicant submits a complete application under Section 202;

(2) DPSQA determines that all employees and operators have successfully passed all required criminal background and maltreatment checks;

(3) DPSQA determines that the applicant satisfies these standards.

~~(d)~~(c) CSSP ~~licenses and CSSP license enhancements~~Agency certifications ~~-~~do not expire until terminated under these standards.

Subchapter 3. Administration.

301. Organization and Ownership.

(a) A CSSP Agency must be authorized and in good standing to do business under the laws of the State of Arkansas.

~~(b)~~

~~(1)~~(b) A CSSP Agency must appoint a single manager as the point of contact for all DAABH, DDS, DMS, and DPSQA matters and provide DAABH, DDS, DMS, and DPSQA with updated contact information for that manager.

~~(2)~~(1) This manager must have authority over the CSSP Agency and all CSSP Agency employees and be responsible for ensuring that requests, concerns, inquires, and enforcement actions are addressed and resolved to the satisfaction of DAABH, DDS, DMS, and DPSQA.

~~(c)~~

~~(1)~~(c) A CSSP Agency cannot transfer its CSSP Agency c~~license~~ ertification ~~or CSSP license enhancement~~ to any person or entity.

~~(2)~~(1) A CSSP Agency cannot change its ownership unless DPSQA approves the application of the new ownership pursuant to sections 202 and 203.

~~(3)~~(2) A CSSP Agency cannot change its name or otherwise operate under a different name than the listed on the CSSP Agency ~~license~~ certification without notice to DPSQA.

(d) A CSSP Agency must maintain documentation of all accreditations, including without limitation:

(1) Initial accreditations;

(2) Accreditation renewals;

(3) Accreditation surveys or other reviews; and

(4) Accreditation enforcement actions.

302. Employees and Staffing Requirements.

~~(a)~~

~~(1)~~(a) A CSSP Agency must appropriately supervise all ~~beneficiaries~~clients based on each ~~beneficiary~~client's needs.

~~(2)~~(1) A Agency CSSP must have enough employees on-site to supervise ~~beneficiaries~~clients in a CSSP location.

(b) A CSSP Agency must meet the minimum staffing-to-~~beneficiary~~client ratio for each ~~beneficiary~~client as provided in each ~~beneficiary~~client's ~~ITP.~~IPOC.

~~(c)~~

~~(1)~~(c) A CSSP Agency must comply with all requirements applicable to employees under these standards, including without limitation criminal background checks and adult and child maltreatment checks.

~~(2)~~(d) A CSSP Agency ~~-~~must verify an employee still meets all requirements under these standards upon request of DPSQA or whenever the CSSP Agency receives information after hiring that would create a reasonable belief that an employee no longer meets all requirements under the standards including without limitation requirements related to criminal background checks and adult and child maltreatment checks.

~~(d)~~

~~(1)~~(e) A CSSP Agency must conduct child maltreatment, adult maltreatment, and criminal background checks for all employees as required by law.

~~(2)~~(f) Except as provided in this section, all CSSP Agency employees, contractors, subcontractors, interns, volunteers, and trainees, as well as all other persons who have routine contact with ~~beneficiaries~~clients within the CSSP Agency program or who provide services within the CSSP Agency program, must successfully pass all required criminal background checks and adult and child maltreatment checks.

~~(e)~~

~~(1)~~(g) Employees must be eighteen (18) years of age or older and have a high school diploma or a GED. ~~.~~

~~(2) Employees must have at least one of the following:~~

~~(A) A high school diploma or a GED;~~

~~(B) One (1) year of relevant, supervised work experience with a public health, human services, or other community service agency; or~~

~~(C) Two (2) years of experience working with individuals with behavioral health issues or developmental disabilities.~~

~~(3) A beneficiary~~client~~'s legal guardian or custodian is not required to have criminal background checks, child maltreatment checks, or adult maltreatment checks if the legal guardian or custodian only volunteers on a field trip and is not left alone with any beneficiary~~client~~.~~

~~(f)~~

~~(1)~~(h) A CSSP Agency must document all scheduled and actual employee staffing.

~~(2)~~(1) The documentation required for ~~of~~ employee staffing includes without limitation employee names, job title or credential, shift role, shift days, and shift times.

~~(g)~~

~~(1) A CSSP must have a licensed professional for medical services on-site at, or on-call for, a CSSP location.~~

~~(2) If a licensed professional for medical services is on-call, the licensed professional must respond:~~

~~(A) By telephone or in-person within twenty (20) minutes; and~~

~~(B) In-person if required by the circumstances.~~

~~(3) A CSSP must document involvement by a licensed professional for medical services with a beneficiary~~client~~ including without limitation:~~

~~(A) The date and time the licensed professional was contacted;~~

~~(B) The date and time the licensed professional responded;~~

~~(C) The date and time the licensed professional came on-site if the licensed professional was on-call and called in due to the circumstances.~~

303. Employee Training.

~~(a)~~

~~(1)~~(a) All employees of a CSSP Agency must receive ~~the following~~ training on the following topics prior to having any direct contact with clients, and at least once every twelve ~~within thirty~~ (~~30~~12) ~~calendar days after beginning employment~~months thereafter:

(A) ~~Emergency and evacuation procedures~~Identification and prevention of adult and child abuse, exploitation, neglect, and maltreatment;

(B) Mandated reporter requirements and procedures;

(C) Incident and accident reporting;

(D) Basic health and safety practices;

(E) Infection control practices;

(F) Identification and mitigation of unsafe environmental factors;

~~(B)~~(G) Emergency restraint procedures; and

~~(C)~~(H) ~~Reporting incidents and accidents as required in these standards and other applicable law or rule~~Client financial safeguards under Section 308.

(b) All employees must receive at least twelve (12) hours of training prior to having any direct contact with clients, and at least once every twelve (12) months thereafter.~~Employees required to receive the training prescribed in subdivision (a)(1) must receive annual re-training on those topics at least once every twelve (12) months~~

(c) Time spent training on the topics listed in subsection (a) cannot be counted towards the training prescribed in this subsection (b).

(A) ~~(B)~~ The twelve (12) hours of training must include training on the following topics:

(i) Care planning for individuals with intellectual and developmental disabilities;

(ii) Care planning for individuals with autism spectrum disorders;

(iii) De-escalation techniques;

(iv) Behavioral health illnesses; and

(v) Behavioral modification or prevention training.

~~(2) Time spent training on the topics listed in subsection (a)(1) cannot be counted towards the training prescribed in this subsection (a)(2).~~

(d) All employees must obtain and maintain in good standing the following credentials when performing services on behalf of a CSSP Agency:

(A) CPR certification from one of the following:

(i) American Heart Association;

(ii) Medic First Aid, or

(iii) American Red Cross; and

(B) First aid certification from one of the following:

(i) American Heart Association;

(ii) Medic First Aid; or

(iii) American Red Cross.

(e) Employees who have not completed the required certifications cannot be counted towards staffing requirements.

~~(b)~~

(f) Employees assigned to a specific client or group of clients must receive client-specific training in the amount necessary to safely meet the individualized needs of those clients prior to providing services to those clients and at least every 12 months, thereafter. ~~.All employees involved in any way with services provided to beneficiaries or who have routine contact with beneficiaries within the CSSP program must receive the following training before having contact with beneficiaries and no later than thirty (30) calendar days after beginning employment:~~

(2) Client-specific training must at a minimum include training on the following for each client:

~~PCSP;~~

(A) Medication management plan, if applicable;

(B) Behavioral support needs;

(C) Behavioral prevention and intervention plan or Positive Behavioral Support Plan~~;~~

(D) Permitted interventions, if applicable; and

(E) Setting-specific emergency and evacuation procedures.

(3) Client-specific training pursuant to this subsection (fe) may count towards the training requirements of subsection (ba)~~(2)~~.

~~(1) Client-specific training must be conducted at least once every twelve (12) months.~~

~~(A) Twelve (12) hours of training for employees;~~

~~(B) Basic health and safety practices;~~

~~(C) Infection control and infection control practices;~~

~~(D) Identification and mitigation of unsafe environmental factors;~~

~~(E) Identification and prevention of adult and child maltreatment;~~

~~(F) Emergency restraint procedures allowed in these standards; and~~

~~(G) Financial safeguards for beneficiaries required in these standards.~~

~~(2)~~

~~(A) The training required in subdivision (b)(1)(A) must include at least care planning for behavioral health, care planning for individuals with development disabilities, care planning for individuals with intellectual disabilities, social determinants of health, behavioral modification or intervention training, and training for autism spectrum disorders.~~

~~(B) A CSSP must demonstrate that the training provided to satisfy the training required in subdivision (b)(1)(A) sufficiently covers the required topics for the training.~~

~~(C) The training required in subdivision (b)(1)(A) is in addition to the training prescribed in subdivision (b)(1)(B) through (b)(1)(G) and no training can count towards fulfilling the requirements of subdivisions (b)(1)(A) and any requirements in subdivisions (b)(1)(B) through (b)(1)(G).~~

~~(3)~~(g) An employee who is a licensed professional is not required to receive the training prescribed in subdivision (cb) or (~~f~~)~~1~~).

~~(4) Employees required to receive the training prescribed in subdivision (b)(1) must receive annual re-training on~~ subdivision B,1,B through B,1,G ~~those topics at least once every twelve (12) months.~~

~~(c)~~

~~(1) All employees involved in any way with services provided to beneficiaries or who have routine contact with beneficiaries within the CSSP program must obtain and maintain in good standing throughout their employment the following credentials:~~

~~(A) CPR certification by the American Heart Association, Medic First Aid, or the American Red Cross unless a licensed medical professional determines that the employee is incapable of performing CPR; and~~

~~(B) First aid certification by American Heart Association, Medic First Aid, or the American Red Cross unless a licensed medical professional determines that the employee is incapable of performing first aid.~~

~~(2) Employees not certified under subdivision (b)(1) cannot be counted towards staffing requirements.~~

~~(d)~~

~~(1)~~

~~(A) Employees assigned to a specific beneficiary or group of specific beneficiaries must receive training specific to such beneficiaries as required to meet the individualized needs of those beneficiaries.~~

~~(B) Employees must complete training required under subdivision (c)(1)(A) before providing services to the specific beneficiary or group of specific beneficiaries.~~

~~(2) Beneficiary-specific training must include at least the following training for each beneficiary that is sufficient for the employee to meet that beneficiary's needs:~~

~~(A) The beneficiary's ITP;~~

~~(B) The beneficiary's behavior management plan and permitted interventions, if applicable;~~

~~(C) The beneficiary's medication administration and side effects, if applicable;~~

~~(D) The beneficiary's medical needs; and~~

~~(E) Setting-specific emergency and evacuation procedures.~~

304. Employee Records.

(a) A CSSP Agency must maintain a personnel file for each employee that includes:

(1) A detailed job description;

(2) All required criminal background checks;

(3) All required Child Maltreatment Central Registry checks;

(4) All required Adult and Long-term Care Facility Resident Maltreatment Central Registry checks;

(5) All conducted drug screens;

~~(5)~~(6) All required sex offender registry searches;

~~(6)~~(7) Signed statement that the employee will comply with the CSSP~~'s~~ Agency's ~~drug~~ screen and drug use policies;

~~(7)~~(8) Copy of current state or federal identification;

~~(8)~~(9) Copy of valid state-issued driver's license, if driving as required in the job description~~, and documentation of completion of any required driver safety courses~~;

~~(9)~~(10) Documentation demonstrating that the employee received all training required in Section 303;

~~(10)~~

~~(A)~~(11) Documentation demonstrating that the employee obtained and maintained in good standing all certifications required in Section 303;

~~(B)~~(A) If the employee was excepted from any certifications required in Section 303, documentation demonstrating that the employee was excepted from such certifications.

~~(11)~~(12) Documentation demonstrating that the employee obtained and maintained in good standing all professional licensures, certifications, or credentials for the employee or the service the employee is performing that are required for the employee or the service the employee is performing; and

~~(12)~~(13) Documentation demonstrating the employee meets all continuing education, in-service, or other training requirements applicable to that employee under these standards and any professional licensures, certifications, or credentials held by that employee.

(b) A CSSP Agency must retain all employee records for five (5) years from the date an employee is no longer an employee of the CSSP Agency or, if longer, the final conclusion

of all reviews, appeals, investigations, administrative actions, or judicial actions related to that employee that are pending at the end of the five-year period.

305. ~~Beneficiary~~Client Service Records.

~~(a)~~

~~(1)~~(a) A CSSP Agency must maintain a separate, updated, and complete service record for each ~~beneficiary~~client documenting the services provided to the ~~beneficiary~~client and all other documentation required under these standards.

~~(2)~~(b) A CSSP Agency must maintain each ~~beneficiary~~client service record in a uniformly organized manner and available to employees providing services to ~~beneficiaries~~clients as necessary for those employees to provide services.

~~(b)~~(c) A ~~beneficiary~~client's service record must include a summary document at the front that includes:

(1) The ~~beneficiary~~client's full name;

(2) The ~~beneficiary~~client's address and county of residence;

(3) The ~~beneficiary~~client's telephone number and email address, if available;

(4) The ~~beneficiary~~client's date of birth;

(5) The ~~beneficiary~~client's primary language;

(6) The ~~beneficiary~~client's diagnoses;

(7) The ~~beneficiary~~client's medications, dosage, and frequency, if applicable;

(8) The ~~beneficiary~~client's known allergies;

(9) The ~~beneficiary~~client's entry date into the CSSP Agency program;

(10) The ~~beneficiary~~client's exit date from the CSSP program, if applicable;

(11) The ~~beneficiary~~client's Social Security Number;

(12) The ~~beneficiary~~client's Medicaid number;

(13) The ~~beneficiary~~client's commercial or private health insurance information;

(14) The name, address, phone number, email address, if available, of the ~~beneficiary~~client's legal guardian or custodian, if applicable; and

(15) The name, address, and phone number of the ~~beneficiary~~client's primary care physician.

~~(c) A beneficiaryclient's service record must include at least the following information and documentation:~~

~~(1) The beneficiaryclient's ITP for each home- and community-based service that the beneficiaryclient receives from the CSSP;~~

~~(2) The beneficiaryclient's behavioral management prevention and intervention plan, if applicable;~~

~~(3) The beneficiaryclient's daily activity logs or other documentation of home- and community-based service delivery;~~

~~The beneficiaryclient's medication management plan, if applicable;~~

~~(4) andThe client's medication logs;~~

~~(5) Copies of any assessments or evaluations completed on the beneficiaryclient;~~

~~(6) Copies of any orders that place the beneficiaryclient in the custody of another person or entity; and~~

~~(7) Copies of any leases or residential agreements related to the beneficiaryclient's care.~~

~~(d)~~

~~(1)~~(d) A CSSP Agency must ensure that each ~~beneficiary~~client service record is kept confidential and available only to:

(A) Employees who need to know the information contained in the ~~beneficiary~~client's service record;

(B) Persons or entities who need to know the information contained in the ~~beneficiary~~client service record in order to provide services to the ~~beneficiary~~client;

(C) DPSQA and any governmental entity with jurisdiction or other authority to access the ~~beneficiary~~client's service record;

(D) The ~~beneficiary~~client's legal guardian or custodian; and

~~(E)~~ Any other individual authorized in writing by the legal guardian or custodian.

~~(2)~~(E)

~~(A)~~(e) A CSSP Agency must keep ~~beneficiary~~client service records in a file cabinet or room that is always locked.

~~(B)~~

~~(i)~~(A) A CSSP Agency may use electronic records in addition to or in place of physical records to comply with these standards.

~~(ii)~~(B) A CSSP Agency that uses electronic records must take reasonable steps to backup all electronic records and reconstruct a ~~beneficiary~~client's service record in the event of a breakdown in the CSSP's electronic records system.

~~(e)~~(f) A CSSP Agency must retain all ~~beneficiary~~client service records for five (5) years from the date the ~~beneficiary~~client last exits from the CSSP Agency or, if longer, the final conclusion of all reviews, appeals, investigations, administrative actions, or judicial actions related to ~~beneficiary~~client that are pending at the end of the five-year period.

306. Marketing and Solicitation.

(a) A CSSP Agency can market its services.

(b) A CSSP Agency cannot solicit a ~~beneficiary~~client or his or her family.

307. Third-party Service Agreements.

(a) A CSSP Agency may contract in writing with third-party vendors to provide services or otherwise satisfy requirements under these standards.

(b) A CSSP Agency must ensure that all third-party vendors comply with these standards and all other applicable laws, rules, and regulations.

308. Financial Safeguards.

(a) A client shall have full use and access to a client's own funds or other assets, and a CSSP may not limit a client's use or access to a client's own funds or other assets, unless the client or the client's legal guardian or custodian provides informed written consent or the CSSP otherwise has the legal authority to limit a client's use or access of the client's own funds or other assets.

(1) Limitation of a client's use or access includes without limitation designating the amount a client may use or access, limiting the amount a client may use for a particular purpose, and limiting the timeframes during which a client may use or access the client's funds or other assets.

(b) A CSSP may use, manage, or access a client's funds or other assets only for the benefit of the client and only then if the client's legal guardian or custodian provides informed written consent or the CSSP otherwise has the legal authority to use, manage, or access the client's funds or other assets.

(c) The management, use, or access to a client's funds or other assets includes without limitation serving as a representative payee of a client, receiving benefits on behalf of the client, and safeguarding funds or personal property for the client.

(d) A CSSP may use, manage, or access a client's funds or other assets only to the extent permitted by law.

(e) A CSSP must ensure that a client receives the benefit of the goods and services for which the client's funds or other assets are used.

(f) A CSSP must safeguard client funds or other assets whenever a CSSP manages, uses, or has access to a client's funds or other assets.

(g) A CSSP must maintain financial records that document all uses of the client's funds or other assets and comply with generally accepted accounting practices whenever the CSSP manages, uses, or has access to a client's funds or other assets.

(h) A CSSP must, upon request, make available to a client or a client's legal guardian or custodian all financial records related to a client.

(i) A CSSP must maintain separate accounts for each client's funds or other assets whenever the CSSP manages a client's funds or other assets.

(j) All interest derived from a client's funds or other assets shall accrue to the client's account.

309. Emergency Plans and Drills.

(a) A CSSP must have a written emergency plan for all locations in which the CSSP offers home and community-based services, including without limitation client residences and CSSP facilities.

(A) The written emergency plan must provide the procedures to follow in the event of emergencies to safeguard the health and safety of clients and ensure continuity of services to the extent possible.

(B) A written emergency plan must address all foreseeable emergencies including without limitation fires, floods, tornados, utility disruptions,

bomb threats, active shooters, outbreaks of infectious disease, and public health emergencies.

(2) A CSSP must evaluate all written emergency plans at least annually and update as needed.

(b) When a CSSP is not providing home and community-based services to a client in a CSSP location, the written emergency plan must be appropriate for the client and the location in which home and community-based services are provided.

(c) When a CSSP is providing home and community-based services to a client in a CSSP location,

(1) The written emergency plan must include at least:

(A) Designated relocation sites and evacuation routes;

(B) Procedures for notifying legal guardians and custodians of relocation;

(C) Procedures for ensuring each client's safe return to the CSSP community facility or residence;

(D) Procedures to address the special needs of each client;

(E) Procedures to address interruptions in the delivery of home and community-based services;

(F) Procedures for reassigning employee duties in an emergency; and

(G) Procedures for annual training of employees regarding the emergency plan.

(2)

(A) A CSSP must conduct emergency fire drills at least once a month.

(B) A CSSP must conduct other emergency drills as required by the CSSP's accreditation.

(C) A CSSP must document all emergency drills completed and include at least:

(i) The date of the emergency drill;

(ii) The type of emergency drill;

(iii) The time of day the emergency drill was conducted;

(iv) The number of clients participating in the emergency drill;

(v) The length of time taken to complete the emergency drill; and

(vi) Notes regarding any aspects of the emergency procedure or drill that need improvement based on the performance of the emergency drill.

310. Infection Control.

(a)

(1) A CSSP must follow all applicable guidance and directives from the Arkansas Department of Health (ADH) related to infection control including without limitation guidance and directives on preventing the spread of infectious diseases, hand hygiene, handling potentially infectious material, use of personal protective equipment, tuberculosis, blood borne pathogens, and coronaviruses.

(2) A CSSP must provide personal protective equipment for all employees and clients as may be required in the circumstances.

(3) Employees and clients must wash their hands with soap before eating, after toileting, and as otherwise appropriate to prevent the spread of infectious diseases.

(b)

(1) A CSSP cannot allow a client, employee, or any other person who has an infectious disease to enter a CSSP location unless the client or employee is a resident of the CSSP location.

(2) A client who becomes ill while at a CSSP location must be separated from other clients to the extent possible.

(3) The CSSP must notify a client's legal guardian or custodian if the client becomes ill while at a CSSP location.

311. Compliance with State and Federal Laws, Rules, and Other Standards.

(a) A CSSP must comply with all applicable state and federal laws and rules including without limitation:

(1) The Americans with Disabilities Act of 1990 (ADA);

(2) The Disability Rights Act of 1964;

(3) The Health Insurance Portability and Accountability Act (HIPAA);

(4) The Privacy Act of 1974; and

(5) All applicable laws and rules governing the protection of medical, social, personal, financial, and electronically stored records.

(b) A CSSP location must comply with all:

(1) Building codes and local ordinances;

(2) Fire and safety inspections and requirements of the State Fire Marshal or local authorities;

(3) ADH requirements including without limitation requirements regarding water, plumbing, and sewage;

(4) Arkansas Department of Labor and Licensing requirements including without limitation requirements regarding water heaters and boilers; and

(5) Other federal, state, or local requirements applicable to the CSSP location, property, and structures.

(c) A CSSP must maintain documentation of compliance with applicable state, local, and federal laws, rules, codes, and standards.

(d) A violation of any applicable state, local, or federal laws, rules, codes, or standards constitutes a violation of these standards.

(e)

(1) In the event of a conflict between these standards and other applicable state, local, or federal laws, rules, or standards, the stricter requirement shall apply.

In the event of an irreconcilable conflict between these standards and other applicable state, local, or federal laws, rules, or standards these standards shall govern to the extent not governed by federal laws or rules or state law.

312 Emergency Response Services

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

1. A 24-hour emergency telephone number;

2. The applicant/provider must:

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

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

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

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

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

4. Response strategies based upon:

a. Time and place of occurrence;

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

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

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

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

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

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

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

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

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

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

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

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

~~606~~313. Restraints and Other Restrictive Interventions.

(a)

(1) A CSSP cannot use a restraint or seclusion on a client unless:

(A) The restraint is required as an emergency safety intervention; and

(B) The use of the restraint is covered by the CSSP's accreditation.

(2) An emergency safety intervention is required:

(A) An immediate response with a restraint is required to address an unanticipated resident behavior;

(B) The resident behavior places the resident or others at serious threat of harm if no intervention occurs; and

(C) The resident is in a secure CSSP location secure unit.

(b) If a CSSP uses a restraint, the CSSP must:

(1) Comply with the use of the restraint as prescribed by the client's behavior management plan;

(2) Continuously monitor the client during the entire use of the restraint; and

(3) Maintain in-person visual and auditory observation of the client by an employee during the entire use of the restraint.

(c)

(1) A CSSP must document each use of a restraint whether the use was permitted or not.

(2) The documentation must include at least the following:

(A) The behavior precipitating the use of the restraint;

(B) The length of time the restraint was used;

(C) The name of the individual that authorized the use of the restraint;

(D) The names of all individuals involved in the use of the restraint; and

(E) The outcome of the use of the restraint.

~~308. Financial Safeguards.~~

~~(a)~~

~~(1) A beneficiaryclient shall have full use and access to a beneficiaryclient's own funds or other assets, and a CSSP may not limit a beneficiaryclient's use or access to a beneficiaryclient's own funds or other assets, unless the beneficiaryclient or the beneficiaryclient's legal guardian or custodian provides informed written consent or the CSSP otherwise has the legal authority to limit a beneficiaryclient's use or access of the beneficiaryclient's own funds or other assets.~~

~~(2) Limitation of a beneficiaryclient's use or access includes without limitation designating the amount a beneficiaryclient may use or access, limiting the amount a beneficiaryclient may use for a particular purpose, and limiting the timeframes during which a beneficiaryclient may use or access the beneficiaryclient's funds or other assets.~~

~~(b)~~

~~(1)~~

~~(A) A CSSP may use, manage, or access a beneficiaryclient's funds or other assets only for the benefit of the beneficiaryclient and only then if the beneficiaryclient's legal guardian or custodian provides informed written consent or the CSSP otherwise has the legal authority to use, manage, or access the beneficiaryclient's funds or other assets.~~

~~(B) The management, use, or access to a beneficiaryclient's funds or other assets includes without limitation serving as a representative payee of a beneficiaryclient, receiving benefits on behalf of the beneficiaryclient, and safeguarding funds or personal property for the beneficiaryclient.~~

~~(2) A CSSP may use, manage, or access a beneficiaryclient's funds or other assets only to the extent permitted by law.~~

~~(3) A CSSP must ensure that a beneficiaryclient receives the benefit of the goods and services for which the beneficiaryclient's funds or other assets are used.~~

~~(c) A CSSP must safeguard beneficiaryclient funds or other assets whenever a CSSP manages, uses, or has access to a beneficiaryclient's funds or other assets.~~

~~(d)~~

~~(1) A CSSP must maintain financial records that document all uses of the beneficiaryclient's funds or other assets and comply with generally accepted accounting practices whenever the CSSP manages, uses, or has access to a beneficiaryclient's funds or other assets.~~

~~(2) A CSSP must, upon request, make available to a beneficiaryclient or a beneficiaryclient's legal guardian or custodian all financial records related to a beneficiaryclient.~~

~~(e)~~

~~(1) A CSSP must maintain separate accounts for each beneficiaryclient's funds or other assets whenever the CSSP manages a beneficiaryclient's funds or other assets.~~

~~(2) All interest derived from a beneficiaryclient's funds or other assets shall accrue to the beneficiaryclient's account.~~

~~309. Emergency Plans and Drills.~~

~~(a)~~

~~(1) A CSSP must have a written emergency plan for all locations in which the CSSP offers home- and community-based services, including without limitation beneficiaryclient residences and CSSP locations.~~

~~(2)~~

~~(A) The written emergency plan must provide the procedures to follow in the event of emergencies to safeguard the health and safety of beneficiariesclients and ensure continuity of services to the extent possible.~~

~~(B) A written emergency plan must address all foreseeable emergencies including without limitation fires, floods, tornados, utility disruptions, bomb threats, active shooters, outbreaks of infectious disease, and public health emergencies.~~

~~(3) A CSSP must evaluate all written emergency plans at least annually and update as needed.~~

~~(b) When a CSSP is not providing home- and community-based services to a beneficiaryclient in a CSSP location, the written emergency plan must be appropriate for the beneficiaryclient and the location in which home- and community-based services are provided.~~

~~(c) When a CSSP is providing home- and community-based services to a beneficiaryclient in a CSSP location,~~

~~(1) The written emergency plan must include at least:~~

~~(A) Designated relocation sites and evacuation routes;~~

~~(B) Procedures for notifying legal guardians and custodians of relocation;~~

~~(C) Procedures for ensuring each beneficiary~~client~~'s safe return to the CSSP community location or residence;~~

~~(D) Procedures to address the special needs of each beneficiary~~client~~;~~

~~(E) Procedures to address interruptions in the delivery of home and community-based services;~~

~~(F) Procedures for reassigning employee duties in an emergency; and~~

~~(G) Procedures for annual training of employees regarding the emergency plan.~~

~~(2)~~

~~(3) A CSSP must conduct emergency fire drills at least once a month.~~

~~(A) A CSSP must conduct other emergency drills as required by the CSSP's accreditation.~~

~~(B) A CSSP must document all emergency drills completed and include at least:~~

~~(i) The date of the emergency drill;~~

~~(ii) The type of emergency drill;~~

~~(iii) The time of day the emergency drill was conducted;~~

~~(iv) The number of beneficiaries~~clients~~ participating in the emergency drill;~~

~~(v) The length of time taken to complete the emergency drill; and~~

~~(vi) Notes regarding any aspects of the emergency procedure or drill that need improvement based on the performance of the emergency drill.~~

~~310. Infection Control.~~

~~(a)~~

(1) A CSSP must follow all applicable guidance and directives from the Arkansas Department of Health (ADH) related to infection control including without limitation guidance and directives on preventing the spread of infectious diseases, hand hygiene, handling potentially infectious material, use of personal protective equipment, tuberculosis, blood borne pathogens, and coronaviruses.

(2) A CSSP must provide personal protective equipment for all employees and beneficiariesclients as may be required in the circumstances.

(3) Employees and beneficiariesclients must wash their hands with soap before eating, after toileting, and as otherwise appropriate to prevent the spread of infectious diseases.

(b)

(1) A CSSP cannot allow a beneficiaryclient, employee, or any other person who has an infectious disease to enter a CSSP location unless the beneficiaryclient or employee is a resident of the CSSP location.

(2) A beneficiaryclient who becomes ill while at a CSSP location must be separated from other beneficiariesclients to the extent possible.

(3) The CSSP must notify a beneficiaryclient's legal guardian or custodian if the beneficiaryclient becomes ill while at a CSSP location.

311. Compliance with State and Federal Laws, Rules, and Other Standards.

(a) A CSSP must comply with all applicable state and federal laws and rules including without limitation:

(1) The Americans with Disabilities Act of 1990 (ADA);

(2) The Disability Rights Act of 1964;

(3) The Health Insurance Portability and Accounting Act (HIPAA);

(4) The Privacy Act of 1974; and

(5) All applicable laws and rules governing the protection of medical, social, personal, financial, and electronically stored records.

(b) A CSSP location must comply with all:

(1) Building codes and local ordinances;

~~(2) Fire and safety inspections and requirements of the State Fire Marshal or local authorities;~~

~~(3) ADH requirements including without limitation requirements regarding water, plumbing, and sewage;~~

~~(4) Arkansas Department of Labor and Licensing requirements including without limitation requirements regarding water heaters and boilers; and~~

~~(5) Other federal, state, or local requirements applicable to the CSSP location, property, and structures.~~

~~(c) A CSSP must maintain documentation of compliance with applicable state, local, and federal laws, rules, codes, and standards.~~

~~(d) A violation of any applicable state, local, or federal laws, rules, codes, or standards constitutes a violation of these standards.~~

~~(e)~~

~~(1) In the event of a conflict between these standards and other applicable state, local, or federal laws, rules, or standards, the stricter requirement shall apply.~~

~~(2) In the event of an irreconcilable conflict between these standards and other applicable state, local, or federal laws, rules, or standards these standards shall govern to the extent not governed by federal laws or rules or state law.~~

Subchapter 4. Facility Requirements.

401. General Requirements.

(a) A CSSP must meet the home and community-based services settings regulations as established by 42 CFR 441.301(c) (4)-(5).

(1) A CSSP must comply with this subchapter for all CSSP locations.

(b) (1) No A CSSP residential setting location can have house no more than sixteen (16) beneficiariesclients as residents of the CSSP location at any one time.

(2) A CSSP residential setting housing one (1) or more CES Waiver clients can house more than four (4) total clients only if the following requirements are met:

(A) Each client residing in the residential setting must be a CES Waiver client diagnosed with an intellectually disability and a significant co-occurring deficit, which includes without limitation individuals with an intellectual disability and significant:

(i) Behavioral health needs; or

(ii) Physical health needs.

(B) The CSSP residential setting must house no more than eight (8) CES Waiver clients.

(c) Male and female clients cannot share a bedroom.

402. Specific Requirements.

(a) CSSP owned or leased residential settings must meet the following specific requirements:

The interior of the residential setting must:

Be maintained at a comfortable temperature;

Have appropriate interior lighting;

Be well-ventilated;

Have a running source of potable water in the kitchen and each bathroom;

~~Be maintained in a safe, clean, and sanitary condition;~~

~~Be free of:~~

~~Offensive odors;~~

~~Pests;~~

~~Lead-based paint; and~~

~~Hazardous materials.~~

~~The exterior of the residential setting's physical structure must be maintained in good repair, and free of holes, cracks, and leaks, including without limitation the:~~

~~Roof;~~

~~Foundation;~~

~~Doors;~~

~~Windows;~~

~~Siding;~~

~~Porches;~~

~~Patios;~~

~~Walkways; and~~

~~Driveway.~~

~~The surrounding grounds of the residential setting must be maintained in a safe, clean, and manicured condition free of trash and other objects.~~

~~Broken furniture and appliances on or about the premises of a residential setting must immediately be either repaired or appropriately discarded off premises and replaced.~~

~~(b) CSSP owned or leased residential settings must at a minimum include:~~

~~A functioning hot water heater;~~

~~A functioning HVAC unit(s) able to heat and cool;~~

- An operable on-site telephone that is available at all hours and reachable with a phone number for outside callers;
- All emergency contacts and other necessary contact information related to a client's health, welfare, and safety in a readily available location, including without limitation:
  - Poison control;
  - The client's personal care physician; and
  - Local police;
- One (1) or more working flashlights;
- A smoke detector;
- A carbon monoxide detector;
- A first aid kit that includes at least the following:
  - Adhesive band-aids of various sizes;
  - Sterile gauze squares;
  - Adhesive tape;
  - Antiseptic;
  - Thermometer;
  - Scissors;
  - Disposable gloves; and
  - Tweezers;
- Fire extinguishers in number and location to satisfy all applicable laws and rules, but at least one (1) functioning fire extinguisher is required at each residence;
- Screens for all windows and doors used for ventilation;
- Screens or guards attached to the floor or wall to protect floor furnaces, heaters, hot radiators, exposed water heaters, air conditioners, and electric fans;

A reasonably furnished living and dining area;

A kitchen with equipment, utensils, and supplies necessary to properly store, prepare, and serve three (3) meals a day;

Have written instructions and diagrams noting emergency evacuation routes to be used in case of fire, severe weather, or other emergency posted at least every twenty-five (25) feet, in all stairwells, in and by all elevators, and in each room used by clients; and

Lockable storage containers or closets for any chemicals, toxic substances, and flammable substances that must be stored at the residential setting.

(c) CSSP owned or leased residential settings must provide each client with:

An individual bed measuring at least thirty-six (36) inches wide with:

A firm mattress that is at least four (4) inches thick and covered with moisture repellant material;

Pillows; and

Linens, which must be cleaned or replaced at least weekly;

Bedroom furnishings, which at a minimum include:

Shelf space;

A chest of drawers or dresser; and

Adequate closet space for belongings;

An entrance that can be accessed without going through a bathroom or another person's bedroom;

An entrance with a lockable door; and

One (1) or more windows that can open and provide an outside view.

(d) CSSP owned or leased residential settings must meet the following bathroom requirements:

Each bathroom must have the following:

Toilet;

Sink with running hot and cold water;

~~Toilet tissue;~~

~~Liquid soap; and~~

~~Towels or paper towels;~~

~~At least one (1) bathroom in each residential setting must have a shower or bathtub;~~

~~All toilets, bathtubs, and showers must provide for individual privacy; and~~

~~All toilets, bathtubs, and showers must be designed and installed in an accessible manner for the client.~~

~~(e) CSSP owned or leased residential settings that house more than one (1) client must:~~

~~Provide at least fifty (50) square feet of separate bedroom space for each client;~~

~~Provide at least one (1) bathroom with a shower/bathtub, sink, and toilet for every four (4) clients; and~~

~~Provide each client with their own locked storage container for client valuables.~~

~~(f) CSSP owned or leased residential settings that house more than four (4) clients must have lighted "exit" signs at all exit locations.~~

~~(e) A CSSP location must:~~

~~(1) Be heated, air-conditioned, well-lighted, well-ventilated, and well-maintained at a comfortable temperature;~~

~~(2) Be safe, clean, maintained, in good repair, and sanitary, including without limitation as to the CSSP location's exterior, surrounding property, and interior floors and ceilings;~~

~~(3) Be free of offensive odors, pests, and potentially hazardous objects including without limitation explosives and broken equipment;~~

~~(4) Have drinking water available to beneficiaries and employees;~~

~~(5) Have an emergency alarm system throughout the facility to alert employees and beneficiaries when there is an emergency;~~

~~(6) Have at least one (1) toilet and one (1) sink for every twelve (12) beneficiaries, with running hot and cold water, toilet tissue, liquid soap, and paper towels or air dryers;~~

~~(7) Have at least one operable telephone on site that is available at all hours and reachable with a phone number for outside callers;~~

~~(8) Have working smoke and carbon monoxide detectors in all areas used by beneficiaries or employees;~~

~~(9) Have a first aid kit that includes at least the following:~~

~~(A) Adhesive band-aids of various sizes;~~

~~(B) Sterile gauze squares;~~

~~(C) Adhesive tape;~~

~~(D) Roll of gauze bandages;~~

~~(E) Antiseptic;~~

~~(F) Thermometer;~~

~~(G) Scissors;~~

~~(H) Disposable gloves; and~~

~~(I) Tweezers;~~

~~(10) Have enough fire extinguishers in number and location to satisfy all applicable laws and rules, but no fewer than two fire extinguishers;~~

~~(11) Have screens for all windows and doors used for ventilation;~~

~~(12) Have screens or guards attached to the floor or wall to protect floor furnaces, heaters, hot radiators, exposed water heaters, air conditioners, and electric fans;~~

~~(13) Have no lead-based paint;~~

~~(14) Have lighted "exit" signs at all exit locations;~~

~~(15) Have written instructions and diagrams noting emergency evacuation routes and shelters to be used in case of fire, severe weather, or other emergency posted at least every twenty-five (25) feet, in all stairwells, in and by all elevators, and in each room used by beneficiaries;~~

(16) Have a copy of Title VI and VII of the Civil Rights Law of 1964 and all required legal notices prominently posted as required;

(17) Have an emergency power system to provide lighting and power to essential electrical devices throughout the CSSP location, including without limitation power to exit lighting and fire detection, fire alarm, and fire extinguishing systems;

(18) Have chemicals, toxic substances, and flammable substances stored in locked storage cabinets or closets;

(19) Have the CSSP location's telephone, hours of operation, and hours of access, if applicable, posted at all public entrances;

(20) Prohibit the possession of firearms or other weapons except by authorized law enforcement personnel; and

(21) Prohibit smoking, use of tobacco products, and the consumption of prescription medication without a prescription, alcohol, and illegal drugs.

402. Residential Requirements

(a) A CSSP location that houses one or more beneficiaries as a resident must also:

(1) Provide at least twenty (20) square feet of separate bedroom space for each beneficiary;

(2) Provide storage space for personal items in each beneficiary's living space;

(3) Provide at least one (1) window that can open and provide an outside view;

(4) Provide at least three (3) meals daily for each resident, with no more than fourteen (14) hours between any two meals;

(5) Provide separate bedroom areas for male and female beneficiaries;

(6) Provide at least one (1) shower for every six (6) beneficiaries, with running hot and cold water, liquid soap, and bath towels;

(7) Provide a bed measuring at least thirty-six (36) inches wide, linens, pillows, a firm mattress at least four (4) inches thick and covered with moisture repellant material, and other needed household items for each resident;

(8) Provide a locked storage container for beneficiary valuables; and

(9) Provide a dining area for beneficiaries.

Section 403. Setting Exceptions and Variations.

(a) Any client need or behavior that requires a variation or exception to the setting requirements set out in Sections 401 or 402 must be justified in the client's PCSP.

(b) The justification for a variation or exception to any settings requirement set out in Sections 401 or 402 must at a minimum include:

The specific, individualized need or behavior that requires a variation or exception;

The positive interventions and supports used prior to the implementation of the variation or exception;

The less intrusive methods of meeting the need or managing the behavior that were attempted but did not work;

A clear description of the applicable variation or exception;

The regular data collection and reviews that will be conducted to measure the ongoing effectiveness of the variation or exception;

A schedule of periodic reviews to determine if the variation or exception is still necessary or can be terminated;

The informed consent of the client or legal guardian; and

An assurance that interventions and supports will cause no harm to the client.

(b)

(1)

(A) A CSSP location may have secure units and non-secure units.

(B) A CSSP location secure unit is also known as Therapeutic Communities, Level 1.

(2) A CSSP location secure unit must have:

(A) Physical and procedural safeguards appropriate based on the needs of all beneficiariesclients to ensure the safety of all beneficiariesclients and employees; and

(B) Enough employees present in the CSSP location secure unit to ensure the safety of all residents and staff.

~~(3) A CSSP may place a beneficiaryclient in a CSSP location secure unit only if:~~

~~(A) The beneficiaryclient is subject to a court order of commitment to a secure facility; or~~

~~(B) Placement is otherwise required in the beneficiaryclient's ITP.~~

~~(4) A CSSP location secure unit may be exempted from one or more requirements in subdivision (a) for specific beneficiariesclients if such an exemption is required by a court order of commitment or the beneficiaryclient's ITP.~~

~~(5) A CSSP must have plans for each beneficiaryclient in a CSSP location secure unit to transition the beneficiaryclient from the secure unit to a less secure placement.~~

Subchapter 5. Entries and Exits.

501. Entries.

(a) A CSSP may enroll and provide home- and community-based services to a beneficiaryclient who is eligible to receive the home- and community-based services provided.

(b) A CSSP must document the enrollment of all beneficiariesclients in its program.

502. Exits.

(a) A CSSP may exit a beneficiaryclient from its program if the beneficiaryclient becomes ineligible for home- and community-based services, chooses to use another CSSP for his or her home- and community-based services, or for any other lawful reason.

(b) A CSSP must document the exit of all beneficiariesclients from its program.

(c) A CSSP must provide reasonable assistance to all beneficiariesclients exiting its program including without limitation by:

(1) Assisting the beneficiaryclient in transferring to another CSSP or other service provider; and

(2) Providing copies of the beneficiaryclient's service records to the beneficiaryclient, the beneficiaryclient's legal guardian or custodian, and the CSSP or other service provider to which the beneficiaryclient transfers after exiting the program.client

(d) A CSSP shall remain responsible for the health, safety, and welfare of the exiting beneficiaryclient until all transitions to new service providers are complete.

Subchapter 6. Programs and Services.

601. Individualized Treatment Plans

(a)

(1) Each beneficiaryclient must have an ITP that covers each home- and community-based service that is provided to the beneficiaryclient by the CSSP.

(2) An ITP must provide for each home- and community-based service:

(A) In the least restrictive setting possible; and

(B) In the community in which the beneficiaryclient resides, to the extent possible.

(b) Each ITP must include at least:

(1) The beneficiaryclient's treatment objectives;

(2) The beneficiaryclient's treatment regimen, which includes without limitation the specific medical and remedial services, therapies, and enrichment activities that will be used to achieve the beneficiaryclient's treatment objectives and how those services, therapies, and enrichment activities will achieve the treatment objectives;

(3) The evaluations and documentation that supports the medical necessity of the services, therapies, or activities specified in the treatment regimen;

(4) The delivery schedule for the home- and community-based service that includes the frequency and duration of each type of service, therapy, activity, session, or encounter for that home- and community-based service;

(5) The required job title or credential of the employee or employees that will furnish each service, therapy, or activity;

(6) The minimum employee-to-beneficiaryclient ratios required for the beneficiaryclient, if applicable, including without limitation increased or decreased employee-to-staff ratios required for any particular periods or activities;

(7) The setting in which the home- and community-based service will be provided, including if applicable the name and physical address of the place of service;

(8) The written consent of the beneficiaryclient for treatment, or, if the beneficiaryclient lacks capacity, the written consent for treatment by the beneficiaryclient's legal guardian or custodian; and

~~(9) The schedule for completing re-evaluations of the beneficiary~~client~~'s condition and updating the ITP.~~

Subchapter 4. Entries and Exists

401. Entries.

(a) A CSSP Agency may enroll and provide home and community-based services to a client who is eligible to receive the home and community-based services provided.

(b) A CSSP Agency must document the enrollment of all clients in its program.

402. Exits.

(a) A CSSP Agency may exit a client from its program if the client becomes ineligible for home and community-based services, chooses to use another CSSP Agency for his or her home and community-based services, or for any other lawful reason.

(b) A CSSP Agency must document the exit of all clients from its program.

(c) A CSSP Agency must provide reasonable assistance to all clients exiting its program including without limitation by:

(1) Assisting the client in transferring to another CSSP Agency or other service provider; and

(2) Providing copies of the client's service records to the client, the client's legal guardian or custodian, and the CSSP Agency or other service provider to which the client transfers after exiting the program. Records released at a minimum should include treatment summary, current IPOC, medication logs, and other records requested by the client in compliance with clinical discretion as allowed by law and accreditation.

(d) A CSSP Agency shall remain responsible for the health, safety, and welfare of the exiting client until all transitions to new service providers are complete.

Subchapter 5. Incident and Accident Reporting.

501. Incidents to be Reported.

(a) A CSSP Agency must report all alleged, suspected, observed, or reported occurrences of any of the following events.

(1) Death of a client;

(2) Serious injury to a client;

(3) Adult or child maltreatment of a client;

(4) Any event where an employee threatens or strikes a client;

(5) Unauthorized use of a restrictive intervention on a client, including seclusion, a restraint, a chemical restraint, or a mechanical restraint;

(6) Any situation where the whereabouts of a client are unknown for more than one (1) hour;

(7) Any situation where services to the client are interrupted for more than one (1) hour;

(8) Events involving a risk of death, serious physical or psychological injury, or serious illness to a client;

(9) Medication errors made by an employee that cause or have the potential to cause death, serious injury, or serious illness to a client;

(10) Any act or admission that jeopardizes the health, safety, or quality of life of a client;

(11) Motor vehicle accidents involving a client;

(12) A positive case of a client or a staff member for any infectious disease that is the subject of a public health emergency declared by the Governor, ADH, the President of the United States, or the United States Department of Health and Human Services; and

(13) Any event that requires notification of the police, fire department, or coroner.

(b) Any CSSP Agency may report any other occurrences impacting the health, safety, or quality of life of a client.

502. Reporting Requirements.

(a) A CSSP Agency must:

(1) Submit all reports of the following events within one (1) hour of the event:

(A) Death of a client;

(B) Serious injury to a client; and

(C) Any incident that a CSSP Agency should reasonably know might be of interest to the public or the media.

(2) Submit reports of all other incidents within forty-eight (48) hours of the event.

(b) A CSSP Agency must submit reports of all incidents to DPSQA as provided through DPSQA's website: https://humanservices.arkansas.gov/about-dhs/dpsqa.

(c) Reporting under these standards does not relieve a CSSP Agency of complying with other applicable reporting or disclosure requirements under state or federal laws, rules, or regulations.

503. Notification to Custodians and Legal Guardians.

(a) A CSSP Agency must notify the custodian or legal guardian of a client of any reportable incident involving a client, as well as any injury or accident involving a client even if the injury or accident is not otherwise required to be reported in this Section.

(b) A CSSP Agency should maintain documentation evidencing notification required in subdivision (a).

Subchapter 6. Enforcement.

601. Monitoring.

(a)

(1) DPSQA shall monitor a CSSP Agency to ensure compliance with these standards.

(2)

(A) A CSSP Agency must cooperate and comply with all monitoring, enforcement, and any other regulatory or law enforcement activities performed or requested by DPSQA or law enforcement.

(B) Cooperation required under these standards includes without limitation cooperation and compliance with respect to investigations, surveys, site visits, reviews, and other regulatory actions taken by DPSQA or any third-party contracted by DHS to monitor, enforce, or take other regulatory action on behalf of DHS, DDS, DAABH, DMS, or DPSQA.

(b) Monitoring includes without limitation:

(1) On-site surveys and other visits including without limitation complaint surveys and initial site visits;

(2) On-site or remote file reviews;

(3) Requests for documentation and records required under these standards;

(4) Requests for information; and

(5) Investigations related to complaints received.

(c) DHS may contract with a third party to monitor, enforce, or take other regulatory action on behalf of DHS, DDS, DAABH, DMS, or DPSQA.

602. Written Notice of Enforcement Action.

(a) DPSQA shall provide written notice to a CSSP Agency of all enforcement actions taken against a CSSP.

(b) DPSQA shall provide written notice to the CSSP Agency by mailing the imposition of the enforcement action to the manager appointed by the CSSP Agency pursuant to Section 301.

603. Remedies.

(a)

(1) DPSQA shall not impose any remedies imposed by an enforcement action unless:

(A) The CSSP Agency is given notice and an opportunity to be heard pursuant to Section 802 and Subchapter 10; or

(B) DPSQA determines that public health, safety, or welfare imperatively requires emergency action;

(2) If DPSQA imposes a remedy as an emergency action before the CSSP Agency has notice and an opportunity to be heard pursuant to subdivision (a)(1), DPSQA shall:

(A) Provide immediate notice to the CSSP Agency of the enforcement action; and

(B) Provide the CSSP Agency with an opportunity to be heard pursuant to Subchapter 10.

(b) DPSQA may impose on a CSSP Agency any of the following enforcement actions for the CSSP Agency's failure to comply with these standards:

(1) Plan of correction;

(2) Directed in-service training plan;

(3) Moratorium on new admissions;

(4) Transfer of clients;

(5) Monetary penalties;

(6) Suspension of CSSP Agency certification;

(7) Revocation of CSSP Agency certification; and

(8) Any remedy authorized by law or rule including without limitation section 25-15-217 of the Arkansas Code.

(c) DPSQA shall determine the imposition and severity of these enforcement remedies on a case-by-case basis using the following factors:

(1) Frequency of non-compliance;

(2) Number of non-compliance issues;

(3) Impact of non-compliance on a client's health, safety, or well-being;

(4) Responsiveness in correcting non-compliance;

(5) Repeated non-compliance in the same or similar areas;

(6) Non-compliance with previously or currently imposed enforcement remedies;

(7) Non-compliance involving intentional fraud or dishonesty; and

(8) Non-compliance involving violation of any law, rule, or other legal requirement.

(d)

(1) DPSQA shall report any noncompliance, action, or inaction by a CSSP Agency to appropriate agencies for investigation and further action.

(2) DPSQA shall report non-compliance involving Medicaid billing requirements to the DMS, the Arkansas Attorney General's Medicaid Fraud Control Unit, and the Office of Medicaid Inspector General.

(e) These enforcement remedies are not mutually exclusive and DPSQA may apply multiple remedies simultaneously to a failure to comply with these standards.

(f) The failure to comply with an enforcement remedy imposed by DPSQA constitutes a separate violation of these standards.

604. Moratorium.

(a) DPSQA may prohibit a CSSP Agency from accepting new clients.

(b) A CSSP Agency prohibited from accepting new admissions may continue to provide services to existing clients.

605. Transfer of Clients.

(a) DPSQA may require a CSSP Agency to transfer a client to another CSSP Agency if DPSQA finds that the CSSP Agency cannot adequately provide services to the client.

(b) A CSSP Agency must continue providing services until the client is transferred to his or her new service provider of choice.

(c) A transfer of a client may be permanent or for a specific term depending on the circumstances.

606. Monetary Penalties.

(a) DPSQA may impose on a CSSP Agency a civil monetary penalty not to exceed five hundred dollars ($500) for each violation of these standards.

(b)

(1) DPSQA may file suit to collect a civil monetary penalty assessed pursuant to these standards if the CSSP Agency does not pay the civil monetary penalty within sixty (60) calendar days from the date DPSQA provides written notice to the CSSP of the imposition of the civil monetary penalty.

(2) DPSQA may file suit in Pulaski County Circuit Court or the circuit court of any county in which the CSSP Agency is located.

607. Suspension and Revocation of CSSP Certification.

(a)

(1) DPSQA may temporarily suspend a CSSP Agency certification if the CSSP Agency fails to comply with these standards.

(2) If a CSSP Agency's certification is suspended, the CSSP Agency must immediately stop providing CSSP Agency services until DPSQA reinstates its certification

(b)

(1) DPSQA may permanently revoke a CSSP Agency certification if the CSSP Agency fails to comply with these standards.

(2) If a CSSP Agency's certification is revoked, the CSSP Agency must immediately stop providing services and comply with the permanent closure requirements in Section 901(a).

Subchapter 7. Closure.

701. Closure

(a)

(1) A CSSP Agency certification ends if a CSSP Agency permanently closes, whether voluntarily or involuntarily, and is effective the date of the permanent closure as determined by DPSQA.

(2) A CSSP Agency that intends to permanently close, or does permanently close without warning, whether voluntarily or involuntarily, must immediately:

(A) Provide the legal guardian or custodian of each client with written notice of the closure;

(B) Provide the legal guardian or custodian of each client with written referrals to at least three (3) other appropriate service providers;

(C) Assist each client and his or her legal guardian or custodian in transferring services and copies of client records to any new service providers;

(D) Assist each client and his or her legal guardian or custodian in transitioning to new service providers; and

(E) Arrange for the storage of client records to satisfy the requirements in Section 305.

(b)

(1) A CSSP Agency that intends to voluntarily close temporarily due to natural disaster, pandemic, completion of needed repairs or renovations, or for similar circumstances may request to temporarily close its facility while maintaining its CSSP certification for up to one (1) year from the date of the request.

(2) A CSSP Agency must comply with subdivision (a)(2)'s requirements for notice, referrals, assistance, and storage of client records if DPSQA grants a CSSP Agency request for a temporary closure.

(3)

(A) DPSQA may grant a temporary closure if the CSSP Agency demonstrates that it is reasonably likely it will be able to reopen after the temporary closure.

(B) DPSQA shall end a CSSP Agency temporary closure and direct that the CSSP permanently close if the CSSP Agency fails to demonstrate that it is reasonably likely that it will be able to reopen after the temporary closure.

(4)

(A) DPSQA may end a CSSP Agency's temporary closure if the CSSP Agency demonstrates that it is in full compliance with these standards.

(B) DPSQA shall end a CSSP Agency's temporary closure and direct that the CSSP permanently close if the CSSP Agency fails to become fully compliant with these standards within one (1) year from the date of the request.

Subchapter 8. Appeals.

801. Reconsideration of Adverse Regulatory Actions.

(a)

(1) A CSSP Agency may ask for reconsideration of any adverse regulatory action taken by DPSQA by submitting a written request for reconsideration to: Division of Provider Services and Quality Assurance, Office of the Director: Requests for Reconsideration of Adverse Regulatory Actions, P.O. Box 1437, Slot 427, Little Rock, Arkansas 72203.

(2) The written request for reconsideration of an adverse regulatory action taken by DPSQA must be submitted by the CSSP Agency and received by DPSQA within thirty (30) calendar days of the date the CSSP Agency received written notice of the adverse regulatory action.

(3) The written request for reconsideration of an adverse regulatory action taken by DPSQA must include without limitation the specific adverse regulatory action taken, the date of the adverse regulatory action, the name of the CSSP Agency against whom the adverse regulatory action was taken, the address and contact information for the CSSP against whom the adverse regulatory action was taken, and the legal and factual basis for reconsideration of the adverse regulatory action.

(b)

(1) DPSQA shall review each timely received written request for reconsideration and determine whether to affirm or reverse the adverse regulatory action taken based on these standards.

(2) DPSQA may request, at its discretion, additional information as needed to review the adverse regulatory action and determine whether the adverse regulatory action taken should be affirmed or reversed based on these standards.

(c)

(1) DPSQA shall issue in writing its determination on reconsideration within thirty (30) days of receiving the written request for reconsideration or within thirty (30) days of receiving all information requested by DPSQA under subdivision (b)(2), whichever is later.

(2) DPSQA shall issue its determination to the CSSP using the address and contact information provided in the request for reconsideration.

(d) DPSQA may also decide to reconsider any adverse regulatory action on its own accord any time it determines, in its discretion, that an adverse regulatory action is not consistent with these standards.

802. Appeal of Regulatory Actions.

(a)

(1) A CSSP Agency may administratively appeal any adverse regulatory action to the DHS Office of Appeals and Hearings (OAH) except for provider appeals related to the payment for Medicaid claims and services governed by the Medicaid Fairness Act, Ark. Code Ann §§ 20-77-1701 to -1718, which shall be governed by that Act.

(2) OAH shall conduct administrative appeals of adverse regulatory actions pursuant to DHS Policy 1098 and other applicable laws and rules.

(b) A CSSP Agency may appeal any adverse regulatory action or other agency action to circuit court as allowed by the Administrative Procedures Act, Ark. Code Ann. §§ 25-15-201 to -220.

Subchapter 9. Intensive Level Services

~~608~~901. CSSP Intensive Certification Service Requirements.

(a) CSSP Intensive Certification must meet all standards applicable to CSSP Basic Certification found in subchapters 3 to 8, in addition to the requirements set out in this subchapter.

Intensive CSSP Agency Certification

902. Employees and Staffing Requirements.

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

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

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

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

2. Corporate Compliance Officer:

a. Manages policy, practice standards and compliance

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

c. Has no direct responsibility for billings or collections;

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

3. Medical Director:

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

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

vii. Medical director services may be acquired by contract.
a. Be accountable for all medical services that may be delivered by a CSSP Agency;

b. Be responsible for CSSP Agency medical care and service quality and compliance;

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

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

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

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

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

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

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

a. Be accountable for all services (professional and paraprofessional) that may be delivered by a CSSP Agency;

b. Be responsible for CSSP Agency care and service quality and compliance;

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

d. Assure that licensed professionals directly supervise Qualified Community Support Staff in accordance with service provided;

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

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

a. Provide counseling services as defined in the Medicaid Counseling Services manual.

4. Multidisciplinary Team Leader (Individual who has licensure and training applicable to the treatment of the individual client indicated in the individualized plan of care)

a. Develop an individualized plan of care which directs the provision of services;
b. Monitor and supervise the delivery of services contained in the individualized plan of care;
c. Monitor and supervise work assignments of Certified Peer Specialists;
d. Provide direct supervision of Qualified Community Support Staff ;
e. Provide case consultation and in-service training;
f. Periodically (in accordance with a schedule tailored to the client's condition and care needs and previously recorded in the provider's official records) communicate individualized client-specific instructions to the Qualified Community Support Staff describing the manner and methods for the delivery of paraprofessional services;

4. Qualified Community Support Staff
Provide Home and Community Based Service under the supervision of a licensed Multidisciplinary Team Leader.

5. Certified Peer Support Specialist
Must meet all certification requirements as set forth by the Division of Aging, Adult and Behavioral Health Services (DAABHS)

903. Employee Training

Qualified Community Support Staff must complete all training requirements for CSSP Base Agency

In addition to the training curriculum for CSSP Agency Base training must contain information specific to the population being served, i.e. child and adolescent, adult, dually diagnosed, etc. The curriculum must include, but is not limited to:

6. Record keeping: including observing beneficiary, reporting or recording observations, time, or employment records.
8. Knowledge of appropriate relationships with beneficiary.
9. Group interaction.
11. Listening techniques.
12. Confidentiality.
18. Awareness of community resources to sustains individuals within community settings.
19. Cultural competency.
20. Ethical issues in practice.
21. Childhood development, if serving the child and adolescent population.

iv. There must be written examination of the Qualified Community Support Staff
vi. The Qualified Community Support Staff who successfully completes the training must be awarded a certificate. This certificate must state the person is qualified to work in an agency under professional supervision as a Qualified Community Support Staff .
vii. In-service training sessions are required at a minimum of once per 12-month period after the successful completion of the initial training for Qualified Community Support Staff. The in-service training must total a minimum of eight (8) hours each 12-month period beginning with the date of certification as a Qualified Behavioral Health Provider and each 12-month period thereafter. The in-service training may be conducted, in part, in the field. Documentation of in-service hours will be maintained in the employee's personnel record and will be available for inspection by regulatory agencies.

~~(a)~~ ~~(b)~~

~~(1) A CSSP must provide all services as prescribed in each beneficiary's ITP, including home- and community-based services.~~

~~(2)~~

~~(A) A CSSP is not required to meet the requirements in paragraphs (b) and (c) below for beneficiaries who are unavailable for services, but only to the extent the beneficiary is actually unavailable for services.~~

(B) A beneficiary is unavailable for services if the beneficiary is:

(i) In an ineligible setting including without limitation a hospital, jail, or extended home visit; or

(ii) Unable to participate in services due to being diagnosed with COVID-19, flu, or other conditions as determined by the beneficiary's primary care or attending physician or the Arkansas Department of Health.

(b) For community reintegration, a CSSP must:

(1) Provide educational services to all beneficiaries either at the CSSP location or at a local school if that is appropriate and compliant with Arkansas Department of Education requirements;

(2) Provide at least twenty (20) hours of home- and community-based services for each beneficiary per week, with at least five (5) hours provided by community support staff on an individual basis and not in a group setting;

(3) Provide at least one (1) medical service encounter for each beneficiary per month;

(4) Provide at least three (3) professional service encounters for each beneficiary per week, including at least one (1) professional service encounters on an individual basis and not in a group setting; and

(5) Provide enrichment activities for each beneficiary based on each beneficiary's treatment objectives and needs.

(c) For therapeutic communities, a CSSP must:

(1) Provide at least twenty (20) hours of adult rehabilitation day treatment for each beneficiary per week, which may include time from medical and professional service encounters;

(2) Provide at least fifteen (15) hours of additional home- and community-based services for each beneficiary per week, which may include time from medical and professional service encounters and time from adult rehabilitation day treatment in excess of the twenty (20) hours required in subdivision (c)(1);

(3) Provide at least one (1) medical service encounter for each beneficiary per month;

(4) Provide at least three (3) professional service encounters for each beneficiary per week, including at least one (1) professional service encounters on an individual basis and not in a group setting; and

~~(5) Provide enrichment activities for each beneficiary based on each beneficiary's treatment objectives and needs.~~

~~(d) For mobile crisis services, a CSSP must:~~

~~(1) Provide mobile crisis services twenty-four (24) hours a day, seven (7) days a week; and~~

~~(2) Provide all mobile crisis services with a licensed professional.~~

Subchapter 10. CSSP Enhanced Certification

1001. CSSP Enhanced Certification Service Requirements.

(a) CSSP Enhanced Certification must meet all standards applicable to CSSP Base and Intensive Certification in addition to the requirements set out in this subchapter.

~~**Subchapter 4. Facility Requirements.**~~

1002. General Requirements.

(a) A CSSP must meet the home and community-based services settings regulations as established by 42 CFR 441.301(c) (4)-(5).

(b)

(1) A CSSP Agency Therapeutic Community or Community Reintegration Program can house no more than sixteen (16) clients.

(2) A CSSP facility housing one (1) or more CES Waiver clients can house more than four (4) total clients only if the following requirements are met:

(A) Each client residing in the facility must be a CES Waiver client diagnosed with an intellectually disability and a significant co-occurring deficit, which includes without limitation individuals with an intellectual disability and significant:

(i) Behavioral health needs; or

(ii) Physical health needs.

(B) The CSSP facility must house no more than eight (8) CES Waiver clients.

(c) Male and female clients cannot share a bedroom.

1003. Specific Requirements.

(a) CSSP Agency Enhanced owned or leased facilities must meet the following specific requirements:

(1) The interior of the facility must:

(A) Be maintained at a comfortable temperature;

(B) Have appropriate interior lighting;

(C) Be well-ventilated;

(D) Have a running source of potable water in the kitchen and each bathroom;

(E) Be maintained in a safe, clean, and sanitary condition;

(F) Be free of:

(i) Offensive odors;

(ii) Pests;

(iii) Lead-based paint; and

(iv) Hazardous materials.

(2) The exterior of the facility's physical structure must be maintained in good repair, and free of holes, cracks, and leaks, including without limitation the:

(A) Roof;

(B) Foundation;

(C) Doors;

(D) Windows;

(E) Siding;

(F) Porches;

(G) Patios;

(H) Walkways; and

(I) Driveway.

(3) The surrounding grounds of the facility must be maintained in a safe, clean, and manicured condition free of trash and other objects.

(4) Broken furniture and appliances on or about the premises of a facility must immediately be either repaired or appropriately discarded off premises and replaced.

(b) CSSP owned or leased facilities must at a minimum include:

(1) A functioning hot water heater;

(2) A functioning HVAC unit(s) able to heat and cool;

(3) An operable on-site telephone that is available at all hours and reachable with a phone number for outside callers;

(4) All emergency contacts and other necessary contact information related to a client's health, welfare, and safety in a readily available location, including without limitation:

(A) Poison control;

(B) The client's personal care physician; and

(C) Local police;

(5) One (1) or more working flashlights;

(6) A smoke detector;

(7) A carbon monoxide detector;

(8) A first aid kit that includes at least the following:

(A) Adhesive band-aids of various sizes;

(B) Sterile gauze squares;

(C) Adhesive tape;

(D) Antiseptic;

(E) Thermometer;

(F) Scissors;

(G) Disposable gloves; and

(H) Tweezers;

(9) Fire extinguishers in number and location to satisfy all applicable laws and rules, but at least one (1) functioning fire extinguisher is required at each residence;

(10) Screens for all windows and doors used for ventilation;

(11) Screens or guards attached to the floor or wall to protect floor furnaces, heaters, hot radiators, exposed water heaters, air conditioners, and electric fans;

(12) A reasonably furnished living and dining area;

(13) A kitchen with equipment, utensils, and supplies necessary to properly store, prepare, and serve three (3) meals a day;

(14) Written instructions and diagrams noting emergency evacuation routes to be used in case of fire, severe weather, or other emergency posted at least every twenty-five (25) feet, in all stairwells, in and by all elevators, and in each room used by clients; and

(15) Lockable storage containers or closets for any chemicals, toxic substances, and flammable substances that must be stored at the facility.

(c) CSSP owned or leased facilitys must provide each client with:

(1) An individual bed measuring at least thirty-six (36) inches wide with:

(1) A firm mattress that is at least four (4) inches thick and covered with moisture repellant material;

(2) Pillows; and

(3) Linens, which must be cleaned or replaced at least weekly;

(2) Bedroom furnishings, which at a minimum include:

(1) Shelf space;

(2) A chest of drawers or dresser; and

(3) Adequate closet space for belongings;

(3) An entrance that can be accessed without going through a bathroom or another person's bedroom;

(4) An entrance with a lockable door; and

(5) One (1) or more windows that can open and provide an outside view.

(d) CSSP owned or leased facility must meet the following bathroom requirements:

(1) Each bathroom must have the following:

(A) Toilet;

(B) Sink with running hot and cold water;

(C) Toilet tissue;

(D) Liquid soap; and

(E) Towels or paper towels;

(2) At least one (1) bathroom in each facility must have a shower or bathtub;

(3) All toilets, bathtubs, and showers must provide for individual privacy; and

(4) All toilets, bathtubs, and showers must be designed and installed in an accessible manner for the client.

(e) CSSP owned or leased facilities that house more than one (1) client must:

(1) Provide at least fifty (50) square feet of separate bedroom space for each client;

(2) Provide at least one (1) bathroom with a shower/bathtub, sink, and toilet for every four (4) clients; and

(3) Provide each client with their own locked storage container for client valuables.

(f) CSSP owned or leased facilities that house more than four (4) clients must have lighted "exit" signs at all exit locations.

1004. Setting Exceptions and Variations.

(a) Any client need or behavior that requires a variation or exception to the setting requirements set out in Sections 401 or 402 must be justified in the client's PCSP.

(b) The justification for a variation or exception to any settings requirement set out in Sections 401 or 402 must at a minimum include:

(1) The specific, individualized need or behavior that requires a variation or exception;

(2) The positive interventions and supports used prior to the implementation of the variation or exception;

(3) The less intrusive methods of meeting the need or managing the behavior that were attempted but did not work;

(4) A clear description of the applicable variation or exception;

(5) The regular data collection and reviews that will be conducted to measure the ongoing effectiveness of the variation or exception;

(6) A schedule of periodic reviews to determine if the variation or exception is still necessary or can be terminated;

(7) The informed consent of the client or legal guardian; and

(8) An assurance that interventions and supports will cause no harm to the client.

(4)

(A) A CSSP location may have secure units and non-secure units.

(B) A CSSP location secure unit is also known as Therapeutic Communities, Level 1.

(5) A CSSP location secure unit must have:

(A) Physical and procedural safeguards appropriate based on the needs of all clients to ensure the safety of all clients and employees; and

(B) Enough employees present in the CSSP location secure unit to ensure the safety of all residents and staff.

(6) A CSSP may place a client in a CSSP location secure unit only if:

(A) The client is subject to a court order of commitment to a secure facility; or

(B) Placement is otherwise required in the client's ITP.

(7) A CSSP location secure unit may be exempted from one or more requirements in subdivision (a) for specific clients if such an exemption is required by a court order of commitment or the client's ITP.

(8) A CSSP must have plans for each client in a CSSP location secure unit to transition the client from the secure unit to a less secure placement.

1005. General Nutrition and Food Service Requirements.

(a)

(1) A CSSP must ensure that any meals, snacks, or other food services provided to clients by the CSSP conform to U.S. Department of Agriculture guidelines including without limitation portion size, ADH requirements, and other applicable laws and rules.

(2) All food brought in from outside sources must be:

(A) From food service providers approved by ADH and transported per ADH requirements;

(B) In individual, commercially pre-packaged containers; or

(C) Individual meals or snacks brought from home by a client or a client's family.

(3)

(A) A violation of U.S. Department of Agriculture guidelines, ADH requirements, or other applicable laws or rules related to nutrition and food service constitutes a violation of these standards.

(B) In the event of a conflict between these standards and the requirements of U.S. Department of Agriculture guidelines, ADH requirements, or other applicable laws or rules related to nutrition and food service, the stricter requirement shall apply.

(C) In the event of an irreconcilable conflict between these standards and the requirements of U.S. Department of Agriculture guidelines, ADH requirements, or other applicable laws or rules related to nutrition and food service, these standards shall govern the extent not governed by federal laws or rules or state law.

(b)

(1) A CSSP must ensure that food provided to clients meets the specialized diet requirements of each client arising from medical conditions or other individualized needs including without limitation allergies, diabetes, and hypertension.

(2) A CSSP must ensure that all food prepared on-site is prepared, cooked, served, and stored in a manner that protects against contamination and spoilage.

(3) A CSSP must not use a perishable food item after its expiration date;

(4) A CSSP must keep all food service surfaces clean and in sanitary condition.

(5) A CSSP must serve all food on individual plates, bowls, or other dishes that can be sanitized or discarded.

(6) A CSSP must ensure that all food scraps are placed in garbage cans with airtight lids and bag liners that are emptied as necessary and no less than once every day.

(7) A CSSP must store all food separately from medications, medical items, or hazardous items.

(8)

(A) A CSSP must ensure that all refrigerators used for food storage are maintained at a temperature of 41 degrees Fahrenheit or below.

(B) A CSSP must ensure that all freezers used for food storage are maintained at a temperature of 0 degrees Fahrenheit or below.

(9) A CSSP must have a licensed professional for medical services on-site at, or on-call for, a CSSP location.

(10) If a licensed professional for medical services is on call, the licensed professional must respond:

a. In-person or remotely within twenty (20) minutes; and

b. In-person if required by the circumstances.

(11) A CSSP must document involvement by a licensed professional for medical services with a client including without limitation:

a. The date and time the licensed professional was contacted;

b. The date and time the licensed professional responded;

c. The date and time the licensed professional came on site if the licensed professional was on call and called in due to the circumstances.

1006. Medications.

(a) A client can self-administer medication as provided in the client's ITP.

(b)

a. A CSSP can administer medication only as provided in the client's ITP or prescribed or otherwise ordered by a physician or other health care professional authorized to prescribe or otherwise order medication.

b. A CSSP can administer medication only by licensed nurses or other health care professionals authorized to administer medication.

c. A CSSP cannot administer prescription medication to a client without a prescription documented in the client's service record.

(c)

a. A CSSP must develop a medication management plan for all clients, if applicable.

b. A medication management plan must include without limitation:

i. The name of each medication;

ii. The name of the prescribing physician or other health care professional if the medication is by prescription;

iii. A description of each medication prescribed and any symptom or symptoms to be addressed by each medication;

iv. How each medication will be administered, including without limitation times of administration, doses, delivery, and persons who may lawfully administer each medication;

v. How each medication will be charted;

vi. A list of the potential side effects caused by each medication; and

vii. The consent to the administration of each medication by the client or, if the client lacks capacity, by the client's legal guardian or custodian.

(d)

a. A CSSP must maintain a medication log in a uniformly organized manner detailing the administration of all medication to a client, including without limitation prescribed medication and over-the-counter medication.

b. Each medication log must be available at each location in which a client receives home and community-based services and must document the following for each administration of a medication:

i. The name and dosage of medication administered;

ii. The symptom for which the medication was used to address;

iii. The method the medication was administered;

iv. The date and time the medication was administered;

v. The name of the employee who administered the medication or assisted in the administration of the medication;

vi. Any adverse reaction or other side effect from the medication;

vii. Any transfer of medication from its original container into individual dosage containers by the client's legal guardian or custodian;

viii. Any error in administering the medication and the name of the supervisor to whom the error was reported; and

ix. The prescription and the name of the prescribing physician or other health care professional if the medication was not previously listed in the medication management plan.

c. Medication errors must be:

i. Immediately reported to a supervisor;

ii. Documented in the medication log; and

iii. Reported as required under all applicable laws and rules including without limitation the laws and rules governing controlled substances.

(e) All medications stored for a client by a CSSP must be:

a. Kept in the original medication container unless the client's legal guardian or custodian transfers the medication into individual dosage containers;

b. Labeled with the client's name;

c. Stored in an area, medication cart, or container that is always locked; and

d. Returned to a client's legal guardian or custodian, or destroyed or otherwise disposed of in accordance with applicable laws and rules, if the medication is no longer to be administered to a client.

(f) A CSSP must store all medications requiring cold storage in a separate refrigerator that is used only for the purpose of storing medications.

1007. Daily Service Logs.

(a)

(1) A CSSP must document daily the delivery of each home and community-based service provided to a client.

(2) Documentation required may be satisfied by a daily service log or other documentation of home and community-based service delivery.

(b) The daily service log or other documentation of home and community-based service delivery must include at least:

(1) The specific home and community-based service provided;

(2) The date each home and community-based service was provided by the CSSP;

(3) The beginning and ending time each home and community-based service was provided by the CSSP;

(4) The name, title, and credential of each person providing home and community-based service for each date and time;

(5) The relationship of the home and community-based service to the treatment objectives described in the client's ITP; and

(6) Progress notes that describe each client's status and progress toward the client's treatment objectives.

(c)

(1) Each daily service log entry must be signed by the employee responsible for the home and community-based service or services provided.

(2) Each daily service log entry must be included in the client's service record.

~~**602. Daily Service Logs.**~~

~~(a)~~

~~(1) A CSSP must document daily the delivery of each home- and community-based service provided to a beneficiary~~client~~.~~

(2) Documentation required may be satisfied by a daily service log or other documentation of home- and community-based service delivery.

(b) The daily service log or other documentation of home- and community-based service delivery must include at least:

(1) The specific home- and community-based service provided;

(2) The date each home- and community-based service was provided by the CSSP;

(3) The beginning and ending time each home- and community-based service was provided by the CSSP;

(4) The name, title, and credential of each person providing home- and community-based service for each date and time;

(5) The relationship of the home- and community based service to the treatment objectives described in the beneficiaryclient's ITP; and

(6) Progress notes that describe each beneficiaryclient's status and progress toward the beneficiaryclient's treatment objectives.

(c)

(1) Each daily service log entry must be signed by the employee responsible for the home- and community-based service or services provided.

(2) Each daily service log entry must be included in the beneficiaryclient's service record.

603. Arrivals, Departures, and Transportation.

(a)

(1) A CSSP must ensure that beneficiariesclients safely arrive to and depart from a CSSP location and safely transition to and from the location where home- and community-based services are provided when the services are not provided at a CSSP location.

(2)

(A) A CSSP must document the arrival and departure of each beneficiaryclient to and from a CSSP location.

(B) Documentation of arrivals and departures to and from CSSP locations must include without limitation the beneficiaryclient's name, age, and date of

birth, date and time of arrival and departure, name of the person or entity that provided transportation, and method of transportation.

(3)

(A) A manager or designee of a CSSP must:

(i) Review the beneficiaryclient arrival and departure documentation each day and compare it with the CSSP's attendance record;

(ii) Sign and date the beneficiaryclient arrival and departure documentation verifying that all beneficiariesclients for the day safely arrived to and departed from the CSSP location.

(B) A CSSP must maintain beneficiaryclient arrival and departure documentation for one (1) year from the date of transportation.

(b) The requirements in subdivisions (c) through (f) apply to all transportation provided by a CSSP.

(1) Transportation to which these requirements apply includes without limitation transportation provided to a beneficiaryclient by any person or entity on behalf of the CSSP and regardless of whether the person is an employee, or the transportation is a billed service; and

(2) Transportation to which these requirements apply also includes periodic transportation, including without limitation transportation provided at the request of a beneficiaryclient's legal guardian or custodian to have a beneficiaryclient occasionally dropped off or picked up due to a scheduling conflict with the legal guardian or custodian.

(c)

(1) All employees transporting beneficiariesclients or present in vehicles during the transportation of beneficiariesclients shall meet the following requirements before transporting beneficiariesclients:

(A) Be at least twenty-one (21) years of age or the minimum age required by the CSSP's commercial automobile insurance, whichever is higher;

(B) Hold a current valid driver's license or commercial driver's license as required by state law; and

(C) Successfully complete a driver safety training course.

(2)

(A) The staff-to-beneficiaryclient ratio in a vehicle in which beneficiariesclients are transported must be at least 1 staff for every eight (8) beneficiariesclients if any beneficiaryclient is less than eighteen (18) years old.

(B) The staff-to-beneficiaryclient ratio in a vehicle in which beneficiariesclients are transported must be at least 1 staff for every fifteen (15) beneficiariesclients if all beneficiaryclient are eighteen (18) years old or older.

(d)

(1) Each vehicle used to transport beneficiariesclients must:

(A) Be licensed and maintained in proper working condition, including without limitation air conditioning and heating systems; and

(B) Have a seating space and a specific appropriate restraint system for each beneficiaryclient transported.

(2)

(A) Any vehicle designed or used to transport eight (8) or more passengers and one (1) driver must have a safety alarm device.

(B) The safety alarm device must:

(i) Always be in working order and properly maintained;

(ii) Installed so that the driver is required to walk to the very back of the vehicle to reach the switch that deactivates the alarm;

(iii) Be installed correctly in accordance with the device manufacturer's recommendations; and

(iv) Sound the alarm for at least one minute after the activation of the safety alarm device.

(3)

(A) A CSSP must maintain commercial insurance coverage for any vehicle used to transport beneficiariesclients.

(B) The commercial insurance coverage must include at least:

(i) $100,000 combined single limit;

(ii) $100,000 for uninsured motorist;

(iii) $100,000 for under-insured motorist; and

(iv) $5,000 personal injury protection for each passenger based on the number of passengers the vehicle is manufactured to transport.

(C) A CSSP must maintain documentation of all required commercial insurance coverage.

(e)

(1) A CSSP must maintain a roster of beneficiariesclients for each vehicle each day listing the driver, other persons, and name, age, date of birth, and emergency contact information for all beneficiariesclients that will be transported in that vehicle.

(A) The daily roster shall be used to check beneficiariesclients on and off the vehicle when they are picked up or dropped off at home, the CSSP location, or other location.

(B) The employee who conducts the walk-through required by subdivision (f) must sign the vehicle roster once the employee confirms that all beneficiariesclients have exited the vehicle.

(2)

(A) A manager or designee of a CSSP must:

(i) Review the daily roster each day and compare it with the CSSP's attendance record;

(ii) Sign and date the daily roster verifying that all beneficiariesclients for the day safely arrived to and departed from home, the CSSP location, or other location.

(B) A CSSP must maintain the daily roster for one (1) year from the date of transportation.

(f)

(1) An employee must walk through a vehicle used to transport beneficiariesclients after each trip and physically inspect each seat after unloading to ensure that no beneficiariesclients are left on the vehicle.

(2) The walk-through inspection for any vehicles designed or used to transport eight (8) or more passengers and one (1) driver must be conducted in one of the following ways:

(A)

(i) An employee unloads all beneficiariesclients from the vehicle, walks or otherwise moves through the interior of the vehicle to ensure that no beneficiariesclients remain on board, and deactivates the safety alarm device.

(ii) This option can only be used if all beneficiariesclients are able to unload from the vehicle in less than one (1) minute.

(B)

(i) An employee supervises the beneficiariesclients during unloading and a second employee immediately walks or otherwise moves through the interior of the vehicle to ensure that no beneficiariesclients remain on board and deactivates the safety alarm device.

(ii) The employee who deactivated the safety alarm device will remain near the safety alarm device deactivation switch until all beneficiariesclients have unloaded to ensure that no beneficiaryclient is left on board.

(iii) This option will require at least two (2) employees, one to supervise the beneficiariesclients and one to remain near the safety alarm device deactivation switch.

(C)

(i) An employee deactivates the safety alarm device and unloads all beneficiariesclients immediately upon arrival.

(ii) Immediately after unloading, an employee will start the vehicle and move it to a different location for final parking, which must reactivate the safety alarm device.

(iii) An employee deactivates the safety alarm device and walks or otherwise moves through the interior of the vehicle to ensure that no beneficiariesclients remain on board and deactivates the safety alarm device.

604. Medications.

(a) A beneficiaryclient can self-administer medication as provided in the beneficiaryclient's ITP.

(b)

(1) A CSSP can administer medication only as provided in the beneficiaryclient's ITP or prescribed or otherwise ordered by a physician or other health care professional authorized to prescribe or otherwise order medication.

(2) A CSSP can administer medication only by licensed nurses or other health care professionals authorized to administer medication.

(3) A CSSP cannot administer prescription medication to a beneficiaryclient without a prescription documented in the beneficiaryclient's service record.

(c)

(1) A CSSP must develop a medication management plan for all beneficiariesclients.

(2) A medication management plan must include without limitation:

(A) The name of each medication;

(B) The name of the prescribing physician or other health care professional if the medication is by prescription;

(C) A description of each medication prescribed and any symptom or symptoms to be addressed by each medication;

(D) How each medication will be administered, including without limitation times of administration, doses, delivery, and persons who may lawfully administer each medication;

(E) How each medication will be charted;

(F) A list of the potential side effects caused by each medication; and

(G) The consent to the administration of each medication by the beneficiaryclient or, if the beneficiaryclient lacks capacity, by the beneficiaryclient's legal guardian or custodian.

(d)

~~(1) A CSSP must maintain a medication log in a uniformly organized manner detailing the administration of all medication to a beneficiaryclient, including without limitation prescribed medication and over-the-counter medication.~~

~~(2) Each medication log must be available at each location in which a beneficiaryclient receives home- and community-based services and must document the following for each administration of a medication:~~

~~(A) The name and dosage of medication administered;~~

~~(B) The symptom for which the medication was used to address;~~

~~(C) The method the medication was administered;~~

~~(D) The date and time the medication was administered;~~

~~(E) The name of the employee who administered the medication or assisted in the administration of the medication;~~

~~(F) Any adverse reaction or other side effect from the medication;~~

~~(G) Any transfer of medication from its original container into individual dosage containers by the beneficiaryclient's legal guardian or custodian;~~

~~(H) Any error in administering the medication and the name of the supervisor to whom the error was reported; and~~

~~(I) The prescription and the name of the prescribing physician or other health care professional if the medication was not previously listed in the medication management plan.~~

~~(3) Medication errors must be:~~

~~(A) Immediately reported to a supervisor;~~

~~(B) Documented in the medication log; and~~

~~(C) Reported as required under all applicable laws and rules including without limitation the laws and rules governing controlled substances.~~

~~(e) All medications stored for a beneficiaryclient by a CSSP must be:~~

~~(1) Kept in the original medication container unless the beneficiaryclient's legal guardian or custodian transfers the medication into individual dosage containers;~~

~~(2) Labeled with the beneficiaryclient's name;~~

(3) Stored in an area, medication cart, or container that is always locked; and

(4) Returned to a beneficiaryclient's legal guardian or custodian, or destroyed or otherwise disposed of in accordance with applicable laws and rules, if the medication is no longer to be administered to a beneficiaryclient.

(f) A CSSP must store all medications requiring cold storage in a separate refrigerator that is used only for the purpose of storing medications.

605. Behavior Management Plans.

(a)

(1)

(A) A CSSP shall develop and implement a written behavior management plan for a beneficiaryclient if a beneficiaryclient's behavioral issues are disruptive, persistent, and may jeopardize the beneficiaryclient's placement or increase the risk of harm to the beneficiaryclient or others.

(B) Such behaviors may include without limitation destructive, aggressive, suicidal, homicidal, or sexual acting out behaviors.

(2) A behavior management plan:

(A) May be included in a beneficiaryclient's ITP;

(B) Must involve the fewest and shortest interventions possible; and

(C) Cannot punish or use interventions that are physically or emotionally painful, frighten, or put the beneficiaryclient at medical risk.

(b)

(1) All written behavior management plans must include at least the following:

(A) Each behavior to be decreased or increased;

(B) Events or other stimuli that may trigger a beneficiaryclient's behavior to be decreased or increased;

(C) What should be provided or avoided in a beneficiaryclient's environment to incentivize or disincentivize behaviors to be decreased or increased;

(D) Specific methods employees should use to manage a beneficiaryclient's behaviors and whether restraints are permitted as an intervention subject to Section 606;

(E) Interventions or other actions for employees to take if a triggering event occurs; and

(F) Interventions or other actions for employees to take if a behavior to be decreased or increased occurs.

(2) If a behavior management plan permits the use of restraints as an intervention, the behavior management plan must also include:

(A) The specific need for the use of a restraint that is particularized to the beneficiaryclient and the restraint permitted;

(B) Other interventions and supports to be used prior to a restraint;

(C) The specific restraint permitted, how long the restraint may be used, and how often the restraint must be reviewed to determine if the restraint is still necessary or can be terminated;

(D) Documentation of less restrictive methods of behavior modification that were attempted but did not work; and

(E) The informed written consent of the beneficiaryclient or the beneficiaryclient's legal guardian or custodian.

(c)

(1)

(A) A CSSP must reevaluate behavior management plans at least quarterly.

(B) A CSSP must refer the beneficiaryclient to an appropriately licensed professional for re-evaluation if the behavior management plan is not achieving the desired results.

(2) A CSSP must regularly collect and review data regarding the use and effectiveness of all behavior management plans, including as to the use and effectiveness of restraints and other interventions.

(3) The collection and review of data regarding the use and effectiveness of behavior management plans must include at least:

(A) The date and time any intervention is used;

(B) The duration of each intervention;

(C) The employee or employees involved in each intervention; and

(D) The event or circumstances that triggered the need for the intervention.

606. Restraints and Other Restrictive Interventions.

(a)

(1) A CSSP cannot use a restraint or seclusion on a beneficiaryclient unless:

(A) The restraint is required as an emergency safety intervention; and

(B) The use of the restraint is covered by the CSSP's accreditation.

(2) An emergency safety intervention is required:

(A) An immediate response with a restraint is required to address an unanticipated resident behavior;

(B) The resident behavior places the resident or others at serious threat of harm if no intervention occurs; and

(C) The resident is in a secure CSSP location secure unit.

(b) If a CSSP uses a restraint, the CSSP must:

(1) Comply with the use of the restraint as prescribed by the beneficiaryclient's behavior management plan;

(2) Continuously monitor the beneficiaryclient during the entire use of the restraint; and

(3) Maintain in-person visual and auditory observation of the beneficiaryclient by an employee during the entire use of the restraint.

(c)

(1) A CSSP must document each use of a restraint whether the use was permitted or not.

(2) The documentation must include at least the following:

(A) The behavior precipitating the use of the restraint;

(B) The length of time the restraint was used;

(C) The name of the individual that authorized the use of the restraint;

(D) The names of all individuals involved in the use of the restraint; and

(E) The outcome of the use of the restraint.

607. General Nutrition and Food Service Requirements.

(a)

(1) A CSSP must ensure that any meals, snacks, or other food services provided to beneficiariesclients by the CSSP conform to U.S. Department of Agriculture guidelines including without limitation portion size, ADH requirements, and other applicable laws and rules.

(2) All food brought in from outside sources must be:

(A) From food service providers approved by ADH and transported per ADH requirements;

(B) In individual, commercially pre-packaged containers; or

(C) Individual meals or snacks brought from home by a beneficiaryclient or a beneficiaryclient's family.

(3)

(A) A violation of U.S. Department of Agriculture guidelines, ADH requirements, or other applicable laws or rules related to nutrition and food service constitutes a violation of these standards.

(B) In the event of a conflict between these standards and the requirements of U.S. Department of Agriculture guidelines, ADH requirements, or other applicable laws or rules related to nutrition and food service, the stricter requirement shall apply.

(C) In the event of an irreconcilable conflict between these standards and the requirements of U.S. Department of Agriculture guidelines, ADH requirements, or other applicable laws or rules related to nutrition and food service, these standards shall govern the extent not governed by federal laws or rules or state law.

(b)

(1) A CSSP must ensure that food provided to beneficiariesclients meets the specialized diet requirements of each beneficiaryclient arising from medical conditions or other individualized needs including without limitation allergies, diabetes, and hypertension.

(2) A CSSP must ensure that all food prepared on-site is prepared, cooked, served, and stored in a manner that protects against contamination and spoilage.

(3) A CSSP must not use a perishable food item after its expiration date;

(4) A CSSP must keep all food service surfaces clean and in sanitary condition.

(5) A CSSP must serve all food on individual plates, bowls, or other dishes that can be sanitized or discarded.

(6) A CSSP must ensure that all food scraps are placed in garbage cans with airtight lids and bag liners that are emptied as necessary and no less than once every day.

(7) A CSSP must store all food separately from medications, medical items, or hazardous items.

(8)

(A) A CSSP must ensure that all refrigerators used for food storage are maintained at a temperature of 41 degrees Fahrenheit or below.

(B) A CSSP must ensure that all freezers used for food storage are maintained at a temperature of 0 degrees Fahrenheit or below.

Subchapter 7. Incident and Accident Reporting.

701. Incidents to be Reported.

(a) A CSSP must report all alleged, suspected, observed, or reported occurrences of any of the following events.

(1) Death of a beneficiaryclient;

(2) Serious injury to a beneficiaryclient;

(3) Adult or child maltreatment of a beneficiaryclient;

(4) Any event where an employee threatens or strikes a beneficiaryclient;

(5) Unauthorized use of a restrictive intervention on a beneficiaryclient, including seclusion, a restraint, a chemical restraint, or a mechanical restraint;

(6) Any situation where the whereabouts of a beneficiaryclient are unknown for more than one (1) hour;

(7) Any situation where services to the beneficiaryclient are interrupted for more than one (1) hour;

(8) Events involving a risk of death, serious physical or psychological injury, or serious illness to a beneficiaryclient;

(9) Medication errors made by an employee that cause or have the potential to cause death, serious injury, or serious illness to a beneficiaryclient;

(10) Any act or admission that jeopardizes the health, safety, or quality of life of a beneficiaryclient;

(11) Motor vehicle accidents involving a beneficiaryclient;

(12) A positive case of a beneficiaryclient or a staff member for any infectious disease that is the subject of a public health emergency declared by the Governor, ADH, the President of the United States, or the United States Department of Health and Human Services; and

(13) Any event that requires notification of the police, fire department, or coroner.

(b) Any CSSP may report any other occurrences impacting the health, safety, or quality of life of a beneficiaryclient.

702. Reporting Requirements.

(a) A CSSP must:

(1) Submit all reports of the following events within one (1) hour of the event:

(A) Death of a beneficiaryclient;

(B) Serious injury to a beneficiaryclient; and

(C) Any incident that a CSSP should reasonably know might be of interest to the public or the media.

(2) Submit reports of all other incidents within forty-eight (48) hours of the event.

~~(b) A CSSP must submit reports of all incidents to DPSQA as provided through DPSQA's website: https://humanservices.arkansas.gov/about-dhs/dpsqa.~~

~~(c) Reporting under these standards does not relieve a CSSP of complying with other applicable reporting or disclosure requirements under state or federal laws, rules, or regulations.~~

~~703. Notification to Custodians and Legal Guardians.~~

~~(a) A CSSP must notify the custodian or legal guardian of a beneficiaryclient of any reportable incident involving a beneficiaryclient, as well as any injury or accident involving a beneficiaryclient even if the injury or accident is not otherwise required to be reported in this Section.~~

~~(b) A CSSP should maintain documentation evidencing notification required in subdivision (a).~~

~~Subchapter 8. Enforcement.~~

~~801. Monitoring.~~

~~(a)~~

~~(1) DPSQA shall monitor a CSSP to ensure compliance with these standards.~~

~~(2)~~

~~(A) A CSSP must cooperate and comply with all monitoring, enforcement, and any other regulatory or law enforcement activities performed or requested by DPSQA or law enforcement.~~

~~(B) Cooperation required under these standards includes without limitation cooperation and compliance with respect to investigations surveys, site visits, reviews, and other regulatory actions taken by DPSQA or any third-party contracted by DHS to monitor, enforce, or take other regulatory action on behalf of DHS, DDS, DAABH, DMS, or DPSQA.~~

~~(b) Monitoring includes without limitation:~~

~~(1) On-site surveys and other visits including without limitation complaint surveys and initial site visits;~~

~~(2) On-site or remote file reviews;~~

~~(3) Requests for documentation and records required under these standards;~~

~~(4) Requests for information; and~~

~~(5) Investigations related to complaints received.~~

~~(c) DHS may contract with a third party to monitor, enforce, or take other regulatory action on behalf of DHS, DDS, DAABH, DMS, or DPSQA.~~

~~802. Written Notice of Enforcement Action.~~

~~(a) DPSQA shall provide written notice to the CSSP of all enforcement actions taken against a CSSP.~~

~~(b) DPSQA shall provide written notice to the CSSP by mailing the imposition of the enforcement action to the manager appointed by the CSSP pursuant to Section 301.~~

~~803. Remedies.~~

~~(a)~~

~~(1) DPSQA shall not impose any remedies imposed by an enforcement action unless:~~

~~(A) The CSSP is given notice and an opportunity to be heard pursuant to Section 802 and Subchapter 10; or~~

~~(B) DPSQA determines that public health, safety, or welfare imperatively requires emergency action;~~

~~(2) If DPSQA imposes a remedy as an emergency action before the CSSP has notice and an opportunity to be heard pursuant to subdivision (a)(1), DPSQA shall:~~

~~(A) Provide immediate notice to the CSSP of the enforcement action; and~~

~~(B) Provide the CSSP with an opportunity to be heard pursuant to Subchapter 10.~~

~~(b) DPSQA may impose on a CSSP any of the following enforcement actions for the CSSP's failure to comply with these standards:~~

~~(1) Plan of correction;~~

~~(2) Directed in-service training plan;~~

~~(3) Moratorium on new admissions;~~

~~(4) Transfer of beneficiaries~~clients~~;~~

~~(5) Monetary penalties;~~

~~(6) Suspension of CSSP license;~~

~~(7) Revocation of CSSP license; and~~

~~(8) Any remedy authorized by law or rule including without limitation section 25-15-217 of the Arkansas Code.~~

~~(c) DPSQA shall determine the imposition and severity of these enforcement remedies on a case-by-case basis using the following factors:~~

~~(1) Frequency of non-compliance;~~

~~(2) Number of non-compliance issues;~~

~~(3) Impact of non-compliance on a beneficiary~~client~~'s health, safety, or well-being;~~

(4) Responsiveness in correcting non-compliance;

(5) Repeated non-compliance in the same or similar areas;

(6) Non-compliance with previously or currently imposed enforcement remedies;

(7) Non-compliance involving intentional fraud or dishonesty; and

(8) Non-compliance involving violation of any law, rule, or other legal requirement.

(d)

(1) DPSQA shall report any noncompliance, action, or inaction by a CSSP to appropriate agencies for investigation and further action.

(2) DPSQA shall report non-compliance involving Medicaid billing requirements to the DMS, the Arkansas Attorney General's Medicaid Fraud Control Unit, and the Office of Medicaid Inspector General.

(e) These enforcement remedies are not mutually exclusive and DPSQA may apply multiple remedies simultaneously to a failure to comply with these standards.

(f) The failure to comply with an enforcement remedy imposed by DPSQA constitutes a separate violation of these standards.

804. Moratorium.

(a) DPSQA may prohibit a CSSP from accepting new beneficiariesclients.

(b) A CSSP prohibited from accepting new admissions may continue to provide services to existing beneficiariesclients.

805. Transfer of BeneficiariesClients.

(a) DPSQA may require a CSSP to transfer a beneficiaryclient to another CSSP if DPSQA finds that the CSSP cannot adequately provide services to the beneficiaryclient.

(b) A CSSP must continue providing services until the beneficiaryclient is transferred to his or her new service provider of choice.

(c) A transfer of a beneficiaryclient may be permanent or for a specific term depending on the circumstances.

806. Monetary Penalties.

~~(a) DPSQA may impose on a CSSP a civil monetary penalty not to exceed five hundred dollars ($500) for each violation of these standards.~~

~~(b)~~

~~(1) DPSQA may file suit to collect a civil monetary penalty assessed pursuant to these standards if the CSSP does not pay the civil monetary penalty within sixty (60) calendar days from the date DPSQA provides written notice to the CSSP of the imposition of the civil monetary penalty.~~

~~(2) DPSQA may file suit in Pulaski County Circuit Court or the circuit court of any county in which the CSSP is located.~~

~~807. Suspension and Revocation of CSSP License.~~

~~(a)~~

~~(1) DPSQA may temporarily suspend a CSSP license if the CSSP fails to comply with these standards.~~

~~(2) If a CSSP's license is suspended, the CSSP must immediately stop providing CSSP services until DPSQA reinstates its license.~~

~~(b)~~

~~(1) DPSQA may permanently revoke a CSSP license if the CSSP fails to comply with these standards.~~

~~(2) If a CSSP's license is revoked, the CSSP must immediately stop providing services and comply with the permanent closure requirements in Section 901(a).~~

~~Subchapter 9. Closure.~~

~~901. Closure~~

~~(a)~~

~~a. A CSSP license ends if a CSSP permanently closes, whether voluntarily or involuntarily, and is effective the date of the permanent closure as determined by DPSQA.~~

~~b. A CSSP that intends to permanently close, or does permanently close without warning, whether voluntarily or involuntarily, must immediately:~~

~~i. Provide the legal guardian or custodian of each beneficiary~~client with ~~written notice of the closure;~~

~~ii. Provide the legal guardian or custodian of each beneficiary~~client with ~~written referrals to at least three (3) other appropriate service providers;~~

~~iii. Assist each beneficiary~~client and his or her legal guardian or custodian in ~~transferring services and copies of beneficiary~~client ~~records to any new service providers;~~

~~iv. Assist each beneficiary~~client and his or her legal guardian or custodian in ~~transitioning to new service providers; and~~

~~v. Arrange for the storage of beneficiary~~client ~~records to satisfy the requirements in Section 305.~~

~~(b)~~

~~a. A CSSP that intends to voluntarily close temporarily due to natural disaster, pandemic, completion of needed repairs or renovations, or for similar circumstances may request to temporarily close its facility while maintaining its CSSP license for up to one (1) year from the date of the request.~~

~~b. A CSSP must comply with subdivision (a)(2)'s requirements for notice, referrals, assistance, and storage of beneficiary~~client ~~records if DPSQA grants a CSSP request for a temporary closure.~~

~~c.~~

~~i. DPSQA may grant a temporary closure if the CSSP demonstrates that it is reasonably likely it will be able to reopen after the temporary closure.~~

ii. DPSQA shall end a CSSP temporary closure and direct that the CSSP permanently close if the CSSP fails to demonstrate that it is reasonably likely that it will be able to reopen after the temporary closure.

d.

i. DPSQA may end a CSSP's temporary closure if the CSSP demonstrates that it is in full compliance with these standards.

ii. DPSQA shall end a CSSP's temporary closure and direct that the CSSP permanently close if the CSSP fails to become fully compliant with these standards within one (1) year from the date of the request.

~~Subdivision 10. Appeals.~~

~~1001. Reconsideration of Adverse Regulatory Actions.~~

~~(a)~~

~~(1) A CSSP may ask for reconsideration of any adverse regulatory action taken by DPSQA by submitting a written request for reconsideration to: Division of Provider Services and Quality Assurance, Office of the Director: Requests for Reconsideration of Adverse Regulatory Actions, P.O. Box 1437, Slot 427, Little Rock, Arkansas 72203.~~

~~(2) The written request for reconsideration of an adverse regulatory action taken by DPSQA must be submitted by the CSSP and received by DPSQA within thirty (30) calendar days of the date the CSSP received written notice of the adverse regulatory action.~~

~~(3) The written request for reconsideration of an adverse regulatory action taken by DPSQA must include without limitation the specific adverse regulatory action taken, the date of the adverse regulatory action, the name of the CSSP against whom the adverse regulatory action was taken, the address and contact information for the CSSP against whom the adverse regulatory action was taken, and the legal and factual basis for reconsideration of the adverse regulatory action.~~

~~(b)~~

~~(1) DPSQA shall review each timely received written request for reconsideration and determine whether to affirm or reverse the adverse regulatory action taken based on these standards.~~

~~(2) DPSQA may request, at its discretion, additional information as needed to review the adverse regulatory action and determine whether the adverse regulatory action taken should be affirmed or reversed based on these standards.~~

~~(c)~~

~~(1) DPSQA shall issue in writing its determination on reconsideration within thirty (30) days of receiving the written request for reconsideration or within thirty (30) days of receiving all information requested by DPSQA under subdivision (b)(2), whichever is later.~~

~~(2) DPSQA shall issues its determination to the CSSP using the address and contact information provided in the request for reconsideration.~~

~~(d) DPSQA may also decide to reconsider any adverse regulatory action on its own accord any time it determines, in its discretion, that an adverse regulatory action is not consistent with these standards.~~

~~1002. Appeal of Regulatory Actions.~~

~~(a)~~

~~(1) A CSSP may administratively appeal any adverse regulatory action to the DHS Office of Appeals and Hearings (OAH) except for provider appeals related to the payment for Medicaid claims and services governed by the Medicaid Fairness Act, Ark. Code Ann §§ 20-77-1701 to -1718, which shall be governed by that Act.~~

~~(2) OAH shall conduct administrative appeals of adverse regulatory actions pursuant to DHS Policy 1098 and other applicable laws and rules.~~

~~(b) A CSSP may appeal any adverse regulatory action or other agency action to circuit court as allowed by the Administrative Procedures Act, Ark. Code Ann. §§ 25-15-201 to -220.~~

TOC required

272.800 State Plan Requirement 3-1-19

The PASSE Provider Agreement with a PASSE must provide that payments provided for under the contract will be denied for new enrollees when, and for so long as, payment for those enrollees is denied by CMS under § 438.730(e).

280.000 HOME AND COMMUNITY BASED SPECIALTY SERVICES

281.000 Home and Community Based Service Providers 3-1-19

The PASSE is responsible for the credentialing of home and community based service (HCBS) providers. All HCBS providers must be enrolled in Arkansas Medicaid as an HCBS provider. In order to enroll in Arkansas Medicaid as a Home and Community Based Service provider, the HCBS provider must be credentialed as such by the PASSE.

282.000 Rehabilitative Level Services 3-1-19

The PASSE is responsible for providing Rehabilitative Level Behavioral Health Services that will improve the health of beneficiaries who need intensive levels of specialized care due to the behavioral health issues. Rehabilitative Level Behavioral Health Services are for individuals who have been identified to meet Tier II Level of Care as determined by DHS through the Behavioral Health Independent Assessment. At this level of need, services are provided in a counseling services setting but the level of need requires a broader array of services.

Rehabilitative Level Services are Home and community based behavioral health services with care coordination for the purpose of treating mental health and/or substance abuse conditions. Services shall be rendered and coordinated through a team based approach. Rehabilitative Level Services home and community based settings shall include services rendered in, but not limited to, a beneficiary's home, community, behavioral health clinic/ office, healthcare center, physician office, and/ or school.

282.001 Behavioral Assistance 3-1-19

Behavioral Assistance is a specific outcome oriented intervention provided individually or in a group setting with the child/youth and/or his/her caregiver(s) that will provide the necessary support to attain the goals of the treatment plan. Services involve applying positive behavioral interventions and supports within the community to foster behaviors that are rehabilitative and restorative in nature. The intervention should result in sustainable positive behavioral changes that improve functioning, enhance the quality of life and strengthen skills in a variety of life domains.

Behavioral Assistance is designed to support youth and their families in meeting behavioral goals in various community settings. The service is targeted for children and adolescents who are at risk of out-of-home placement or who have returned home from residential placement and need flexible wrap-around supports to ensure safety and support community integration. The service is tied to specific treatment goals and is developed in coordination with the youth and their family. Behavioral Assistance aids the family in implementing safety plans and behavioral management plans when youth are at risk for offending behaviors, aggressions, and oppositional defiance. Staff provides supports to youth and their families during periods when behaviors have been typically problematic – such as during morning preparation for school, at bedtime, after school, or other times when there is evidence of a pattern of escalation of problem difficult behaviors. The service may be provided in school classrooms or on school busses for short periods of time to help a youth's transition from hospitals or residential settings but is not intended as a permanent solution to problem difficult behaviors at school.

282.002 Adult Rehabilitative Day Service 3-1-19

A continuum of care provided to recovering individuals living in the community based on their level of need. This service includes educating and assisting the individual with accessing supports and services needed. The service assists the recovering individual to direct their resources and support systems. Activities include training to assist the person to learn, retain, or improve specific job skills, and to successfully adapt and adjust to a particular work environment. This service includes training and assistance to live in and maintain a household of their choosing in the community. In addition, transitional services to assist individuals adjust after receiving a higher level of care. The goal of this service is to promote and maintain community integration.

An array of face-to-face rehabilitative day activities providing a preplanned and structured group program for identified beneficiaries that aimed at long-term recovery and maximization of self-sufficiency, as distinguished from the symptom stabilization function of acute day treatment. These rehabilitative day activities are person- and family-centered, recovery-based, culturally competent, provide needed accommodation for any disability and must have measurable outcomes. These activities assist the beneficiary with compensating for or eliminating functional deficits and interpersonal and/or environmental barriers associated with their chronic mental illness. The intent of these services is to restore the fullest possible integration of the beneficiary as an active and productive member of his/her family, social and work community and/or culture with the least amount of ongoing professional intervention. Skills addressed may include: emotional skills, such as coping with stress, anxiety or anger; behavioral skills, such as proper use of medications, appropriate social interactions and managing overt expression of symptoms like delusions or hallucinations; daily living and self-care skills, such as personal care and hygiene, money management and daily structure/use of time; cognitive skills, such as problem solving, understanding illness and symptoms and reframing; community integration skills and any similar skills required to implement a beneficiary's master treatment plan.

282.003 Peer Support 3-1-19

Peer Support is a consumer centered service provided by individuals (ages 18 and older) who self-identify as someone who has received or is receiving behavioral health services and thus is able to provide expertise not replicated by professional training. Peer providers are trained and certified peer specialists who self-identify as being in recovery from behavioral health issues. Peer support is a service to work with beneficiaries to provide education, hope, healing, advocacy, self-responsibility, a meaningful role in life, and empowerment to reach fullest potential. Specialists will assist with navigation of multiple systems (housing, supportive employment, supplemental benefits, building/rebuilding natural supports, etc.) which impact beneficiaries' functional ability. Services are provided on an individual or group basis, and in either the beneficiary's home or community environment.

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

282.004 Family Support Partners 3-1-19

A service provided by peer counselors, of Family Support Partners (FSP), who model recovery and resiliency for caregivers of children and youth with behavioral health care needs or developmental disabilities. FSP come from legacy families and use their lived experience, training, and skills to help caregivers and their families identify goals and actions that promote recovery and resiliency and maintain independence. A FSP may assist, teach and model appropriate child-rearing strategies, techniques and household management skills. This service provides information on child development, age-appropriate behavior, parental expectations, and

childcare activities. It may also assist the member's family in securing resources and developing natural supports.

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

282.005 Pharmacologic Counseling by RN 3-1-19

A specific, time limited one-to-one intervention by a nurse with a beneficiary and/or caregivers, related to their psychopharmological treatment. Pharmaceutical Counseling involves providing medication information orally or in written form to the beneficiary and/or caregivers. The service should encompass all the parameters to make the beneficiary and/or family understand the diagnosis prompting the need for the medication and any lifestyle modification required.

282.006 Supportive Life Skills Development 3-1-19

A service that provides support and training for youth and adults on a one on one or group basis. This service should be a strength-based, culturally appropriate process that integrates the member into their community as they develop their recovery plan or habilitation plan. This service is designed to assist members in acquiring the skills needed to support as independent a lifestyle as possible, enable them to reside in their community (in their own home, with family, or in an alternative living setting), and promote a strong sense of self-worth. In addition, it aims to assist members in setting and achieving goals, learning independent life skills, demonstrating accountability, and making goal-oriented decisions related to independent living.

Topics may include: educational or vocational training, employment, resource and medication management, self-care, household maintenance, health, socialization, community integration, wellness, and nutrition. For clients with developmental or intellectual disability, supportive life skills development may focus on acquiring skills to complete activities of daily living (ADLs) and instrumental activities of daily living (IADLs), such as communication, bathing, grooming, cooking, shopping, or budgeting.

282.007 Child and Youth Support Services 3-1-19

Child and Youth Support Services are clinical, time-limited services for principal caregivers designed to increase a child's positive behaviors and encourage compliance with parents at home; working with teachers/schools to modify classroom environment to increase positive behaviors in the classroom; and increase a child's social skills, including understanding of feelings, conflict management, academic engagement, school readiness, and cooperation with teachers and other school staff. This service is intended to increase parental skill development in managing their child's symptoms of their illness and training the parents in effective interventions and techniques for working with the schools.

Services might include an In-Home Case Aide. An In-Home Case Aide is an intensive, time-limited therapy for youth in the beneficiary's home or, in rare instances, a community based setting. Youth served may be in imminent risk of out-of-home placement or have been recently reintegrated from an out-of-home placement. Services may deal with family issues related to the promotion of healthy family interactions, behavior training, and feedback to the family.

282.008 Supportive Employment 3-1-19

Supportive Employment is designed to help beneficiaries acquire and keep meaningful jobs in a competitive job market. The service actively facilitates job acquisition by sending staff to

accompany beneficiaries on interviews and providing ongoing support and/or on-the-job training once the beneficiary is employed.

Service settings may vary depending on individual need and level of community integration, and may include the beneficiary's home. Services delivered in the home are intended to foster independence in the community setting and may include training in menu planning, food preparation, housekeeping and laundry, money management, budgeting, following a medication regimen, and interacting with the criminal justice system.

282.009 Supportive Housing 3-1-19

Supportive Housing is designed to ensure that beneficiaries have a choice of permanent, safe, and affordable housing. An emphasis is placed on the development and strengthening of natural supports in the community. This service assists beneficiaries in locating, selecting, and sustaining housing, including transitional housing and chemical free living; provides opportunities for involvement in community life; and fosters independence.

Service settings may vary depending on individual need and level of community integration, and may include the beneficiary's home. Services delivered in the home are intended to foster independence in the community setting and may include training in menu planning, food preparation, housekeeping and laundry, money management, budgeting, following a medication regimen, and interacting with the criminal justice system.

282.011 Partial Hospitalization 3-1-19

Partial Hospitalization is an intensive nonresidential, therapeutic treatment program. It can be used as an alternative to and/or a step-down service from inpatient residential treatment or to stabilize a deteriorating condition and avert hospitalization. The program provides clinical treatment services in a stable environment on a level equal to an inpatient program, but on a less than 24-hour basis. The environment at this level of treatment is highly structured, and there should be a staff-to-patient ratio sufficient to ensure necessary therapeutic services. Partial Hospitalization may be appropriate as a time-limited response to stabilize acute symptoms, transition (step-down from inpatient), or as a stand-alone service to stabilize a deteriorating condition and avert hospitalization.

282.012 Mobile Crisis Intervention 3-1-19

A short-term, on-site, face-to-face therapeutic response to a member experiencing a behavioral health crisis for the purpose of identifying, assessing, treating and stabilizing the situation and reducing immediate risk of danger to the member or others consistent with the member's risk management/safety plan, if available. This service is available 24 hours per day, seven days per week, and 365 days per year; and is available after hours and on weekends when access to immediate response is not available through appropriate agencies.

The service includes a crisis assessment, engagement in a crisis planning process, which may result in the development /update of one or more Crisis Planning Tools (Safety Plan, Advanced Psychiatric Directive, etc.) that contain information relevant to and chosen by the beneficiary and family, crisis intervention and/or stabilization services including on-site face-to-face therapeutic response, psychiatric consultation, and urgent psychopharmacology intervention, as needed; and referrals and linkages to all medically necessary behavioral health services and supports, including access to appropriate services and supports, including access to appropriate services along the behavioral health continuum of care.

282.013 Therapeutic Host Homes 3-1-19

A home or family setting that that consists of high intensive, individualized treatment for the member whose behavioral health or developmental disability needs are severe enough that they would be at risk of placement in a restrictive residential setting.

A therapeutic host parent is trained to implement the key elements of the member's PCSP in the context of family and community life, while promoting the PCSP's overall objectives and goals. The host parent should be present at the PCSP development meetings and should act as an advocate for the member.

282.014 Recovery Support Partners (for Substance Abuse) 3-1-19

A continuum of care provided to recovering members living in the community. Recovery Support partners may educate and assist the individual with accessing supports and needed services, including linkages to housing and employment services. Additionally, the Recovery Support Partner assists the recovering member with directing their resources and building support systems. The goal of the Recovery Support Partner is to help the member integrate into the community and remain there.

282.015 Substance Abuse Detox (Observational) 3-1-19

A set of interventions aimed at managing acute intoxication and withdrawal from alcohol or other drugs. Services help stabilize the member by clearing toxins from his or her body. Detoxification (detox) services are short term and may be provided in a crisis unit, inpatient, or outpatient setting. Detox services may include evaluation, observation, medical monitoring, and addiction treatment. The goal of detox is to minimize the physical harm caused by the abuse of substances and prepare the member for ongoing substance abuse treatment.

283.000 Intensive Level Services 3-1-19

The PASSE is responsible for providing Intensive Level Behavioral Health Services that will improve the health of beneficiaries who need intensive levels of specialized care due to the behavioral health issues. Intensive Level Behavioral Health Services are for individuals who have been identified to meet Tier III Level of Care as determined by DHS through the Behavioral Health Independent Assessment. Eligibility for this level of need will be identified by additional criteria, which could lead to inpatient admission or residential placement.

Intensive Level Services are the most intensive behavioral health services for the purpose of treating mental health and/or substance abuse conditions. Services shall be rendered and coordinated through a team based approach with a focus on discharge planning.

283.001 Therapeutic Communities 3-1-19

Therapeutic Communities are highly structured residential environments or continuums of care in which the primary goals are the treatment of behavioral health needs and the fostering of personal growth leading to personal accountability. Services address the broad range of needs identified by the person served. Therapeutic Communities employs community-imposed consequences and earned privileges as part of the recovery and growth process. In addition to daily seminars, group counseling, and individual activities, the persons served are assigned responsibilities within the therapeutic community setting. Participants and staff members act as facilitators, emphasizing personal responsibility for one's own life and self-improvement. The service emphasizes the integration of an individual within his or her community, and progress is measured within the context of that community's expectation.

283.002 Residential Community Reintegration Program 3-1-19

The Residential Community Reintegration Program is designed to serve as an intermediate level of care between Inpatient Psychiatric Facilities and home and community-based behavioral health services. The program provides twenty-four hour per day intensive therapeutic care provided in a small group home setting for children and youth with emotional and/or behavior problems which cannot be remedied by less intensive treatment. The program is intended to prevent acute or sub-acute hospitalization of youth, or incarceration. The program is also offered as a step-down or transitional level of care to prepare a youth for less intensive treatment. A

Residential Community Reintegration Program shall be appropriately certified by the Department of Human Services to ensure quality of care and the safety of beneficiaries and staff.

A Residential Community Reintegration Program shall ensure the provision of educational services to all beneficiaries in the program. This may include education occurring on campus of the Residential Community Reintegration Program or the option to attend a school off campus if deemed appropriate in according with the Arkansas Department of Education.

283.003 Planned Respite 3-1-19

Temporary direct care and supervision for a beneficiary due to the absence or need for relief of the non-paid primary caregiver. Planned respite can occur at medical or specialized camps, day care programs, the member's home or place of residence, the respite care provider's home or place of residence, foster homes, a Human Development Center, or a licensed respite facility.

The primary purpose of Planned Respite is to relieve the principal care giver of the member with a behavioral health or developmental disability need so that stressful situations are de-escalated and the care giver and member have a therapeutic and safe outlet.

283.004 Emergency Respite 3-1-19

Emergency Respite is temporary direct care and supervision for a member who is experiencing an acute behavioral crisis or developmental disability need. Emergency respite can in a facility setting, including a Human Development Center.

The primary purpose of Emergency Respite is to de-escalate stressful situations and return the member back into the community.

284.000 Community and Employment Supports (CES) Waiver Services 3-1-19

The purpose of Community and Employment Support (CES) Waiver services are to support individuals of all ages who have a developmental disability, meet ICF level of care and require waiver support services to live in the community and prevent institutionalization.

The goals of the CES Waiver are to support beneficiaries in all major life activities, promote community inclusion through integrated employment options and community experiences, and provide comprehensive care coordination and service delivery under the 1915(b) PASSE Waiver Program.

284.001 CES Supported Employment 3-1-19

CES Supported Employment is a tailored array of services that offers ongoing support to members with the most significant disabilities to assist in their goal of working in competitive integrated work settings for at least minimum wage. It is intended for individuals for whom competitive employment has not traditionally occurred, or has been interrupted or intermittent as a result of a significant disability, and who need ongoing supports to maintain their employment.

CES Supported Employment consists of the following supports:

A. Discovery Career Planning – Information is gathered about a member's interests, strengths, skills, the types of supports that are most effective, and the types of environments and activities where the member is at his or her best. Discovery/Career Planning services should result in the development of the Individual Career Profile which includes specific recommendations regarding the member's employment support needs, preferences, abilities and characteristic of optimal work environment. The following activities may be a component of Discovery/Career Planning: review of the member's work history, interest and skills; job exploration; job shadowing; informational interviewing including mock interviews; job and task analysis activities; situational assessments to assess the member's interest and aptitude in a particular type of job; employment

preparation (i.e. resume development); benefits counseling; business plan development for self-employment; and volunteerism.

B. Employment Path – Members receiving Employment Path services must have goals related to employment in integrated community settings in their Person Centered Support Plan (PCSP). Service activities must be designed to support such employment goals. Employment Path services can replace non-work services. Activities under Employment Path should develop and teach soft skills utilized in integrated employment which include but are not limited to following directions, attending to tasks, problem solving skills and strategies, mobility training, effective and appropriate communication-verbal and nonverbal, and time management.

C. Employment Supports – Job Development services are individualized services that are specific in nature to obtaining certain employment opportunity. The initial outcome of Job Development Services is a Job Development Plan to be incorporated with the Individual Career Profile. The Job development plan should specify at a minimum the short and long term employment goals, target wages, tasks hours and special conditions that apply to the worksite for that member; jobs that will be developed and/or a description of customized tasks that will be negotiated with potential employers; initial list of employer contacts and plan for how many employers will be contacted each week; conditions for use of on-site job coaching.

D. Employment Supports Job Coaching – Employment Supports Job Coaching are on-site activities that may be provided to a member once employment is obtained. Activities provided under this services may include, but are not limited to, the following: Complete job duty and task analysis; assist the member in learning to do the job by the least intrusive method; develop compensatory strategies if needed to cue member to complete job; analyze work environment during initial training/learning of the job, and make determinations regarding modifications or assistive technology.

284.002 Supportive Living **3-1-19**

Supportive living is an array of individually tailored services and activities to enable members to reside successfully in their own home, with family or in an alternative living setting (apartment, or provider owned group home). Supportive living services must be provided in an integrated community setting.

Supportive living includes care, supervision, and activities that directly relate to active treatment goals and objectives set forth in the member's PCSP. It excludes room and board expenses, including general maintenance, upkeep, or improvement to the home.

Supportive living supervision and activities are meant to assist the member to acquire, retain, or improve skills in a wide variety of areas that directly affect the person's ability to reside as independently as possible in the community. The habilitation objective to be served by each activity should be documented in the member's PCSP. Examples of supervision and activities that may be provided as part of supportive living include:

A. Decision making, including the identification of and response to dangerously threatening situations, making decisions and choices affecting the member's life, and initiating changes in living arrangements or life activities.

B. Money management, including training, assistance or both in handling personal finances, making purchase and meeting personal financial obligations;

C. Daily living skills, including training in accomplishing routine housekeeping tasks, meal preparation, dressing, personal hygiene, administration of medication (to the extent permitted by state law), proper use of adaptive and assistive devices and household appliances, training on home safety, first aid, and emergency procedures;

D. Socialization, including training and assistance in participating in general community activities and establishing relationships with peers. Activity training includes assisting the member to continue to participate in an ongoing basis;

E. Community integration experiences, including activities intended to instruct the member in daily living and community living in integrated settings, such as shopping, church attendance, sports, and participation sports.

F. Mobility, including training and assistance aimed at enhancing movement within the member's living arrangement, mastering the use of adaptive aids and equipment, accessing and using public transportation, independent travel or movement within the community;

G. Communication, including training in vocabulary building, use of augmentative communication devices, and receptive and expressive language;

H. Behavior shaping and management, including training and assistance in appropriate expression of emotions or desires, compliance, assertiveness, acquisition of socially appropriate behaviors or reduction of inappropriate behaviors;

I. Reinforcement of therapeutic services, including conducting exercises reinforcing physical, occupational, speech, behavioral or other therapeutic programs;

J. Companion activities and therapies, or the use of animals as modalities to motivate members to meet functional goals established for the member's habilitative training, including language skills, increased range of motion, socialization, and the development of self-respect, self-esteem, responsibility, confidence, an assertiveness; and

K. Health maintenance activities, which include tasks that members would otherwise do for themselves or have a family member do, with the exception of injections and IV medication administration.

284.003 Adaptive Equipment 3-1-19

Adaptive equipment is a piece of equipment, or product system that is used to increase, maintain, or improve functional capabilities of members, whether commercially purchased, modified, or customized. The adaptive equipment services include adaptive, therapeutic, or augmentative equipment that enables a member to increase, maintain, or improve their functional capacity to perform daily life tasks that would not be possible otherwise.

Consultation by a medical professional must be conducted to ensure the adaptive equipment will meet the needs of the member.

Adaptive equipment includes enabling technology, such as safe home modifications, that empower members to gain independence through customizable technologies that allow them to safely perform activities of daily living without assistance while still providing monitoring and response for those members, as needed. Enabling technology allows members to be proactive about their daily schedule and integrates member choice.

Adaptive equipment also includes Personal Emergency Response Systems (PERS), which is a stationary or portable electronic device used in the member's place of residence and that enables the member to secure help in an emergency. The system is connected to a response center staffed by trained professionals who respond to activation of the device. PERS services may include the assessment, purchase, installation, and monthly rental fee.

Computer equipment, including software, can be included as adaptive equipment. Specifically, computer equipment includes equipment that allows the member increased control of their environment, to gain independence, or to protect their health and safety.

~~Vehicle modifications are also included as adaptive equipment. Vehicle modifications are adaptions to an automobile or van to accommodate the special needs of the member. The purpose of vehicle modifications is to enable the member to integrate more fully into the community and to ensure the health, safety, and welfare of the member. Vehicle modifications exclude: adaptations or modifications to the vehicle that are of general utility and not of direct medical or habilitative benefit to the member; purchase, down payment, monthly car payment or lease payment; or regularly scheduled maintenance of the vehicle.~~

~~284.004 Community Transition Services~~ ~~3-1-19~~

~~Community Transition Services are non-recurring set-up expenses for members who are transitioning from an institutional or provider-operated living arrangement, such as an ICF or group home, to a living arrangement in a private residence where the member or his or her guardian is directly responsible for his or her own living expenses.~~

~~Community Transition service activities include those necessary to enable a member to establish a basic household, not including room and board, and may include: (a) security deposits that are required to obtain a lease on an apartment or home; (b) essential household furnishings required to occupy and use a community domicile, including furniture, window coverings, food preparation items, and bed/bath linens; (c) set-up fees or deposits for utility or service access, including telephone, electricity, heating and water; (d) services necessary for the member's health and safety such as pest eradication and one-time cleaning prior to occupancy; and (e) moving expenses.~~

~~Community Transition Services should not include payment for room and board; monthly rental or mortgage expense; regular food expenses, regular utility charges; and/or household appliances or items that are intended for purely diversional/recreational purposes.~~

~~284.005 Consultation~~ ~~3-1-19~~

~~Consultation services are clinical and therapeutic services which assist the individual, parents, legally responsible persons, responsible individuals and service providers in carrying out the member's PCSP. Consultation activities are provided by professionals licensed as one of the following:~~

~~A. Psychologist~~

~~B. Psychological Examiner~~

~~C. Mastered Social Worker~~

~~D. Professional counselor~~

~~E. Speech pathologist~~

~~F. Occupational therapist~~

~~G. Registered Nurse~~

~~H. Certified parent educator or provider trainer~~

~~I. Certified communication and environmental control specialist~~

~~J. Qualified Developmental Disabled Professional (QDDP)~~

~~K. Positive Behavior Support (PBS) Specialist~~

~~L. Physical therapist~~

~~M. Rehabilitation counselor~~

~~N. Dietitian~~

~~O. Recreational Therapist~~

~~P. Board Certified Behavior Analyst (BCBA)~~

~~These services are direct in nature. The PASSE will be responsible for maintaining the necessary information to document staff qualifications. Staff, who meets the certification criteria necessary for other consultation functions, may also provide these activities. These activities include, but are not limited to:~~

~~Q. Provision of updated psychological and adaptive behavior assessments;~~

~~R. Screening, assessing and developing therapeutic treatment plans;~~

~~S. Assisting in the design and integration of individual objectives as part of the overall individual service planning process as applicable to the consultation specialty;~~

~~T. Training of direct services staff or family members in carrying out special community living services strategies identified in the member's PCSP as applicable to the consultation specialty;~~

~~U. Providing information and assistance to the persons responsible for developing the member's PCSP as applicable to the consultation specialty;~~

~~V. Participating on the interdisciplinary team, when appropriate to the consultant's specialty;~~

~~W. Consulting with and providing information and technical assistance with other service providers or with direct service staff or family members in carrying out the member's PCSP specific to the consultant's specialty;~~

~~X. Assisting direct services staff or family members to make necessary program adjustments in accordance with the member's PCSP and applicable to the consultant's specialty;~~

~~Y. Determining the appropriateness and selection of adaptive equipment to include communication devices, computers and software consistent with the consultant's specialty;~~

~~Z. Training or assisting members, direct services staff or family members in the set up and use of communication devices, computers and software consistent with the consultant's specialty;~~

~~AA. Screening, assessing and developing positive behavior support plans; assisting staff in implementation, monitoring, reassessment and plan modification consistent with the consultant's specialty;~~

~~BB. Training of direct services staff or family members by a professional consultant in:~~

~~1. Activities to maintain specific behavioral management programs applicable to the member,~~

~~2. Activities to maintain speech pathology, occupational therapy or physical therapy program treatment modalities specific to the member,~~

~~3. The provision of medical procedures not previously prescribed but now necessary to sustain the member in the community.~~

~~CC. Training or assisting by advocacy consultants to members and family members on how to self-advocate.~~

~~DD. Rehabilitation Counseling for the purposes of supported employment supports.~~

EE. Training and assisting members, direct services staff or family members in proper nutrition and special dietary needs.

284.006 Crisis Intervention 3-1-19

Crisis Intervention is delivered in the member's place of residence or other local community site by a mobile intervention team or professional. Intervention shall be available 24 hours a day, 365 days a year. Intervention services shall be targeted to provide technical assistance and training in the areas of behavior already identified. Services are limited to a geographic area conducive to rapid intervention as defined by the provider responsible to deploy the team or professional. Services may be provided in a setting as determined by the nature of the crisis; i.e., residence where behavior is happening, neutral ground, local clinic or school setting, etc., for persons participating in the Waiver program and who are in need of non-physical intervention to maintain or re-establish a behavior management or positive programming plan.

284.007 Environmental Modifications 3-1-19

Modifications made to the member's place of residence that are necessary to ensure the health, welfare and safety of the member or that enable the member to function with greater independence and without which, the member would require institutionalization. Examples of environmental modifications include the installation of wheelchair ramps, widening doorways, modification of bathroom facilities, installation of specialized electrical and plumbing systems to accommodate medical equipment, installation of sidewalks or pads, and fencing to ensure non-elopement, wandering or straying of members with decreased mental capacity or aberrant behaviors.

Exclusions include modifications or repairs to the home which are of general utility and not for a specific medical or habilitative benefit; modifications or improvements which are of an aesthetic value only; and modifications that add to the total square footage of the home.

Environmental modifications that are permanent fixtures to rental property require written authorization and release of current or future liability from the property owner.

284.008 Supplemental Support 3-1-19

Supplemental Support services meet the needs of the member to improve or enable the continuance of community living. Supplemental Support Services will be based upon demonstrated needs as identified in a member's PCSP as unforeseen problems arise that, unless remedied, could cause a disruption in the member's services or placement, or place the member at risk of institutionalization.

284.009 Caregiver Respite 3-1-19

Caregiver respite services are provided on a short term basis to members unable to care for themselves due to the absence of or need for relief to the non-paid primary caregiver. Caregiver respite services do not include room and board charges.

Receipt of respite does not necessarily preclude a member from receiving other services on the same day. For example, a member may receive day services, such as supported employment, on the same day as caregiver respite services.

When caregiver respite is furnished for the relief of a foster care provider, foster care services may not be billed during the period that respite is furnished. Caregiver respite should not be furnished for the purpose of compensating relief or substitute staff for supportive living services. Caregiver respite services are not to supplant the responsibility of the parent or guardian.

Caregiver respite services may be provided through a combination of basic child care & support services required to meet the needs of a child.

Caregiver respite may be provided in the following locations:

A. Member's home or private place of residence;

B. The private residence of a respite care provider;

C. Foster home;

D. Licensed respite facility; or

E. Other community residential facility approved by the member's PASSE, not a private residence. Respite care may occur in a licensed or accredited residential mental health facility.

284.010 Specialized Medical Supplies 3-1-19

Specialized medical equipment and supplies include:

A. Items necessary for life support or to address physical conditions along with ancillary supplies and equipment necessary to the proper functioning of such items;

B. Such other durable and non-durable medical equipment not available under the State plan that is necessary to address the member's functional limitations and has been deemed medically necessary by the prescribing physician;

C. Necessary medical supplies not available under the State plan. Items reimbursed with Waiver funds are in addition to any medical equipment and supplies furnished under the State plan and exclude those items that are not of direct medical or remedial benefit to the member. All items shall meet applicable standards of manufacture, design and installation. The most cost effective item should be considered first.

Additional supply items are covered as a Waiver service when they are considered essential and medically necessary for home and community care.

D. Nutritional supplements;

E. Non-prescription medications. Alternative medicines not Federal Drug Administration approved are excluded from coverage.

F. Prescription drugs minus the cost of drugs covered by Medicare Part D when extended benefits available under state plan are exhausted.

TOC required

203.270 Physician's Role in Behavioral Health Services

~~9-1-20~~1-1-23

Medicaid covers behavioral health services when furnished by qualified providers to eligible Medicaid beneficiaries. A primary care physician referral is required for some behavioral health services when provided outside the physician's office.

For additional information about services that may not require PCP referral, refer to Section 172.100 of this manual.

205.100 Physician's ~~"Direct~~ Supervision~~"~~ in the Provision of Behavioral Health Counseling~~Psychotherapy~~ Services

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

The ~~psychotherapy~~ counseling procedures covered under the Physician Program are allowed as a covered service when provided by the physician or by a qualified practitioner authorized by State licensure to provide ~~psychotherapy services~~them. For additional information about qualified practitioners who can provide counseling services, refer to Section II of the **Counseling Services Medicaid Provider Manual**.

When a practitioner other than a physician provides the services, the practitioner must be under ~~the "direct~~ supervision~~"~~ of ~~the~~a physician in the clinic that is billing for the services. For ~~the purpose of psychotherapy~~ counseling services only, the term ~~"direct~~ supervision~~"~~ means the following:

A. The person who is performing the covered service must be either of the following:

1. A paid employee of the physician who is billing the Medicaid Program. A W-4 must be on file in the physician's office; or
2. A subcontractor of the physician who is billing the Medicaid Program. A contract between the physician and the subcontractor must be on file in the physician's office~~.~~;

And

3. The paid employee or subcontractor must be enrolled with Arkansas Medicaid as a performing provider in a program that allows them to provide counseling services.

B. The physician must monitor and be responsible for the quality of work performed by the employee or subcontractor under his/her ~~"direct~~ supervision~~"~~. The physician must be immediately available to ~~provide~~ give assistance and direction throughout the time the service is being performed.

C. Psychological testing is not covered, except as defined in the Arkansas Medicaid **Diagnostic and Evaluation manual**.

Refer to Section 292.740 of this manual for more information.

~~248.000 Psychotherapy and Psychological Testing~~

~~10-13-03~~

~~The Arkansas Medicaid Program's policy regarding psychology services and psychotherapy is:~~

~~A. Psychotherapy is reimbursable to a physician when provided by a physician or under the physician's "direct supervision." Refer to Section 205.100 and Section 292.740 of this manual.~~

~~B. Psychological testing is not covered, except in a certified community mental health center or in the psychology program for beneficiaries in the Child Health Services (EPSDT) Program when services are provided by a psychologist who is enrolled in the Medicaid Program.~~

292.740 ~~Psychotherapy~~Counseling Services ~~10-13-03~~1-1-23

The ~~psychotherapy~~ **counseling procedures** covered under the Physician Program are allowed as a covered service when provided by the physician or when provided by a qualified practitioner who by State licensure is authorized to provide ~~psychotherapy services~~them. ~~When a practitioner other than the physician provides the services, the services must be under the direct supervision of the physician billing for the service. For the purposes of psychotherapy services only, the term "direct supervision" means the following:~~

~~A. The person who is performing the service must be: (1) a paid employee of the physician (the physician who is billing the Medicaid Program). A W-4 Form must be on file in the physician's office or (2) a subcontractor of the physician (the physician who is billing the Medicaid Program). A contract between the physician and the subcontractor must be on file in the physician's office and~~

~~B. The physician must monitor and be responsible for the quality of work performed by the employee or subcontractor under his "direct supervision." The physician must be immediately available to provide assistance and direction throughout the time the service is being performed.~~

~~Psychotherapy~~ Counseling Services must be provided by a physician ~~rendering psychotherapy~~ or qualified performing provider in ~~his/her~~the physician's office~~,~~ or the outpatient hospital ~~or the nursing home~~. ~~Psychotherapy~~ Counseling codes may not be billed in conjunction with an ~~office visit, a~~inpatient hospital visit, or inpatient psychiatric facility visit and may not be billed when services are performed ~~in a community mental health clinic~~as Medicaid Behavioral Health Counseling Services at another enrolled Arkansas Medicaid provider type site. Only one (1) ~~psychotherapy~~ counseling visit per day is allowed in the physician's office, the outpatient hospital, or nursing home. ~~Psychotherapy~~ Counseling Services provided and billed by a physician's office are defined in the Arkansas Medicaid **Counseling Services provider manual**. The rules set forth in the Counseling Services manual will apply. Any additional services provided by a psychiatrist enrolled in the physician's program will count against the sixteen (1~~2~~6) visits per State Fiscal Year physician benefit limit. Record Review is not covered.

292.741 Behavioral Health Screen~~Individual Medical Psychotherapy~~ ~~7-1-07~~1-1-23

~~The appropriate CPT procedure codes must be used when billing for individual medical psychotherapy. The appropriate National Place of Service code must be entered in Field 24B in the CMS-1500 claim format.~~ A physician, physician's assistant, or advanced nurse practitioner may administer a brief emotional/behavioral assessment screening to a client along with an office visit. The allowable screening is up to two (2) units per visit and is allowable up to four (4) times per state fiscal year without prior authorization. An extension of benefits may be requested if additional screening is medically necessary. If a client is under the age of eighteen (18), and the parent/legal guardian appears depressed, he or she can be screened as well, and the screening billed under the minor's Medicaid number. The provider cannot prescribe meds for the parent under the child's Medicaid number. A parent/legal guardian session will count towards the four (4) counseling screening limit. The physician must have the capacity to treat or refer the parent/guardian for further treatment if the screening results indicate a need, regardless of payor source.

~~292.742 Family/Group Psychotherapy~~ ~~2-1-22~~

~~The following psychotherapy procedure codes are payable by the Arkansas Medicaid Program for family/group psychotherapy:~~

~~**View or print the procedure codes for Physician/Independent Lab/CRNA/Radiation Therapy Center services.**~~

~~Procedure codes are payable when the place of service is the beneficiary's home, the physician's office, a hospital or a nursing home. Procedure code is payable only when the patient is present during the treatment. Procedure codes are payable when the patient is not present; however, the patient may be present during the session, when appropriate.~~

SECTION – ~~OUTPATIENT BEHAVIORAL HEALTH~~ COUNSELING SERVICES

CONTENTS

200.000 ~~OUTPATIENT BEHAVIORAL HEALTH~~COUNSELING SERVICES GENERAL INFORMATION

201.000 Introduction

~~3-1-19~~1-1-23

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

~~Outpatient Behavioral Health~~Counseling Services may be provided to eligible Medicaid ~~beneficiaries~~clients 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.

202.000 Arkansas Medicaid Participation Requirements for ~~Outpatient Behavioral Health~~Counseling Services

~~3-1-19~~1-1-23

All behavioral health providers approved to receive Medicaid reimbursement for services to Medicaid ~~beneficiaries~~clients must meet specific qualifications. ~~for their services and staff. Providers with multiple service sites must enroll each site separately and reflect the actual service site on billing claims.~~

~~Behavioral Health~~ Providers must meet the Provider Participation and enrollment requirements contained within Section 140.000 of this manual as well as the following criteria to be eligible to participate in the Arkansas Medicaid Program:

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

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

1. Licensed Clinical Certified Social Worker (LCSW)

2. Licensed Marital and Family Therapist (LMFT)
3. Licensed Psychologist (LP)
4. Licensed Psychological Examiner – Independent (LPEI)
5. Licensed Professional Counselor (LPC)
6. Licensed Alcohol and Drug Abuse Counselor (LADAC)

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

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

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

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

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

A. Seriousness of the offense(s)

B. Extent of violation(s)

C. History of prior violation(s)

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

~~**202.100 Certification Requirements by the Division of Provider Services and Quality Assurance (DPSQA)** 3-1-19~~

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

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

202.200 Providers with Multiple Sites ~~7-1-17~~1-1-23

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~~1-1-23

~~Outpatient Behavioral Health~~Counseling Services are limited to ~~certified~~ enrolled providers as indicated in 202.000 who offer core ~~behavioral health~~counseling services for the treatment of behavioral disorders. ~~All performing providers, provider groups, and business entities participating in the Medicaid Outpatient Behavioral Health Services (OBH) Program must be certified by the Division Provider Services and Quality Assurance.~~

An ~~Outpatient Behavioral Health~~Counseling Services providers must establish an ~~site specific~~ emergency response plan ~~that complies with the DPSQA Certification Rules for Providers of Outpatient Behavioral Health Services~~. Each ~~agency site~~provider must have 24-hour emergency response capability to meet the emergency treatment needs of the ~~Behavioral Health~~Counseling Services ~~beneficiaries~~clients served by the ~~site~~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.

~~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.~~

All ~~Outpatient Behavioral Health~~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.

~~211.100 Quality Assurance~~ ~~3-1-19~~

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

211.200 Staff Requirements

~~9-1-20~~1-1-23

Each ~~Outpatient Behavioral Health~~Counseling Services provider must ensure that they employ staff which are able and available to provide appropriate and adequate services offered by the provider. ~~Behavioral Health~~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 C~~linical~~ertified Social Worker (LCSW) Licensed Marital and Family Therapist (LMFT) Licensed Psychologist (LP) Licensed Psychological Examiner – Independent (LPEI) Licensed Professional Counselor (LPC)	Yes, must be ~~certified~~ licensed through the relevant licensing board to provide services	Not Required
~~Independently Licensed Clinicians – Parent/Caregiver & Child (Dyadic treatment of Children age 0-47 months & Parent/Caregiver) Provider~~	~~Licensed Clinical Social Worker (LCSW)~~ ~~Licensed Marital and Family Therapist (LMFT)~~ ~~Licensed Psychologist (LP)~~ ~~Licensed Psychological Examiner – Independent (LPEI)~~ ~~Licensed Professional Counselor (LPC)~~	~~Yes, must be certified to provide services~~	~~Not Required~~
Non-independently Licensed Clinicians – Master's/Doctoral	Licensed Master Social Worker (LMSW) Licensed Associate Marital and Family Therapist (LAMFT)	Yes, must be ~~supervised by appropriate Independently Licensed Clinician~~licensed through the relevant licensing board to provide services and be employed by a	Required

PROVIDER TYPE	LICENSES	STATE CERTIFICATION REQUIRED	SUPERVISION
	Licensed Associate Counselor (LAC) Licensed Psychological Examiner (LPE) Provisionally Licensed Psychologist (PLP) Provisionally Licensed Master Social Worker (PLMSW)	certified Behavioral Health Agency, Community Support System Agency, or certified by the Dept. of Education as a school-based mental health provider	
~~Non-independently Licensed Clinicians – Parent/Caregiver & Child (Dyadic treatment of Children age 0-47 months & Parent/Caregiver) Provider~~	~~Licensed Master Social Worker (LMSW)~~ ~~Licensed Associate Counselor (LAC)~~ ~~Licensed Psychological Examiner (LPE)~~ ~~Provisionally Licensed Psychologist (PLP)~~	~~Yes, must be supervised by appropriate Independently Licensed Clinician and must be certified to provide services~~	~~Required~~
Licensed Alcoholism and Drug Abuse Counselor Master's	Licensed Alcoholism and Drug Abuse Counselor (LADAC) Master's Doctoral	Yes, must be licensed through the relevant licensing board to provide services	
Advanced Practice Nurse (APN)	Adult Psychiatric Mental Health Clinical Nurse Specialist Child Psychiatric Mental Health Clinical Nurse Specialist Adult Psychiatric Mental Health APN Family Psychiatric Mental Health APN	~~No, must be part of a certified agency or have a Collaborative Agreement with a Physician~~Must be employed by a certified Behavioral Health Agency, or Community Support System Agency	Collaborative Agreement with Physician Required
Physician	Doctor of Medicine (MD) Doctor of Osteopathic Medicine (DO)	~~No, must provide proof of licensure~~Must be employed by a certified Behavioral Health Agency, or Community	Not Required

PROVIDER TYPE	LICENSES	STATE CERTIFICATION REQUIRED	SUPERVISION
		Support System Agency	

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

When a~~n Outpatient Behavioral Health~~Counseling Services provider files a claim with Arkansas Medicaid, the staff member who actually performed the service must be identified on the claim as the rendering provider. This action is taken in compliance with the federal Improper Payments Information Act of 2002 (IPIA), Public Law 107-300, and the resulting Payment Error Rate Measurement (PERM) program initiated by the Centers for Medicare and Medicaid Services (CMS).

211.300 Certification of Performing Providers ~~3-1-19~~1-1-23

As illustrated in the chart in § 211.200, certain ~~Outpatient Behavioral Health~~Counseling Services ~~performing~~ 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**~~.

211.400 Facility Requirements ~~7-1-17~~1-1-23

The ~~Outpatient Behavioral Health~~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 ~~Outpatient Behavioral Health~~Counseling Services are not provided in buildings, a safe and appropriate setting must be provided.

211.500 Non-Refusal Requirement ~~3-1-19~~1-1-23

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

212.000 Scope ~~3-1-19~~1-1-23

The ~~Outpatient Behavioral Health~~Counseling Services Program provides ~~care,~~ treatment and services which are provided by a certified Behavioral Health Services provider to Medicaid-eligible ~~beneficiaries~~clients that have a Behavioral Health diagnosis as described in the

American Psychiatric Association Diagnostic and Statistical Manual (DSM-5 and subsequent revisions).

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

COUNSELING ~~LEVEL~~ SERVICES

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

213.000 ~~Outpatient Behavioral Health~~Counseling Services Program Entry ~~2-1-22~~1-1-23

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

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

View or print the procedure codes for ~~OBHS~~ counseling services.

213.100 Independent Assessment Referral ~~3-1-19~~1-1-23

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

214.000 Role of Providers of Counseling ~~Level~~ Services ~~3-1-19~~1-1-23

~~Outpatient Behavioral Health~~Counseling Services ~~P~~providers provide ~~C~~counseling ~~Level S~~services by qualified licensed practitioners in an outpatient~~-~~-based setting for the purpose of assessing and treating behavioral health conditions. ~~Counseling Level Services outpatient based setting shall mean services rendered in a behavioral health clinic/ office, healthcare center, physician office, home, shelter, group home, and/or school. The performing provider must provide services only within the scope of their individual licensure. Services available to be provided by Counseling Level Services providers are listed in Section 252.111 through 255.001 of the Outpatient Behavioral Health Services manual.~~

214.100 Parent/Caregiver & Child (Dyadic treatment of Children age 0-47 months & Parent/Caregiver) ~~3-1-19~~1-1-23

~~Outpatient Behavioral Health~~Counseling Services ~~P~~providers may provide dyadic treatment of ~~beneficiary~~clients age zero through forty-seven (0-47) months and the parent/caregiver of the eligible ~~beneficiary~~client. A prior authorization will be required for all dyadic treatment services (the Mental Health Diagnosis and Interpretation of Diagnosis DO NOT require a prior

authorization). All performing providers of parent/caregiver and child ~~Outpatient Behavioral Health~~Counseling Services MUST be certified by DAABHS to provide those services.

Providers will diagnose children through the age of forty-seven (47) months based on the ~~DC: 0-3R~~most current version of the Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood. Providers will then crosswalk the ~~DC: 0-3R~~ diagnosis to a DMS diagnosis. Specified ~~V~~Z and T codes and conditions that may be the focus of clinical attention according to DSM 5 or subsequent editions will be allowable for this population.

214.200 Medication Assisted Treatment and Opioid Use Disorder Treatment Drugs ~~9-1-20~~1-1-23

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~~clients 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.

214.300 Substance Abuse Covered Codes 1-1-23

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

217.100 Primary Care Physician (PCP) Referral ~~6-1-22~~1-1-23

Each ~~beneficiary~~client that receives ~~only C~~counseling ~~Level S~~services in the ~~Outpatient Behavioral Health~~Counseling Services program can receive a limited amount of ~~C~~counseling ~~Level S~~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~~client's medical record.

A ~~beneficiary~~client can receive ten (10) c~~C~~ounseling ~~Level~~ services before a PCP/PCMH referral is necessary. Crisis Intervention (Section 255.001) does not count toward the ten (10) counseling ~~level~~ 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~~client's medical record.

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

The PCP referral or PCMH authorization for ~~C~~counseling ~~Level S~~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~~client's chart as described in Section 171.410.

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

219.110 Daily Limit of ~~Beneficiary~~Client Services ~~7-1-17~~1-1-23

For services that are not reimbursed on a per diem or per encounter rate, Medicaid has established daily benefit limits for all services. ~~Beneficiaries~~Clients will be limited to a maximum of eight (8) hours per twenty-four (24) hour day of ~~Outpatient Behavioral Health~~Counseling Services. ~~Beneficiaries~~Clients will be eligible for an extension of the daily maximum amount of services based on a medical necessity review by the contracted utilization management entity (See Section 231.000 for details regarding extension of benefits).

219.200 Telemedicine (Interactive Electronic Transactions) Services ~~3-1-19~~1-1-23

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

~~220.000 Inpatient Hospital Services~~ ~~3-1-19~~

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

223.000 Exclusions ~~3-1-19~~1-1-23

Services not covered under the ~~Outpatient Behavioral Health~~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~~client for services **(reimbursement for other ~~Outpatient Behavioral Health~~Counseling ~~s~~Services is not allowed for the period of time the Medicaid ~~beneficiary~~client is in transport)**

E. Services to individuals with developmental disabilities that are non-~~psychiatric~~ 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

224.000 Physician's Role ~~3-1-19~~1-1-23

~~Certified~~ Counseling ~~Level S~~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.

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

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

225.000 Diagnosis and Clinical Impression ~~7-1-17~~1-1-23

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

226.000 Documentation/Record Keeping Requirements

226.100 Documentation ~~7-1-17~~1-1-23

All ~~Outpatient Behavioral Health~~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 ~~consist of~~:

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

B. ~~The~~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 t~~T~~he setting in which the services were provided. For all settings other than the provider's enrolled sites, the name and physical address of the place of service must be included

F. Document ~~T~~the relationship of the services to the treatment regimen described in the Treatment Plan

G. Contain ~~U~~updates describing the patient's progress

H. Document involvement, ~~F~~for services that require contact with anyone other than the ~~beneficiary~~client, evidence of conformance with HIPAA regulations, including presence in documentation of Specific Authorizations, i~~s~~f required

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

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

227.000 Prescription for ~~Outpatient Behavioral Health~~Counseling Services ~~3-1-19~~1-1-23

~~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.~~ The~~i~~s approval by the PCP or PCMH will serve as the prescription for ~~C~~counseling ~~Level S~~services in the ~~Outpatient Behavioral Health~~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~~client. The prescription ~~of~~for the services and subsequent renewals must be documented in the ~~beneficiary~~client's medical record.

228.000 Provider Reviews ~~7-1-17~~1-1-23

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

~~228.100 Record Reviews~~ ~~7-1-17~~

~~The Division of Medical Services of the Arkansas Department of Human Services (DHS) has contracted with a third-party vendor to perform on-site Inspections of Care (IOC) and retrospective reviews of outpatient mental health services provided by Outpatient Behavioral Health Services providers.~~ **~~View or print current contractor contact information.~~** ~~The reviews are conducted by licensed mental health professionals and are based on applicable federal and state laws, rules and professionally recognized standards of care.~~

~~228.110 On-Site Inspections of Care (IOC)~~

~~228.111 Purpose of the Review~~ ~~7-1-17~~

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

~~A. Promote Outpatient Behavioral Health services being provided in compliance with federal and state laws, rules and professionally recognized standards of care~~

~~B. Identify and clearly define areas of deficiency where the provision of services is not in compliance with federal and state laws, rules and professionally recognized standards of care~~

~~C. Require provider facilities to develop and implement appropriate corrective action plans to remediate all deficiencies identified~~

~~D. Provide accountability that corrective action plans are implemented~~

~~E. Determine the effectiveness of implemented corrective action plans~~

~~The review tool, process and procedures are available on the contractor's website at~~ **~~http://arkansas.beaconhealthoptions.com/provider/prv-forms.html~~**~~. Any amendments to the review tool will be adopted under the Arkansas Administrative Procedures Act.~~

~~228.112 Provider Notification of IOC~~ ~~7-1-17~~

~~The provider will be notified no more than 48 hours before the scheduled arrival of the inspection team. It is the responsibility of the provider to provide a reasonably comfortable place for the team to work. When possible, this location will provide reasonable access to the patient care areas and the medical records.~~

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

~~The provider shall make the following available upon the IOC Team's arrival at the site:~~

~~A. Medical records of Arkansas Medicaid beneficiaries who are identified by the reviewer~~

~~B. One or more knowledgeable administrative staff member(s) to assist the team~~

~~C. The opportunity to assess direct patient care in a manner least disruptive to the actual provision of care~~

~~D. Staff personnel records, complete with hire dates, dates of credentialing and copies of current licenses, credentials, criminal background checks and similar or related records~~

~~E. Written policies, procedures and quality assurance committee minutes~~

~~F. Clinical Administration, Clinical Services, Quality Assurance, Quality improvement, Utilization Review and Credentialing~~

~~G. Program descriptions, manuals, schedules, staffing plans and evaluation studies~~

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

~~228.114 Cases Chosen for Review~~ ~~3-1-19~~

~~The contractor will review twenty (20) randomly selected cases during the IOC review. If a provider has fewer than 20 open cases, all cases shall be reviewed.~~

~~The review period shall be specified in the provider notification letter. The list of cases to be reviewed shall be given to the provider upon arrival or chosen by the IOC Team from a list for the provider site. The components of the records required for review include:~~

~~A. All required assessments~~

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

~~C. Physician orders and lab results~~

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

~~228.115 Program Activity Observation~~ ~~7-1-17~~

~~The reviewer will observe at least one program activity.~~

~~228.116 Beneficiary/Family Interviews~~ ~~7-1-17~~

~~The provider is required to arrange interviews of Medicaid beneficiaries and family members as requested by the IOC team, preferably with the beneficiaries whose records are selected for review. If a beneficiary whose records are chosen for review is not available, then the interviews shall be conducted with a beneficiary on-site whose records are not scheduled for review. Beneficiaries and family members may be interviewed on-site, by telephone conference or both.~~

~~228.117 Exit Conference~~ ~~7-1-17~~

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

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

~~The contractor shall provide a written report of the IOC team's findings to the provider, DMS Behavioral Health Unit and Arkansas Office of Medicaid Inspector General within 14 calendar days from the last day of on-site inspection. The written report shall clearly identify any area of deficiency and required submission of a corrective action plan.~~

~~The contractor shall provide a notification of either acceptance or requirement of directed correction to the provider, DMS Behavioral Health Unit and Arkansas Office of Medicaid~~

~~Inspector General within 14 calendar days of receiving a proposed corrective action plan and shall monitor corrective actions to ensure the plan is implemented and results in compliance.~~

~~All IOC reviews are subject to policy regarding Administrative Remedies and Sanctions (Section 150.000), Administrative Reconsideration and Appeals (Section 160.000) and Provider Due Process (Section 190.000). DMS will not voluntarily publish the results of the IOC review until the provider has exhausted all administrative remedies. Administrative remedies are exhausted if the provider does not seek a review or appeal within the time period permitted by law or rule.~~

~~228.120 DMS/DAABHS Work Group Reports and Recommendations~~ ~~3-1-19~~

~~The DMS/DAABHS Work Group (comprised of representatives from the Behavioral Health Unit, the Arkansas Office of Medicaid Inspector General, the Division of Aging Adult and Behavioral Health Services (DAABHS), the Division of Provider Services and Quality Assurance, the utilization review agency, as well as other units or divisions as required) will meet monthly to discuss IOC reports.~~

~~If a deficiency related to safety or potential risk to the beneficiary or others is found, then the utilization review agency shall immediately report this to the DMS Director (or the Director's designee).~~

~~228.121 Corrective Action Plans~~ ~~3-1-19~~

~~The provider must submit a Corrective Action Plan designed to correct any deficiency noted in the written report of the IOC. The provider must submit the Corrective Action Plan to the contracted utilization review agency within 30 calendar days of the date of the written report. The contractor shall review the Corrective Action Plan and forward it, with recommendations, to the DMS Behavioral Health Unit, the Arkansas Office of Medicaid Inspector General and Division of Provider Services and Quality Assurance (DPSQA).~~

~~After acceptance of the Corrective Action Plan, the utilization review agency will monitor the implementation and effectiveness of the Corrective Action Plan via on-site review. DMS, its contractor(s) or both may conduct a desk review of beneficiary records. The desk review will be site-specific and not by organization. If it is determined that the provider has failed to meet the conditions of participation, DMS will determine if sanctions are warranted.~~

~~228.122 Actions~~ ~~3-1-19~~

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

~~A. Decertification of any beneficiary determined as not meeting medical necessity criteria for outpatient mental health services~~

~~B. Decertification of any provider determined to be noncompliant with the Division of Provider Services and Quality Assurance (DPSQA) provider certification rules~~

~~C. On-site monitoring by the utilization review agency to verify the implementation and effectiveness of corrective actions~~

~~D. The contractor may recommend, and DMS may require, follow-up inspections of care and/or desk reviews. Follow-up inspections may review the issues addressed by the Corrective Action Plans or may be a complete re-inspection of care, at the sole discretion of the Division of Medical Services~~

~~E. Review and revision of the Corrective Action Plan~~

~~F. Review by the Arkansas Office of Medicaid Inspector General~~

~~G. Formulation of an emergency transition plan for beneficiaries including those in custody of DCFS and DYS~~

~~H. Suspension of provider referrals~~

~~I. Placement in high priority monitoring~~

~~J. Mandatory monthly staff training by the utilization review agency~~

~~K. Provider requirement for one of the following staff members to attend a DMS/DAABHS monthly work group meeting: Clinical Director/Designee (at least a master's level mental health professional) or Executive Officer~~

~~L. Recoupment for services that are not medically necessary or that fail to meet professionally recognized standards for health care~~

~~M. Any sanction identified in Section 152.000~~

228.130 Retrospective Reviews

~~7-1-17~~1-1-23

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

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

228.131 Purpose of the Review

~~7-1-17~~1-1-23

The purpose of the review is to:

A. Ensure that services are delivered in accordance with the counselor's ~~Treatment~~ 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~~clients.

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~~1-1-23

On a calendar quarterly basis, the contractor will select a statistically valid random sample from an electronic data set of all ~~Outpatient Behavioral Health~~Counseling Services ~~beneficiaries~~clients whose dates of service occurred during the three (3) -month selection period. If a ~~beneficiary~~client 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~~client will be substituted. The utilization review process will be conducted in accordance with 42 CFR § 456.23.

A written request for medical record copies will be mailed to each provider who provided services to the ~~beneficiaries~~clients selected for the random sample along with instructions for submitting the medical record. The request will include the ~~beneficiary~~client'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.

228.133 Review Process

~~3-1-19~~1-1-23

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

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

The reviewer will also 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~~client. Each denial letter contains a rationale for the denial that is record-specific and each party is provided information about requesting reconsideration review or a fair hearing.

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

229.000 Medicaid ~~Beneficiary~~Client Appeal Process

~~7-1-17~~1-1-23

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

The appeal request must be in writing and received by the Appeals and Hearings Section 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~~1-1-23

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~~1-1-23

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~~client 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~~1-1-23

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~~1-1-23

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

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

~~**Procedure codes requiring prior authorization:**~~

~~View or print the procedure codes for OBHS services.~~View or print procedure codes that require prior authorization for Counseling Services

231.200 Extension of Benefits ~~7-1-17~~1-1-23

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~~client exceeds eight (8) hours of outpatient services in one 24-hour day, with the exception of any service that is paid on a per diem basis.

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

~~231.300 Substance Abuse Covered Codes 2-1-22~~

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

~~View or print the procedure codes for OBHS services.~~

~~Beneficiaries being treated by an Outpatient Behavioral Health Service provider for a mental health disorder who also have a co-occurring substance use disorder(s), this (these) substance use disorder(s) is (are) listed as a secondary diagnosis. Outpatient Behavioral Health Service~~

~~Agency providers that are certified to provide Substance Abuse services may also provider substance abuse treatment to their behavioral health clients. In the provision of Outpatient Behavioral Health mental health services, the substance use disorder is appropriately focused on with the client in terms of its impact on and relationship to the primary mental health disorder.~~

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

240.000 REIMBURSEMENT

240.100 Reimbursement ~~3-1-19~~1-1-23

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

A. ~~Outpatient~~ Counseling Services

Fifteen (15) -Minute Units, unless otherwise stated

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

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

All billing must reflect a daily total, per ~~Outpatient Behavioral Health~~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
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~~client. There is no "carryover" of time from one day to another or from one ~~beneficiary~~client to another.

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

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

~~B. Inpatient Services~~

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

241.000 Fee Schedule

~~3-1-19~~1-1-23

Arkansas Medicaid provides fee schedules on the ~~Arkansas Medicaid~~**DMS 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~~1-1-23

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.

If the decision of the Assistant Director, Division of Medical Services is unsatisfactory, the provider may then appeal the question to a standing Rate Review Panel, established by the Director of the Division of Medical Services, which will include one member of the Division of

Medical Services, a representative of the provider association and a member of the Department of Human Services (DHS) Management Staff, who will serve as chairman.

The request for review by the Rate Review Panel must be postmarked within 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~~1-1-23

~~Outpatient Behavioral Health~~Counseling Services providers use the CMS-1500 form to bill the Arkansas Medicaid Program on paper for services provided to eligible Medicaid ~~beneficiaries~~clients. Each claim may contain charges for only one (1) ~~beneficiary~~client. **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~~1-1-23

Covered ~~Behavioral Health~~counseling ~~S~~services are outpatient services. Specific ~~Behavioral Health~~Counseling Services are available to inpatient hospital patients (as outlined in Sections 240.000 and 220.100), through telemedicine, and to nursing home residents. ~~Outpatient Behavioral Health~~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 ~~or certified~~ scope of practice to provide the service.

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

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

252.110 Counseling Level Services

252.111 Individual Behavioral Health Counseling

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

CPT®/HCPCS PROCEDURE CODE	PROCEDURE CODE DESCRIPTION
View or print the procedure codes for ~~OBHS~~ counseling 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	• Date of Service • Start and stop times of face-to-face encounter

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 condition, and maintain or improve level of functioning, and/or prevent deterioration. Additionally, tobacco cessation counseling is a component of this service.	with ~~beneficiary~~client • Place of service • Diagnosis and pertinent interval history • Brief mental status and observations • Rationale and description of the treatment used that must coincide with the most recent intake assessment~~Mental Health Diagnosis~~ • ~~Beneficiary~~Client'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
Services provided must be congruent with the objectives and interventions articulated on the most recent ~~Mental Health Diagnosis~~intake assessment. Services must be consistent with established behavioral healthcare standards. Individual Psychotherapy is not permitted with ~~beneficiaries~~clients who do not have the cognitive ability to benefit from the service. This service is not for ~~beneficiaries~~clients under four (4) years of age except in documented exceptional cases. This service will require a Prior Authorization for ~~beneficiaries~~clients four (4) years of age.	30 minutes 45 minutes 60 minutes **View or print the procedure codes for ~~OBHS~~ counseling services.**	DAILY MAXIMUM OF ENCOUNTERS THAT MAY BE BILLED: One (1) encounter between all three (3) codes. YEARLY MAXIMUM OF ENCOUNTERS THAT MAY BE BILLED (extension of benefits can be requested): ~~Counseling Level Beneficiary:~~ Twelve (12) encounters between all three (3) codes

APPLICABLE POPULATIONS	SPECIAL BILLING INSTRUCTIONS
Children, Youth, and Adults Residents of Long-Term Care Facilities	A provider may only bill one (1) Individual Behavioral Health Counseling Code per day per ~~beneficiary~~client. A provider cannot bill any other Individual Behavioral Health Counseling Code on the same date of service for the same ~~beneficiary~~client. ~~For Counseling Level Beneficiaries, there~~ There are twelve (12) total individual counseling encounters allowed per year regardless of code billed for Individual Behavioral Health Counseling, unless prior to an extension of benefits ~~is allowed~~approved by the Quality Improvement Organization contracted with Arkansas Medicaid.
ALLOWED MODE(S) OF DELIVERY	**TIER**

Face-to-face Telemedicine (Adults, Youth, and Children)	Counseling
ALLOWABLE PERFORMING PROVIDERS	**PLACE OF SERVICE (POS)**
• Independently Licensed Clinicians – Master's/Doctoral • Non-independently Licensed Clinicians – Master's/Doctoral • Licensed Alcoholism and Drug Abuse Counselor Master's • Advanced Practice Nurses • Physicians • Providers of services for ~~beneficiaries~~clients under four (4) years of age must be trained and certified in specific evidence-based practices to be reimbursed for those services ○ Independently Licensed Clinicians – Parent/Caregiver and Child (Dyadic treatment of Children from zero through forty-seven (0-47) months of age and Parent/Caregiver) Provider ○ Non-independently Licensed Clinicians – Parent/Caregiver and Child (Dyadic treatment of Children from zero through forty-seven (0-47) months of age and Parent/Caregiver) Provider	02 (Telemedicine), 03 (School), 04 (Homeless Shelter), 10 (Telehealth Provided in Client's Home), 11 (Office) 12 (Patient's Home), 32 (Nursing Facility), 49 (Independent Clinic), 50 (Federally Qualified Health Center), 53 (Community Mental Health Center), 57 (Non-Residential Substance Abuse Treatment Facility), 71 (Public Health Clinic), 72 (Rural Health Clinic)

252.112 Group Behavioral Health Counseling

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

CPT®/HCPCS PROCEDURE CODE	PROCEDURE CODE DESCRIPTION
View or print the procedure codes for ~~OBHS~~ counseling services.	Group psychotherapy (other than of a multiple-family group)
SERVICE DESCRIPTION	**MINIMUM DOCUMENTATION REQUIREMENTS**
Group Behavioral Health Counseling is a face-to-face treatment provided to a group of ~~beneficiaries~~clients. Services leverage the emotional interactions of the group's members to assist in each ~~beneficiary~~client's treatment process, support their rehabilitation effort, and to minimize relapse. Services pertain to a ~~beneficiary~~client's (a) Mental Health or (b) Substance Abuse condition, or both. Additionally, tobacco cessation counseling is a component of this service. Services must be congruent with the age and abilities of the ~~beneficiary~~client, client-centered, and strength-based; with emphasis on needs as	• Date of Service • Start and stop times of actual group encounter that includes identified ~~beneficiary~~client • Place of service • Number of participants • Diagnosis and pertinent interval history • Focus of group • Brief mental status and observations • Rationale for group counseling must coincide with the most recent intake~~Mental Health~~

<table>
<tr><td>identified by the ~~beneficiary~~client and provided with cultural competence.</td><td colspan="2">~~A~~assessment
• ~~Beneficiary~~Client's response to the group counseling that includes current progress or regression and prognosis
• Any ~~changes~~ revisions indicated for diagnosis, or medication concerns
• Plan for next group session, including any homework assignments ~~-~~or crisis plans, or both
• Staff signature/credentials/date of signature</td></tr>
<tr><td>NOTES</td><td>UNIT</td><td>BENEFIT LIMITS</td></tr>
<tr><td>This does NOT include psychosocial groups. ~~Beneficiaries~~Clients eligible for Group Behavioral Health Counseling must demonstrate the ability to benefit from experiences shared by others, the ability to participate in a group dynamic process while respecting the others' rights to confidentiality, and must be able to integrate feedback received from other group members. For groups of ~~beneficiaries~~clients 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~~clients under eighteen (18) years of age, the minimum number that must be served in a specified group is two (2). The maximum that may be served in a specified group is ten (10). A ~~beneficiary~~client must be at least four (4) years of age to receive group therapy. Group treatment must be age and developmentally appropriate, (i.e., sixteen (16) year-olds and four (4) year-olds must not be treated in the same group). Providers may bill for services only at times during which ~~beneficiaries~~clients participate in group activities.</td><td>Encounter</td><td>DAILY MAXIMUM OF ENCOUNTERS THAT MAY BE BILLED: One (1)

YEARLY MAXIMUM OF ENCOUNTERS THAT MAY BE BILLED (extension of benefits can be requested):

~~Counseling Level Beneficiary:~~ Twelve (12) encounters</td></tr>
<tr><td>APPLICABLE POPULATIONS</td><td colspan="2">SPECIAL BILLING INSTRUCTIONS</td></tr>
<tr><td>Children, Youth, and Adults</td><td colspan="2">A provider can only bill one (1) Group Behavioral Health Counseling encounter per day. ~~For Counseling Level Beneficiaries, t~~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.</td></tr>
<tr><td>ALLOWED MODE(S) OF DELIVERY</td><td colspan="2">TIER</td></tr>
<tr><td>Face-to-face

Telemedicine (Adults, eighteen (18) years of age and above)</td><td colspan="2">Counseling</td></tr>
<tr><td>ALLOWABLE PERFORMING PROVIDERS</td><td colspan="2">PLACE OF SERVICE</td></tr>
</table>

• Independently Licensed Clinicians – Master's/Doctoral • Non-independently Licensed Clinicians – Master's/Doctoral • Licensed Alcoholism and Drug Abuse Counselor Master's • Advanced Practice Nurses • Physicians	02 (Telemedicine), 03 (School), 10 (Telehealth Provided in Client's Home), 11 (Office), 49 (Independent Clinic), 49 (Independent Clinic), 50 (Federally Qualified Health Center), 53 (Community Mental Health Center), 57 (Non-Residential Substances Abuse Treatment Facility), 71 (Public Health Clinic), 72 (Rural Health Clinic)

252.113 Marital/Family Behavioral Health Counseling with ~~Beneficiary~~Client Present

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

CPT®/HCPCS PROCEDURE CODE	PROCEDURE CODE DESCRIPTION
View or print the procedure codes for ~~OBHS~~ counseling services.	Family psychotherapy (conjoint psychotherapy) (with patient present)
SERVICE DESCRIPTION	**MINIMUM DOCUMENTATION REQUIREMENTS**
Marital/Family Behavioral Health Counseling with ~~Beneficiary~~Client Present is a face-to-face treatment provided to one (1) or more family members in the presence of a ~~beneficiary~~client. 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~~client's (a) Mental Health or (b) Substance Abuse condition, or both. Additionally, tobacco cessation counseling is a component of this service. Services must be congruent with the age and abilities of the ~~beneficiary~~client, client-centered, and strength-based; with emphasis on needs as identified by the ~~beneficiary~~client and provided with cultural competence. ***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. ~~and is only available for beneficiaries in Tier One (1).~~ Dyadic Infant/Caregiver Psychotherapy is a behaviorally based therapy that involves improving the parent-child relationship by transforming the interaction between the two parties. The primary goal of Dyadic Infant/Parent Psychotherapy is to strengthen the relationship between a child and his or**	• Date of Service • Start and stop times of actual encounter with ~~beneficiary~~client and spouse/family • Place of service • Participants present and relationship to ~~beneficiary~~client • Diagnosis and pertinent interval history • Brief mental status of ~~beneficiary~~client and observations of ~~beneficiary~~client with spouse/family • Rationale, and description of treatment used must coincide with the most recent intake assessment~~Mental Health Diagnosis~~ and improve the impact the ~~beneficiary~~client's condition has on the spouse/family or improve marital/family interactions between the ~~beneficiary~~client and the spouse/family, or both • ~~Beneficiary~~Client and spouse/family's response to treatment that includes current progress or regression and prognosis • Any ~~changes~~ 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

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 Psychotherapy (CPP) and Parent Child Interaction Therapy (PCIT). ****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.**		
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~~client per family, per therapy session, may be billed.	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): ~~Counseling Level Beneficiaries:~~ Twelve (12) encounters
APPLICABLE POPULATIONS	**SPECIAL BILLING INSTRUCTIONS**	
Children, Youth, and Adults	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~~Client Present encounters allowed, per year, unless an extension of benefits is allowed by the Quality Improvement Organization contracted with Arkansas Medicaid. **The following ~~code~~services cannot be billed on the Same Date of Service:**	

	Multi-Family Behavioral Health Counseling Marital/Family Behavioral Health Counseling without ~~Beneficiary~~Client Present ~~–~~Psychoeducation **View or print the procedure codes for ~~OBHS~~ counseling services.**
ALLOWED MODE(S) OF DELIVERY	**TIER**
Face-to-face Telemedicine (Adults, Youth, and Children)	Counseling
ALLOWABLE PERFORMING PROVIDERS	**PLACE OF SERVICE**

• Independently Licensed Clinicians - Master's/Doctoral
• Non-independently Licensed Clinicians – Master's/Doctoral
• Licensed Alcoholism and Drug Abuse Counselor Master's
• Advanced Practice Nurses
• Physicians
• Providers of dyadic services must be trained and certified in specific evidence-based practices to be reimbursed for those services
  ○ Independently Licensed Clinicians - Parent/Caregiver and Child (Dyadic treatment of Children from zero through forty-seven (0-47) months of age and Parent/Caregiver) Provider
  ○ Non-independently Licensed Clinicians - Parent/Caregiver and Child (Dyadic treatment of Children from zero through forty-seven (0-47) months of age and Parent/Caregiver) Provider
	02 (Telemedicine), 03 (School), 04 (Homeless Shelter), 10 (Telehealth Provided in Client's Home), 11 (Office) 12 (Patient's Home), 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~~Client Present

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

CPT®/HCPCS PROCEDURE CODE	PROCEDURE CODE DESCRIPTION
View or print the procedure codes for ~~OBHS~~ counseling services.	Family psychotherapy (without the patient present)
SERVICE DESCRIPTION	**MINIMUM DOCUMENTATION REQUIREMENTS**
Marital/Family Behavioral Health Counseling without ~~Beneficiary~~Client Present is a face-to-face treatment provided to one (1) or more family members outside the presence of a ~~beneficiary~~client. Services are designed to enhance insight into family interactions,	• Date of Service • Start and stop times of actual encounter with spouse/family • Place of service

facilitate inter-family emotional or practical support, and develop alternative strategies to address familial issues, problems, and needs. Services pertain to a ~~beneficiary~~client's (a) Mental Health or (b) Substance Abuse condition, or both. Additionally, tobacco cessation counseling is a component of this service. Services must be congruent with the age and abilities of the ~~beneficiary~~client or family member(s), client-centered, and strength-based; with emphasis on needs as identified by the ~~beneficiary~~client and family and provided with cultural competence.	• Participants present and relationship to ~~beneficiary~~client • Diagnosis and pertinent interval history • Brief observations with spouse/family • Rationale, and description of treatment used must coincide with the ~~Mental Health Diagnosis~~most recent intake assessment and improve the impact the ~~beneficiary~~client's condition has on the spouse/family, or improve marital/family interactions between the ~~beneficiary~~client and the spouse/family, or both • ~~Beneficiary~~Client and spouse/family's response to treatment that includes current progress or regression and prognosis • Rationale for excluding the identified client • Any ~~changes~~ 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	
NOTES	**UNIT**	**BENEFIT LIMITS**
Natural supports may be included in these sessions, if justified in service documentation, and if supported in Mental Health Diagnosis. Only one (1) ~~beneficiary~~client per family per therapy session may be billed.	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): ~~Counseling Level Beneficiaries:~~ Twelve (12) encounters
APPLICABLE POPULATIONS	**SPECIAL BILLING INSTRUCTIONS**	
Children, Youth, and Adults	A provider can only bill one (1) Marital/Family Behavioral Health Counseling with (or without) ~~Beneficiary~~Client encounter per day. **The following codes cannot be billed on the Same Date of Service:**	

	Multi-Family Behavioral Health Counseling Marital/Family Behavioral Health Counseling with ~~Beneficiary~~Client Present ~~–~~Psychoeducation 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. **View or print the procedure codes for ~~OBHS~~ counseling services.**
ALLOWED MODE(S) OF DELIVERY	**TIER**
Face-to-face Telemedicine (Adults, Youth, and Children)	Counseling
ALLOWABLE PERFORMING PROVIDERS	**PLACE OF SERVICE**
• Independently Licensed Clinicians - Master's/Doctoral • Non-independently Licensed Clinicians – Master's/Doctoral • Advanced Practice Nurses • Physicians • Providers of dyadic services must be trained and certified in specific evidence-based practices to be reimbursed for those services • Independently Licensed Clinicians - Parent/Caregiver and Child (Dyadic treatment of Children from zero through forty-seven (0-47) months of age and Parent/Caregiver) Provider • Non-independently Licensed Clinicians - Parent/Caregiver and Child (Dyadic treatment of Children from zero through forty-seven (0-47) months of age and Parent/Caregiver) Provider	02 (Telemedicine), 03 (School), 04 (Homeless Shelter), 10 (Telehealth Provided in Client's Home), 11 (Office) 12 (Patient's Home), 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~~1-1-23

CPT®/HCPCS PROCEDURE CODE	PROCEDURE CODE DESCRIPTION
View or print the procedure codes for ~~OBHS~~ counseling services.	Psychoeducational service; per fifteen (15) minutes
SERVICE DESCRIPTION	**MINIMUM DOCUMENTATION REQUIREMENTS**
Psychoeducation provides ~~beneficiaries~~clients and their families with pertinent information regarding mental illness, substance abuse, and tobacco cessation, and teaches problem-solving, communication, and coping skills to	• Date of Service • Start and stop times of actual encounter with ~~beneficiary~~client and spouse/family

support recovery. Psychoeducation can be implemented in two (2) formats: multifamily group and/or single-family group. Due to the group format, ~~beneficiaries~~clients 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, client-centered, and strength-based; with emphasis on needs as identified by the ~~beneficiary~~client 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.**	• Place of service • Participants present • Nature of relationship with ~~beneficiary~~client • Rationale for excluding the identified ~~beneficiary~~client, if applicable • Diagnosis and pertinent interval history • Rationale and objective used must coincide with ~~Mental Health Diagnosis~~the most recent intake assessment and improve the impact the ~~beneficiary~~client's condition has on the spouse/family or improve marital/family interactions between the ~~beneficiary~~client and the spouse/family, or both • Client and Spouse/family response to treatment that includes current progress or regression and prognosis • Any ~~changes~~ 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 •

NOTES	UNIT	BENEFIT LIMITS
Information to support the appropriateness of excluding the identified ~~beneficiary~~client 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~~client and that support's expected role in attaining treatment goals is documented. Only one (1) ~~beneficiary~~client 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	A provider can only bill a total of forty-eight (48) units of Psychoeducation **The following c~~ode~~s~~ervices~~ cannot be billed on the Same Date of Service:** Marital/Family Behavioral Health Counseling with ~~Beneficiary~~Client Present Marital/Family Behavioral Health Counseling without ~~Beneficiary~~Client Present

	View or print the procedure codes for ~~OBHS~~ counseling services.
ALLOWED MODE(S) OF DELIVERY	**TIER**
Face-to-face Telemedicine (Adults, Youth, and Children)	Counseling
ALLOWABLE PERFORMING PROVIDERS	**PLACE OF SERVICE**

• Independently Licensed Clinicians - Master's/Doctoral
• Non-independently Licensed Clinicians – Master's/Doctoral
• Licensed Alcoholism and Drug Abuse Counselor Master's
• Advanced Practice Nurse
• Physician
• Providers of dyadic services must be trained and certified in specific evidence-based practices to be reimbursed for those services
  ○ Independently Licensed Clinicians - Parent/Caregiver and Child (Dyadic treatment of Children from zero through forty-seven (0-47) months of age and Parent/Caregiver) Provider
  ○ Non-independently Licensed Clinicians - Parent/Caregiver and Child (Dyadic treatment of Children from zero through forty-seven (0-47) months of age and Parent/Caregiver) Provider
	02 (Telemedicine), 03 (School), 04 (Homeless Shelter), 10 (Telehealth Provided in Client's Home), 11 (Office) 12 (Patient's Home), 14 (Group 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)

252.116 Multi-Family Behavioral Health Counseling ~~2-1-22~~1-1-23

CPT®/HCPCS PROCEDURE CODE	**PROCEDURE CODE DESCRIPTION**
View or print the procedure codes for ~~OBHS~~ counseling 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~~clients and their family members or significant others. Services are a more cost-effective alternative to Marital/Family Behavioral Health Counseling,	• Date of Service • Start and stop times of actual encounter with ~~beneficiary~~client and/or spouse/family • Place of service • Participants present

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~~client's (a) Mental Health or (b) Substance Abuse condition. Additionally, tobacco cessation counseling is a component of this service. Services must be congruent with the age and abilities of the ~~beneficiary~~client, client-centered and strength-based; with emphasis on needs as identified by the ~~beneficiary~~client and family and provided with cultural competence.	• Nature of relationship with ~~beneficiary~~client • ~~Rationale for excluding the identified beneficiary~~ • Diagnosis and pertinent interval history • Rationale for and objective used to improve the impact the ~~beneficiary~~client's condition has on the spouse/family and/or improve marital/family interactions between the ~~beneficiary~~client and the spouse/family. • Client and Spouse/Family response to treatment that includes current progress or regression and prognosis • Any ~~changes~~ revisions indicated for the ~~master treatment plan,~~ diagnosis~~,~~ or medication(s) • Plan for next session, including any homework assignments and/or crisis plans • HIPAA compliant Release of Information forms, completed, signed, and dated • Staff signature/credentials/date of signature

NOTES	UNIT	BENEFIT LIMITS
May be provided independently if patient is being treated for substance abuse diagnosis only. Comorbid substance abuse should be provided as integrated treatment utilizing Family Psychotherapy.	Encounter	DAILY MAXIMUM OF 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	There are twelve (12) total Multi-Family Behavioral Health Counseling encounters allowed per year. **The following ~~code~~services cannot be billed on the Same Date of Service:** Marital/Family Behavioral Health Counseling without ~~Beneficiary~~Client Present Marital/Family Behavioral Health Counseling with ~~Beneficiary~~Client Present Interpretation of Diagnosis Interpretation of Diagnosis, Telemedicine **View or print the procedure codes for ~~OBHS~~counseling services.**

ALLOWED MODE(S) OF DELIVERY	TIER
Face-to-face	Counseling
ALLOWABLE PERFORMING PROVIDERS	**PLACE OF SERVICE**
• Independently Licensed Clinicians - Master's/Doctoral • Non-independently Licensed Clinicians – Master's/Doctoral • Licensed Alcoholism and Drug Abuse Counselor Master's • Advanced Practice Nurse • Physician	03 (School), 11 (Office), 49 (Independent Clinic), 50 (Federally Qualified Health Center), 53 (Community Mental Health Center), 57 (Non-Residential Substance Abuse Treatment Facility), 71 (Public Health Clinic), 72 (Rural Health Clinic)

252.117 Mental Health Diagnosis

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

CPT®/HCPCS PROCEDURE CODE	PROCEDURE CODE DESCRIPTION
View or print the procedure codes for ~~OBHS~~ counseling services.	Psychiatric diagnostic evaluation (with no medical services)
SERVICE DESCRIPTION	**MINIMUM DOCUMENTATION REQUIREMENTS**
Mental Health Diagnosis is a clinical service for the purpose of determining the existence, type, nature, and appropriate treatment of a mental illness, or related disorder, as described in the current allowable DSM. This service may 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, client-centered, and strength-based; with emphasis on needs as identified by the ~~beneficiary~~client and provided with cultural competence.	• Date of Service • Start and stop times of the face-to-face encounter with the ~~beneficiary~~client and the interpretation time for diagnostic formulation • Place of service • Identifying information • Referral reason • Presenting problem(s), history of presenting problem(s) including duration, intensity, and response(s) to prior treatment • Culturally and age-appropriate psychosocial history and assessment • Mental status (Clinical observations and impressions) • Current functioning plus strengths and needs ~~in specified life domains~~ • DSM diagnostic impressions • Treatment recommendations ~~and prognosis for treatment~~ • ~~Goals and objectives to be placed in Plan of Care~~ • Staff signature/credentials/date of signature

NOTES	UNIT	BENEFIT LIMITS
This service may be billed for face-to-face contact as well as for time spent obtaining necessary information for diagnostic purposes; however, this time may NOT be used for development or submission of required paperwork processes This service can be provided via telemedicine ***Dyadic treatment is available for parent/caregiver and child for dyadic treatment of children from zero through forty-seven (0-47) months of age and parent/caregiver. A Mental Health Diagnosis will be required for all children through forty-seven (47) months of age to receive services. This service includes up to four (4) encounters for children through the age of forty-seven (47) months of age and can be provided without a prior authorization. This service must include an assessment of:** ○ **Presenting symptoms and behaviors** ○ **Developmental and medical history** ○ **Family psychosocial and medical history** ○ **Family functioning, cultural and communication patterns, and current environmental conditions and stressors** ○ **Clinical interview with the primary caregiver and observation of the caregiver-infant relationship and interactive patterns and** ○ **Child's affective, language, cognitive, motor, sensory, self-care, and social functioning**	Encounter	DAILY MAXIMUM OF ENCOUNTERS THAT MAY BE BILLED: One (1) YEARLY MAXIMUM OF ENCOUNTERS THAT MAY BE BILLED (extension of benefits can be requested): One (1)

APPLICABLE POPULATIONS	SPECIAL BILLING INSTRUCTIONS
Children, Youth, and Adults Residents of Long-Term Care	**The following codes cannot be billed on the Same Date of Service:** Psychiatric Assessment **View or print the procedure codes for ~~OBHS~~counseling services.**

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

ALLOWABLE PERFORMING PROVIDER	PLACE OF SERVICE

• Independently Licensed Clinicians – Master's/Doctoral
• Non-independently Licensed Clinicians – Master's/Doctoral
• Advanced Practice Nurses
• Physicians
• Providers of dyadic services must be trained and certified in specific evidence-based practices to be reimbursed for those services
  ○ Independently Licensed Clinicians – Parent/Caregiver and Child (Dyadic treatment of Children from zero through forty-seven (0-47) months of age and Parent/Caregiver) Provider
  ○ Non-independently Licensed Clinicians – Parent/Caregiver and Child (Dyadic treatment of Children from zero through forty-seven (0-47) months of age and Parent/Caregiver) Provider
	02 (Telemedicine), 03 (School), 04 (Homeless Shelter), 10 (Telehealth Provided in Client's Home), 11 (Office) 12 (Patient's Home), 32 (Nursing Facility), 49 (Independent Clinic), 50 (Federally Qualified Health Center), 53 (Community Mental Health Center), 57 (Non-Residential Substance Abuse Treatment Facility), 71 (Public Health Clinic), 72 (Rural Health Clinic)

252.118 Interpretation of Diagnosis

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

CPT®/HCPCS PROCEDURE CODE	PROCEDURE CODE DESCRIPTION
View or print the procedure codes for ~~OBHS~~counseling 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~~client and their family. Services pertain to a ~~beneficiary~~client'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, client-centered, and strength-based; with emphasis on needs as identified by the ~~beneficiary~~client and provided with cultural competence.	• ~~Start and stop times of face-to-face encounter with beneficiary and/or parent(s) or guardian(s)~~ • Date of service • Start and stop times of face-to-face encounter with client and/or parent(s) or guardian(s) • Place of service • Participants present and relationship to ~~beneficiary~~client • Diagnosis and pertinent interval history • Rationale for and description of the treatment used that must coincide with the most recent intake assessment~~and objective used that must coincide with the Mental Health Diagnosis~~

	• Participant(s) response and feedback • Recommendation for additional supports including referrals, resources, and information • ~~Staff~~ Staff signature/credentials/date of signature(s) •	
NOTES	**UNIT**	**BENEFIT LIMITS**
For ~~beneficiaries~~clients under eighteen (18) years of age, the time may be spent face-to-face with the ~~beneficiary~~client; the ~~beneficiary~~client and the parent(s) or guardian(s); or alone with the parent(s) or guardian(s). For ~~beneficiaries~~clients over eighteen (18) years of age, the time may be spent face-to-face with the ~~beneficiary~~client and the spouse, legal guardian, or significant other. This service can be provided via telemedicine to ~~beneficiaries~~clients eighteen (18) years of age and above. This service can also be provided via telemedicine to ~~beneficiaries~~clients 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. ***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.**	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): ~~Counseling Level Beneficiary:~~ One (1)
APPLICABLE POPULATIONS	**SPECIAL BILLING INSTRUCTIONS**	
Children, Youth, and Adults	**The following ~~code~~services cannot be billed on the Same Date of Service:**	

	Psychoeducation Psychiatric Assessment Multi-Family Behavioral Health Counseling Substance Abuse Assessment **View or print the procedure codes for ~~OBHS~~counseling services.** This service can be provided via telemedicine to ~~beneficiaries~~clients eighteen (18) years of age and above. This service can also be provided via telemedicine to ~~beneficiaries~~clients 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.
ALLOWED MODE(S) OF DELIVERY	**TIER**
Face-to-face Telemedicine Adults, Youth and Children	Counseling
ALLOWABLE PERFORMING PROVIDERS	**PLACE OF SERVICE**
• Independently Licensed Clinicians – Master's/Doctoral • Non-independently Licensed Clinicians – Master's/Doctoral • Licensed Alcoholism and Drug Abuse Counselor Master's • Advanced Practice Nurses • Physicians • Providers of dyadic services must be trained and certified, in specific evidence-based practices, to be reimbursed for those services ○ Independently Licensed Clinicians – Parent/Caregiver and Child (Dyadic treatment of Children from zero through forty-seven (0-47) months of age and Parent/Caregiver) Provider ○ Non-independently Licensed Clinicians – Parent/Caregiver and Child (Dyadic treatment of Children from zero through forty-seven (0-47) months of age and Parent/Caregiver) Provider	02 (Telemedicine), 03 (School), 04 (Homeless Shelter), 10 (Telehealth Provided in Client's Home), 11 (Office) 12 (Patient's Home), 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~~1-1-23

CPT®/HCPCS PROCEDURE CODE	PROCEDURE CODE DESCRIPTION

View or print the procedure codes for ~~OBHS~~counseling services.	Alcohol and/or drug assessment

SERVICE DESCRIPTION	MINIMUM DOCUMENTATION REQUIREMENTS
Substance Abuse Assessment is a service that identifies and evaluates the nature and extent of a ~~beneficiary~~client'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~~client, resulting in a treatment recommendation and referral appropriate to effectively treat the condition(s) identified. Services must be congruent with the age and abilities of the ~~beneficiary~~client, client-centered, and strength-based; with emphasis on needs, as identified by the ~~beneficiary~~client, and provided with cultural competence.	• Date of Service • Start and stop times of the face-to-face encounter with the ~~beneficiary~~client and the interpretation time for diagnostic formulation • Place of service • Identifying information • Referral reason • Presenting problem(s), history of presenting problem(s) including duration, intensity, and response(s) to prior treatment • Cultural and age-appropriate psychosocial history and assessment • Mental status (Clinical observations and impressions) • Current functioning and strengths in specified life domains • DSM diagnostic impressions • Treatment recommendations and prognosis for treatment • Staff signature/credentials/date of signature

NOTES	UNIT	BENEFIT LIMITS
The assessment process results in the assignment of a diagnostic impression, ~~beneficiary~~client recommendation for treatment regimen appropriate to the condition and situation presented by the ~~beneficiary~~client, initial plan (provisional) of care, and referral to a service appropriate to effectively treat the condition(s) identified. If indicated, the assessment process must refer the ~~beneficiary~~client for a psychiatric consultation.	Encounter	DAILY MAXIMUM OF ENCOUNTERS THAT MAY BE BILLED: One (1) YEARLY MAXIMUM OF ENCOUNTERS THAT MAY BE BILLED (extension of benefits can be requested): One (1)

APPLICABLE POPULATIONS	SPECIAL BILLING INSTRUCTIONS
Children, Youth, and Adults	**The following codes cannot be billed on the Same Date of Service:** Interpretation of Diagnosis View or print the procedure codes for ~~OBHS~~counseling services.

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

Telemedicine (Adults, Youth, Children)	
ALLOWABLE PERFORMING PROVIDERS	**PLACE OF SERVICE**
• Independently Licensed Clinicians – Master's/Doctoral • Non-independently Licensed Clinicians – Master's/Doctoral • Advanced Practice Nurses • Physicians • Licensed Alcoholism and Drug Abuse Counselor Master's	02 (Telemedicine), 03 (School), 04 (Homeless Shelter), 10 (Telehealth Provided in Client's Home), 11 (Office) 12 (Patient's Home), 49 (Independent Clinic), 50 (Federally Qualified Health Center), 53 (Community Mental Health Center), 57 (Non-Residential Substance Abuse Treatment Facility), 71 (Public Health Clinic), 72 (Rural Health Clinic)

~~**252.120 Psychological Evaluation**~~ ~~**2-1-22**~~

~~**CPT®/HCPCS PROCEDURE CODE**~~	~~**PROCEDURE CODE DESCRIPTION**~~
~~**View or print the procedure codes for OBHS services.**~~	~~Psychological testing (includes psychodiagnostic assessment of emotionality, intellectual abilities, personality and psychopathology, e.g. MMPI, Rorschach®, WAIS®), per hour of the psychologist's or physician's time, both face-to-face time administering tests to the patient and time interpreting these test results and preparing the report.~~
~~**SERVICE DESCRIPTION**~~	~~**MINIMUM DOCUMENTATION REQUIREMENTS**~~
~~Psychological Evaluation for personality assessment includes psychodiagnostic assessment of a beneficiary's emotional, personality, and psychopathology, e.g., MMPI, Rorschach®, and WAIS®. Psychological testing is billed per hour both face-time administering tests and time interpreting these tests and preparing the report. This service may reflect the mental abilities, aptitudes, interests, attitudes, motivation, emotional and personality characteristics of the beneficiary.~~ ~~Services must be congruent with the age and abilities of the beneficiary, client-centered and strength-based; with emphasis on needs as identified by the beneficiary and provided with cultural competence~~ ~~Medical necessity for this service is met when:~~ ~~• the service is necessary to establish a differential diagnosis of behavioral or psychiatric conditions~~ ~~• history and symptomatology are not readily attributable to a particular psychiatric diagnosis~~	~~• Date of Service~~ ~~• Start and stop times of actual encounter with beneficiary~~ ~~• Start and stop times of scoring, interpretation and report preparation~~ ~~• Place of service~~ ~~• Identifying information~~ ~~• Rationale for referral~~ ~~• Presenting problem(s)~~ ~~• Culturally and age-appropriate psychosocial history and assessment~~ ~~• Mental status/Clinical observations and impressions~~ ~~• Psychological tests used, results, and interpretations, as indicated~~ ~~• DSM diagnostic~~ ~~• Treatment recommendations and findings related to rationale for service and guided by test results~~ ~~• Staff signature/credentials/date of signature(s)~~

• ~~questions to be answered by the evaluation could not be resolved by a Mental Health Diagnosis or Psychiatric Assessment, observation in therapy, or an assessment for level of care at a mental health facility~~ • ~~the service provides information relevant to the beneficiary's continuation in treatment and assists in the treatment process~~		
~~NOTES~~	**~~UNIT~~**	**~~BENEFIT LIMITS~~**
~~This code may not be billed for the completion of testing that is considered primarily educational or utilized for employment, disability qualification, or legal or court related purposes.~~	~~60 minutes~~	~~DAILY MAXIMUM OF UNITS THAT MAY BE BILLED: 4~~ ~~YEARLY MAXIMUM OF UNITS THAT MAY BE BILLED (extension of benefits can be requested): 8~~
~~APPLICABLE POPULATIONS~~	**~~SPECIAL BILLING INSTRUCTIONS~~**	
~~Children, Youth, and Adults~~	~~used for first hour of service~~ ~~used for any additional hours of service~~ **~~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~~**	
• ~~Licensed Psychologist (LP)~~ • ~~Licensed Psychological Examiner (LPE)~~ • ~~Licensed Psychological Examiner – Independent (LPEI)~~	~~03 (School), 11 (Office), 49 (Independent Clinic), 50 (Federally Qualified Health Center), 53 (Community Mental Health Center), 57 (Non-Residential Substance Abuse Treatment Facility), 71 (Public Health Clinic), 72 (Rural Health Clinic)~~	

252.121 Pharmacologic Management ~~2-1-22~~1-1-23

CPT®/HCPCS PROCEDURE CODE	PROCEDURE CODE DESCRIPTION
View or print the procedure codes for ~~OBHS~~counseling services.	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. 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. 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. **View or print the procedure codes for ~~OBHS~~counseling services.**
SERVICE DESCRIPTION	**MINIMUM DOCUMENTATION REQUIREMENTS**
Pharmacologic Management is a service tailored to reduce, stabilize, or eliminate psychiatric symptoms, with the goal of improving functioning, including management and reduction of symptoms. This service includes evaluation of the medication prescription, administration, monitoring, and supervision, as well as informing ~~beneficiaries~~clients 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. Services must be congruent with the age and abilities of the ~~beneficiary~~client, client-centered, and strength-based; with emphasis on needs as identified by the ~~beneficiary~~client and provided with cultural competence.	• Date of Service • Start and stop times of actual encounter with ~~beneficiary~~client • Place of service (When ninety-nine (99) is used for telemedicine, specific locations of the ~~beneficiary~~client, 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~~Client'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), 10 (Telehealth Provided in Client's Home), 11 (Office), 12 (Patient's Home), 49 (Independent Clinic), 50 (Federally Qualified Health Center), 53 (Community Mental Health Center), 57 (Non-Residential Substance Abuse Treatment Facility), 71 (Public Health Clinic), 72 (Rural Health Clinic)	

252.122 Psychiatric Assessment ~~2-1-22~~1-1-23

CPT®/HCPCS PROCEDURE CODE	PROCEDURE CODE DESCRIPTION
View or print the procedure codes for ~~OBHS~~counseling 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~~clients 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~~clients to receive ~~C~~counseling ~~Level S~~services.	• Date of Service • Start and stop times of the face-to-face encounter with the ~~beneficiary~~client and the interpretation time for diagnostic formulation • Place of service • Identifying information • Referral reason • The interview should obtain or verify the following: 1. The ~~beneficiary~~client'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

<table>
<tr><td colspan="2"></td><td>
4. History of problems
5. Treatment history
6. Response to prior treatment interventions
7. Medical history (and examination as indicated)
• For ~~beneficiaries~~clients 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
</td></tr>
<tr><td>NOTES</td><td>UNIT</td><td>BENEFIT LIMITS</td></tr>
<tr><td>This service may be billed for face-to-face contact as well as for time spent obtaining necessary information for diagnostic purposes; however, this time may NOT be used for development or submission of required paperwork processes (i.e. treatment plans, etc.).</td><td>Encounter</td><td>DAILY MAXIMUM OF ENCOUNTERS THAT MAY BE BILLED: One (1)
YEARLY MAXIMUM OF ENCOUNTERS THAT MAY BE BILLED (extension of benefits can be requested): One (1)</td></tr>
<tr><td>APPLICABLE POPULATIONS</td><td colspan="2">SPECIAL BILLING INSTRUCTIONS</td></tr>
<tr><td>Children, Youth, and Adults
Telemedicine (Adults, Youth, and Children)</td><td colspan="2">The following ~~code~~services cannot be billed on the Same Date of Service:
Mental Health Diagnosis
View or print the procedure codes for ~~OBHS~~counseling services.</td></tr>
<tr><td>ALLOWED MODE(S) OF DELIVERY</td><td colspan="2">TIER</td></tr>
</table>

Face-to-face	Counseling
ALLOWABLE PERFORMING PROVIDERS	**PLACE OF SERVICE**
A. an Arkansas-licensed physician, preferably someone with specialized training and experience in psychiatry (child and adolescent psychiatry for ~~beneficiaries~~clients under eighteen (18) years of age) B. an Adult Psychiatric Mental Health Advanced Nurse Practitioner/Family Psychiatric Mental Health Advanced Nurse Practitioner (PMHNP-BC) **The PMHNP-BC must meet all of the following requirements:** A. Licensed by the Arkansas State Board of Nursing B. Practicing with licensure through the American Nurses Credentialing Center C. Practicing under the supervision of an Arkansas-licensed psychiatrist with whom the PMHNP-BC has a collaborative agreement. The findings of the Psychiatric Assessment conducted by the PMHNP-BC, must be discussed with the supervising psychiatrist within forty-five (45) days of the ~~beneficiary~~client entering care. The collaborative agreement must comply with all Board of Nursing requirements and must spell out, in detail, what the nurse is authorized to do and what age group they may treat D. Practicing within the scope of practice as defined by the Arkansas Nurse Practice Act E. Practicing within a PMHNP-BC's experience and competency level	02 (Telemedicine), 03 (School), 04 (Homeless Shelter), 10 (Telehealth Provided in Client's Home), 11 (Office), 12, (Patient's Home), 49 (Independent Clinic), 50 (Federally Qualified Health Center), 53 (Community Mental Health Center), 57 (Non-Residential Substance Abuse Treatment Facility), 71 (Public Health Clinic), 72 (Rural Health Clinic)

252.123 Intensive Outpatient Substance Abuse Treatment **1-1-23**

PROCEDURE CODES	**PROCEDURE CODE DESCRIPTION**
View or print the procedure codes for counseling services.	Intensive outpatient treatment for alcohol and/or substance abuse. Treatment program must operate a minimum of three (3) hours per day and at least three (3) days per week. The treatment is

	based on an individualized plan of care including assessment, counseling, crisis intervention, activity therapies or education.
SERVICE DESCRIPTION	**MINIMUM DOCUMENTATION REQUIREMENTS**
Intensive Outpatient Services provide group based, non-residential, intensive, structured interventions consisting primarily of counseling and education to improve symptoms that may significantly interfere with functioning in at least one (1) life domain (e.g., familial, social, occupational, educational, etc.). Services are goal-oriented interactions with the individual or in group/family settings. This community-based service allows the individual to apply skills in "real world" environments. Such treatment may be offered during the day, before or after work or school, in the evening or on a weekend. The services follow a defined set of policies and procedures or clinical protocols. The service also provides a coordinated set of individualized treatment services to persons who are able to function in a school, work, and home environment but are in need of treatment services beyond traditional outpatient programs. Treatment may appropriately be used to transition persons from higher levels of care or may be provided for persons at risk of being admitted to higher levels of care. Intensive outpatient programs provide nine (9) or more hours per week of skilled treatment, three to five (3-5) times per week in groups of no fewer than three (3) and no more than twelve (12) clients.	• Date of service • Start and stop times of the face-to-face encounter with the client and the interpretation time for diagnostic formulation • Place of service • Identifying information • Referral reason • Presenting problem(s), history of presenting problem(s) including duration, intensity, and response(s) to prior treatment • Diagnostic impressions • Rationale for service including consistency with plan of care • Brief mental status and observations • Current functioning and strengths in specified life domains • Client's response to the intervention that includes current progress or regression and prognosis • Staff signature/credentials/date of signature(s)

NOTES	**UNIT**	**BENEFIT LIMITS**
	Per Diem	YEARLY MAXIMUM OF UNITS THAT MAY BE BILLED: (extension of benefits can be requested) Twenty-four (24)

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

255.000 Crisis Stabilization Intervention 1-1-23

PROCEDURE CODES	PROCEDURE CODE DESCRIPTION
View or print the procedure codes for counseling services.	Crisis Stabilization service, per fifteen (15) minutes
SERVICE DESCRIPTION	**MINIMUM DOCUMENTATION REQUIREMENTS**
Crisis Stabilization Intervention is a scheduled face-to-face (or telemedicine) treatment activity provided to a client who has recently experienced a psychiatric or behavioral health crisis that is expected to further stabilize, prevent deterioration, and serve as an alternative to twenty-four (24) -hour inpatient care. Services are to be congruent with the age, strengths, needed accommodation for any disability, and cultural framework of the client and their family.	• Date of service • Start and stop time of actual encounter with client and possible collateral contacts with caregivers or informed persons • Place of service • Specific persons providing pertinent information and relationship to client • Diagnosis and synopsis of events leading up to crisis situation • Brief mental status and observations • Utilization of previously established psychiatric advance directive or crisis plan as pertinent to current situation OR rationale for crisis intervention activities utilized • Client's response to the intervention that includes current progress or regression and prognosis • Clear resolution of the current crisis and/or plans for further services • Development of a clearly defined crisis plan or revision to existing plan • Staff signature/credentials/date of signature(s)

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

APPLICABLE POPULATIONS	SPECIAL BILLING INSTRUCTIONS
Children, Youth, and Adults	
ALLOWED MODE(S) OF DELIVERY	**TIER**

Face-to-face Telemedicine (Adults, Youth, and Children)	Crisis
ALLOWABLE PERFORMING PROVIDERS	**PLACE OF SERVICE**
• Independently Licensed Clinicians – Master's/Doctoral • Non-independently Licensed Clinicians – Master's/Doctoral (must be employed by Behavioral Health Agency) • Licensed Alcoholism and Drug Abuse Counselor Master's • Advanced Practice Nurses • Physicians (must be employed by Behavioral Health Agency)	02 (Telemedicine) 03 (School), 04 (Homeless Shelter), 10 (Telehealth Provided in Client's Home), 11 (Office) 12 (Patient's Home), 15 (Mobile Unit), 23 (Emergency Room), 33 (Custodial Care facility), 49 (Independent Clinic), 50 (Federally Qualified Health Center), 53 (Community Mental Health Center), 57(Non-Residential Substance Abuse Treatment Facility), 71 (Public Health Clinic), 72 (Rural Health Clinic), 99 (Other Location)

255.001 Crisis Intervention

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

CPT®/HCPCS PROCEDURE CODE	PROCEDURE CODE DESCRIPTION
View or print the procedure codes for ~~OBHS~~counseling services.	Crisis intervention service, per fifteen (15) minutes
SERVICE DESCRIPTION	**MINIMUM DOCUMENTATION REQUIREMENTS**
Crisis Intervention is unscheduled, immediate, short-term treatment activities provided to a Medicaid-eligible ~~beneficiary~~client who is experiencing a psychiatric or behavioral crisis. Services are to be congruent with the age, strengths, needed accommodation for any disability, and cultural framework of the ~~beneficiary~~client and his/her family. These services are designed to stabilize the person in crisis, prevent further deterioration and provide immediate indicated treatment in the least restrictive setting. (These activities include evaluating a Medicaid-eligible ~~beneficiary~~client to determine if the need for crisis services is present.) Services are to be congruent with the age, strengths, needed accommodation for any disability, and cultural framework of the ~~beneficiary~~client and their family.	• Date of service • Start and stop time of actual encounter with ~~beneficiary~~client and possible collateral contacts with caregivers or informed persons • Place of service • Specific persons providing pertinent information ~~in~~ and relationship to ~~beneficiary~~client • Diagnosis and synopsis of events leading up to crisis situation • Brief mental status and observations • Utilization of previously established psychiatric advance directive or crisis plan as pertinent to current situation OR rationale for crisis intervention activities utilized • ~~Beneficiary~~Client's response to the intervention that includes current progress or regression and prognosis • Clear resolution of the current crisis and/or plans for further services • Development of a clearly defined crisis plan or revision to existing plan • Staff signature/credentials/date of signature(s)

NOTES	UNIT	BENEFIT LIMITS
A psychiatric or behavioral crisis is defined as an acute situation, in which an individual is experiencing a serious mental illness or emotional disturbance to the point that the ~~beneficiary~~client or others are at risk for imminent harm, or in which to prevent significant deterioration of the ~~beneficiary~~client's functioning. This service can be provided to ~~beneficiaries~~clients that have not been previously assessed or have not previously received behavioral health services. The provider of this service MUST complete a Mental Health Diagnosis within seven (7) days of provision of this service, if provided to a ~~beneficiary~~client who is not currently a client. **View or print the procedure codes for ~~OBHS~~counseling services.** If the ~~beneficiary~~client cannot be contacted or does not return for a Mental Health Diagnosis appointment, attempts to contact the ~~beneficiary~~client must be placed in the ~~beneficiary~~client's medical record. If the ~~beneficiary~~client needs more time to be stabilized, this must be noted in the ~~beneficiary~~client's medical record and the Division of Medical Services Quality Improvement Organization (QIO) must be notified.	Fifteen (15) minutes	DAILY MAXIMUM OF UNITS THAT MAY BE BILLED: twelve (12) YEARLY MAXIMUM OF UNITS THAT MAY BE BILLED (extension of benefits can be requested): seventy-two (72)

APPLICABLE POPULATIONS	SPECIAL BILLING INSTRUCTIONS
Children, Youth, and Adults	

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

ALLOWABLE PERFORMING PROVIDERS	PLACE OF SERVICE
• Independently Licensed Clinicians – Master's/Doctoral • 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), 10 (Telehealth Provided in Client's Home), 11 (Office) 12 (Patient's Home), 15 (Mobile Unit), 23 (Emergency Room), 33 (Custodial Care facility), 49 (Independent Clinic), 50 (Federally Qualified Health Center), 53 (Community Mental Health Center), 57 (~~-~~Non-Residential Substance Abuse Treatment Facility), 71 (Public Health Clinic), 72 (Rural Health Clinic), 99 (Other Location)

255.003 Acute Crisis Units

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

CPT®/HCPCS PROCEDURE CODE	PROCEDURE CODE DESCRIPTION
View or print the procedure codes for ~~OBHS~~counseling services.	Behavioral Health; short-term residential
SERVICE DESCRIPTION	**MINIMUM DOCUMENTATION REQUIREMENTS**
Acute Crisis Units provide brief (96 hours or less) crisis treatment services to persons eighteen (18) years of age and over, who are experiencing a psychiatric or substance abuse-related crisis, or both, and may pose an escalated risk of harm to self or others. Acute Crisis Units provide hospital diversion and step-down services in a safe environment with psychiatry and substance abuse services on-site at all times, as well as on-call psychiatry available twenty-four (24) hours a day. Services provide ongoing assessment and observation; crisis intervention; psychiatric, substance, and co-occurring treatment; and initiate referral mechanisms for independent assessment and care planning as needed.	• Date of service • Assessment information including mental health and substance abuse psychosocial evaluation, initial discharge plan, strengths and abilities to be considered for community re-entry • Place of service • Specific persons providing pertinent information and relationship to client • Diagnosis and synopsis of events leading up to acute crisis admission • Interpretive summary • Brief mental status and observations • Utilization of previously established psychiatric advance directive or crisis plan as pertinent to current situation OR rationale for crisis intervention activities utilized • Client's response to the intervention that includes current progress or regression and prognosis • Clear resolution of the current crisis and/or plans for further services • Development of a clearly defined crisis plan or revision to existing plan • Thorough discharge plan including treatment and community resources • Staff signature/credentials/date of signature(s)
NOTES	**EXAMPLE ACTIVITIES**

APPLICABLE POPULATIONS	UNIT	BENEFIT LIMITS
Adults	Per Diem	• ~~—~~Ninety-six (96) hours or less per admission; Extension of Bene~~-~~fits 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	

255.004 Substance Abuse Detoxification

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

CPT®/HCPCS PROCEDURE CODE	**PROCEDURE CODE DESCRIPTION**
View or print the procedure codes for ~~OBHS~~counseling services.	Alcohol and/or drug services; detoxification
SERVICE DESCRIPTION	**MINIMUM DOCUMENTATION REQUIREMENTS**
Substance Abuse Detoxification is a set of interventions aimed at managing acute intoxication and withdrawal from alcohol or other drugs. Services help stabilize ~~beneficiaries~~clients by clearing toxins from the ~~beneficiary~~client's body. Services are short-term and may be provided in a crisis unit, inpatient, or outpatient setting, and may include evaluation, observation, medical monitoring, and addiction treatment. Detoxification seeks to minimize the physical harm caused by the abuse of substances and prepares the ~~beneficiary~~client for ongoing treatment.	• Date of service • Assessment information including mental health and substance abuse psychosocial evaluation, initial discharge plan, strengths and abilities to be considered for community re-entry • Place of service • Specific persons providing pertinent information and relationship to client • Diagnosis and synopsis of events leading up to acute crisis admission • Interpretive summary • Brief mental status and observations • Utilization of previously established psychiatric advance directive or crisis plan as pertinent to current situation OR rationale for crisis intervention activities utilized • Client's response to the intervention that includes current progress or regression and prognosis • Clear resolution of the current crisis and/or plans for further services • Development of a clearly defined crisis plan or revision to existing plan • Thorough discharge plan including treatment and community resources

	• Staff signature/credentials/date of signature(s)	
NOTES	**EXAMPLE ACTIVITIES**	
APPLICABLE POPULATIONS	**UNIT**	**BENEFIT LIMITS**
Youth and Adults	N/A	• Six (6) encounters per SFY; Extension of Benefits required for additional encounters
	PROGRAM SERVICE CATEGORY	
	Crisis Services	
ALLOWED MODE(S) OF DELIVERY	**TIER**	
Face-to-face	N/A	
ALLOWABLE PERFORMING PROVIDERS	**PLACE OF SERVICE**	
Substance Abuse Detoxification must be provided in a facility that is ~~certified~~ licensed by the Division of Provider Services and Quality Assurance as a Substance Abuse Detoxification provider.	21 (Inpatient Hospital), 55 (Residential Substance Abuse Treatment Facility)	

256.200 Reserved ~~8-1-18~~1-1-23

~~**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~~	~~02~~
~~School (Including Licensed Child Care Facility)~~	~~03~~
~~Homeless Shelter~~	~~04~~
~~Office (Outpatient Behavioral Health Provider Facility Service Site)~~	~~11~~
~~Patient's Home~~	~~12~~
~~Group Home~~	~~14~~
~~Mobile Unit~~	~~15~~
~~Temporary Lodging~~	~~16~~
~~Inpatient Hospital~~	~~21~~
~~Nursing Facility~~	~~32~~
~~Custodial Care Facility~~	~~33~~
~~Independent Clinic~~	~~49~~

~~Place of Service~~	~~POS Codes~~
~~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~~

256.500 Billing Instructions – Paper Only

~~11-1-17~~1-1-23

To bill for ~~Outpatient Behavioral Health~~Counseling ~~s~~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.

256.510 Completion of the CMS-1500 Claim Form

~~7-1-17~~1-1-23

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~~Client's or participant's 10-digit Medicaid or ARKids First-A or ARKids First-B identification number.
2.	PATIENT'S NAME (Last Name, First Name, Middle Initial)	~~Beneficiary~~Client's or participant's last name and first name.
3.	PATIENT'S BIRTH DATE	~~Beneficiary~~Client's or participant's date of birth as given on the individual's Medicaid or ARKids First-A or ARKids First-B identification card. Format: MM/DD/YY.
	SEX	Check M for male or F for female.
4.	INSURED'S NAME (Last Name, First Name, Middle Initial)	Required if insurance affects this claim. Insured's last name, first name, and middle initial.
5.	PATIENT'S ADDRESS (No., Street)	Optional. ~~Beneficiary~~Client's or participant's complete mailing address (street address or post office box).

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

Field Name and Number		Instructions for Completion
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.
13.	INSURED'S OR AUTHORIZED PERSON'S SIGNATURE	Not required.
14.	DATE OF CURRENT: ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)	Required when services furnished are related to an accident, whether the accident is recent or in the past. Date of the accident.
15.	IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE	Not required.
16.	DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION	Not required.
17.	NAME OF REFERRING PROVIDER OR OTHER SOURCE	Primary Care Physician (PCP) referral or PCMH sign-off is required for ~~Outpatient Behavioral Health~~Counseling Services for all ~~beneficiaries~~clients after ~~3~~ten (10) ~~C~~counseling ~~Level S~~services. 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~~client's or participant's inpatient hospitalization, enter the individual's admission and discharge dates. Format: MM/DD/YY.
19.	RESERVED FOR LOCAL USE	Not applicable to ~~Outpatient Behavioral Health~~Counseling Services.
20.	OUTSIDE LAB?	Not required.
	$ CHARGES	Not required.

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

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

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

257.000 Special Billing Procedures

257.100 Reserved ~~8-1-18~~1-1-23