EXHIBIT U

DEPARTMENT OF HUMAN SERVICES, DIVISION OF MEDICAL SERVICES

SUBJECT: Rebalancing Services for Clients with Intellectual and Developmental Disabilities and Behavioral Health Needs

DESCRIPTION:

Statement of Necessity

This rule includes ten (10) manuals and several accompanying State Plan pages. The manual amendments, enactments, and repeals are all focused on shifting away from a fee-for-service methodology for our clients with high needs (IDD or BH), lessening administrative burden on our providers, supporting the workforce (both paraprofessional and clinical) that are employed to provide services to IDD and BH clients, and raising the quality of the care with evidence-based and recognized service models.

Rule Summary

The following manuals are affected by this rule:

New Manuals:

- Community and Employment Support (CES) Waiver Certification Manual
  - Identifies 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).

    After the public comment period, the agency removed this manual from the rule.

- Home and Community-Based Services for Clients with Intellectual Disabilities and Behavioral Health Needs Manual

  Changes based on Public Comments:
  - Clarified the name of the 1915i state plan outside the PASSE program because it is no longer named the Adult Behavioral Services for Community Independence.
  - Added the word Intervention to the service Crisis Stabilization Intervention because that is the actual name.
  - Added Assertive Community Treatment to the 1915i state plan outside the PASSE because it was inadvertently left off of the service list.
  -
- Diagnostic and Evaluation Manual
  - Sets criteria to determine eligibility for the Division of Development Disabilities Services and treatment planning and diagnostic clarification for the Division of Aging, Adult, and Behavioral Health Services.

  Changes based on Public Comments:

- Based on public comment, language has been amended under the Autism section and under the Institutional Level of Care section to specifically ensure that the clients PCP is involved and makes the referral for the additional evaluations.
- Under Evaluator Requirements for Autism testing, we mimicked the requirements for the other sections to allow LPEs and LPEIs, under their scope of practice, to perform the evaluations.

Amended Manuals:

- Community Support System Provider Certification Manual—Changes include:
  - Adds an Intensive Level to this provider type.
  - Adds an intermediate level between base and enhanced.
  - Adds two new services to this provider type.
  - Changes the term "beneficiary" to "client" throughout the document.
  - Changes the CSSP "licensure" to "Agency Certification" throughout the document.
  - Clarifies that the CSSP is the CSSP Agency, not the specific provider, by updating terminology.
  - Makes technical changes as necessary.

  Changes based on Public Comments:
  - Corrected formatting mistakes.
  - Minor changes to adverse action definition and appeal process based on public comment.
  - Removed definitions for which defined terms were not used elsewhere within document.
  - Several new definitions were added for clarity purposes.
  - "Employee" definition changed based on public comment.
  - Specific criminal background, maltreatment, drug screen, and registry check requirements were included in Section 302 for clarity purposes based on public comment.
  - Section 303 "Employee Training" had multiple changes based on public comment.
  - Section 305 "Client Service Records" had multiple changes based on public comment and for clarity purposes.
  - Section 309 "Emergency Plans and Drills" was moved to become the new section 501 based on public comment and for clarity purposes.
  - Section 311 "Compliance with State and Federal Laws, Rules, and Other Standards" was simplified for clarity purposes based on public comment.
  - Section 312 "Emergency Response Services" was moved to become the new Section 1003 "Behavioral Health Crisis Response Services" for clarity purposes and simplified based upon public comment.
  - The new Section 312 "General Nutrition and Food Service Requirements", Section 313 "Medications" and Section 314 "Service Logs", were moved from Subchapter 10 "Enhanced CSSP Agency Certification" because these standards needed to apply to Base CSSP Agency certification home and

community-based service providers and not just Enhanced CSSP Agency certification providers.
    - New Section 315 “Behavioral Management Plans for IDD Clients” was added due to its unintentionally being left out of the original proposed Rule.
    - New Subchapter 5 “Settings Requirement” was added for clarity purposes based on public comment to create a standalone section applicable to home and community-based service settings. All section in this subchapter were pulled from other portions of the proposed document (primarily the former Subchapter 10 Enhanced CSSP Agency) with slight revisions based on public comment.
    - Subchapter 9 (now 10) was revised and simplified based on public comment.
    - Dozens of other minor typo corrections, terminology corrections, capitalization corrections, and changes for consistency purposes were made throughout.
- PASSE Manual—Removes home and community-based specialty services sections (This information is included in the new HCBS for Clients with IDD and BH Needs Manual).
- Physician’s Manual
    - Section 203.270 modifies PCP referral policy for some behavioral health services if place of service is not the physician’s office.
    - Renames Section 205.100 as Physician’s Supervision in the Provision of Behavioral Health Counseling Services, and adds Hyperlinks to the new Counseling Services provider manual and the new Diagnostic and Evaluation provider manual.
    - Removes Section 248.000, Psychotherapy and Psychological Testing.
    - Renames Section 292.740 Counseling Services, and modifies rule regarding who can provide these services to clients and where counseling may occur.
    - Renames Section 292.741 Behavioral Health Screen, and adds screening services.
    - Removes Section 292.742, Family/Group Psychotherapy.
    - Updates term psychotherapy to behavioral health counseling in Sections 205.100 and 292.740.

    Changes based on Public Comments:
    - o 205.100—Added reference to PCCM program.
    - o 292.740—Added limitations for Place of Service Codes for counseling services.
    - o 292.741—Added that the emotional/behavioral assessment is “standardized”.
- Outpatient Behavioral Health Services Manual is amended and will become the Counseling Services Manual
    - Updates term Outpatient Behavioral Health Services to Counseling Services throughout the manual.
    - Changes staff requirements for providers.
    - Clarifies the physician’s role in the relationships with Counseling Services providers.

- Requires prior authorization for certain counseling services for beneficiaries under the age of four (4).
- Limits individuals solely licensed as Licensed Alcoholism and Drug Abuse Counselors (LADAC) to only provide services to individuals with a primary substance use diagnosis.
- Adds Licensed Alcoholism and Drug Abuse Counselor Master's to allowable performing providers list for specific procedure codes.
- Updates minimum documentation requirements for specific procedure codes.
- Adds services, service descriptions, and minimum documentation requirements for Intensive Outpatient Substance Abuse Treatment and Crisis Stabilization Intervention.
- Updates minimum documentation requirements for Acute Crisis Units and Substance Abuse Detoxification.

Changes Based on Public Comments:

- Section 202.200 Providers with Multiple Sites: Removed this section. No longer applicable due to end of moratorium and changes to Behavioral Health system.
- Section 211.200 Staff Requirements: Language updated to include individuals who are contracted by a certified Behavioral Health Agency or Community Support System Agency.
- Section 213.000: Order of paragraphs changed to be consistent with program entry.
- Section 217.100 Primary Care Physician (PCP) Referral: Duplicative language was removed.
- Section 224.000 Physician's Role: Clarify the responsibility of Counseling Services providers to communicate with PCPs.
- Section 226.100: Removed Item C. and edited item D.
- Section 252.121 Pharmacological Management: Removed language inconsistent with changes to delivery of services under current telemedicine policy.
- Section 255.000: Crisis Stabilization Intervention: Duplicate language removed. Staff requirements included in Section 211.200
- Section 255.001 Crisis Intervention: Added language to clarify no PCP referral is required for Crisis Intervention.
- Section 255.001 Crisis Intervention: Duplicate language removed. Staff requirements included in Section 211.200

Repealed Manuals:

- Independent Licensed Practitioner Certification Manual—The repeal will allow ILPs to enroll in Medicaid with proof of their clinical license. This is consistent with how Medicaid treats other professionals.
- School-Based Mental Health Manual and corresponding Medicaid State Plan pages—these services are contained in other programs.
- Adult Behavioral Health Services for Community Independence Manual—these services are now outlined in the new Home and Community-Based Services for Clients with Intellectual Disabilities and Behavioral Health Needs Manual.

PUBLIC COMMENT: A public hearing was held on this rule on October 27, 2022. The public comment period expired on November 13, 2022. Due to its length, the public comment summary is provided separately.

Lacey Johnson, an attorney with the Bureau of Legislative Research, asked the following questions and received the following responses:

1. What is the statutory authority for the monetary penalties allowed by CSSP Manual § 606(a) and DDS CES Waiver Provider Manual § 806(a)?

RESPONSE: The statutory authority for imposition fines for both is derived from A.C.A. 20-48-1003(b)(1)(B)(i-iii): Administration (Community and Employment Supports Services Waiver Program Provider Fee):

> (1) In accordance with the Arkansas Administrative Procedure Act, § 25-15-201 et seq., the Division of Medical Services of the Department of Human Services shall promulgate rules and prescribe forms for:
> (A) The proper imposition and collection of the provider fee;
> (B)(i) The enforcement of this subchapter, including without limitation certification nonrenewal, letters of caution, sanctions, or fines.
> (ii) The fine for failure to comply with payment and reporting requirements shall be at least one thousand dollars ($1,000) but no more than one thousand five hundred dollars ($1,500).
> (iii) The fine and, if applicable, the outstanding balance of the provider fee shall accrue interest at the maximum rate permitted by law from the date the fine and, if applicable, the provider fee is due until payment of the outstanding balance of the fine and, if applicable, the provider fee;

2. Do the dieticians listed in the DDS CES Waiver Provider Manual § 610(b)(12) fall under one of the exemptions listed in Ark. Code Ann. § 17-83-104? If not, why does the manual not require licensure by the Arkansas Dietetics Licensing Board? **RESPONSE:** The section 610 mimics the CES waiver approved by CMS.

The proposed effective date is January 1, 2023.

FINANCIAL IMPACT: The agency indicated that this rule has a financial impact.

Per the agency, the total estimated cost to implement this rule is $350,000 for the current fiscal year ($99,330 in general revenue and $250,670 in federal funds) and $700,000 for the next fiscal year ($198,660 in general revenue and $501,340 in federal funds). The total estimated cost by fiscal year to state, county, and municipal government to implement this rule is $99,330 for the current fiscal year and $198,660 for the next fiscal year.

The agency indicated that there is a new or increased cost or obligation of at least $100,000 per year to a private individual, private entity, private business, state government, county government, municipal government, or to two or more of those entities combined. Accordingly, the agency provided the following written findings:

(1) a statement of the rule's basis and purpose;

This rule includes ten (10) manuals and several accompanying State Plan pages. The manual amendments, enactments, and repeals are all focused on shifting away from a fee for payment methodology for our clients with high needs (IDD or BH), lessening administrative burden on our providers, supporting the workforce (both paraprofessional and clinical) that are employed to provide services to IDD and BH clients, and raising the quality of the care with evidence-based and/or recognized service models.

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

The manual amendments, enactments, and repeals are all focused on shifting away from a fee for payment methodology for our clients with high needs (IDD or BH), lessening administrative burden on our providers, supporting the workforce (both paraprofessional and clinical) that are employed to provide services to IDD and BH clients, and raising the quality of the care with evidence-based and/or recognized service models.

(3) a description of the factual evidence that:
(a) justifies the agency's need for the proposed rule; and

This rule includes a large amount of policy work aimed to position both our provider types and service array to provide more home and community-based services to our clients with IDD and BH.

(b) describes how the benefits of the rule meet the relevant statutory objectives and justify the rule's costs;

This rule includes a large amount of policy work aimed to position both our provider types and service array to provide more home and community-based services to our clients with IDD and BH.

(4) a list of less costly alternatives to the proposed rule and the reasons why the alternatives do not adequately address the problem to be solved by the proposed rule;

There are no less costly alternatives.

(5) a list of alternatives to the proposed rule that were suggested as a result of public comment and the reasons why the alternatives do not adequately address the problem to be solved by the proposed rule;

N/A

(6) a statement of whether existing rules have created or contributed to the problem the agency seeks to address with the proposed rule and, if existing rules have created or contributed to the problem, an explanation of why amendment or repeal of the rule creating or contributing to the problem is not a sufficient response; and

N/A

(7) an agency plan for review of the rule no less than every ten (10) years to determine whether, based upon the evidence, there remains a need for the rule including, without limitation, whether:
(a) the rule is achieving the statutory objectives;
(b) the benefits of the rule continue to justify its costs; and
(c) the rule can be amended or repealed to reduce costs while continuing to achieve the statutory objectives.

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

LEGAL AUTHORIZATION: The Department of Human Services has the responsibility to administer assigned forms of public assistance and is specifically authorized to maintain an indigent medical care program (Arkansas Medicaid). *See* Ark. Code Ann. §§ 20-76-201(1), 20-77-107(a)(1). The Department has the authority to make rules that are necessary or desirable to carry out its public assistance duties. Ark. Code Ann. § 20-76-201(12). The Department and its divisions also have the authority to promulgate rules as necessary to conform their programs to federal law and receive federal funding. Ark. Code Ann. § 25-10-129(b).

DHS Responses to Public Comments Regarding Rebalancing Services for Clients with Intellectual and Developmental Disabilities and Behavioral Health Needs

Joel Landreneau, Executive Director
Arkansas Council for Behavioral Health
Public hearing held remotely on October 27, 2022, at 1:00 p.m.

Comment: We have a number of observations to make about these rules, but I'm going to keep my remarks today brief and focus on one that I think is the probably one of the most concerning and that is the definition of enhanced services on page five of the draft includes the Service Adult Rehabilitation day, and that is, that was a lot of discussion about where it should go. DHS was telling us that this was a facility Deli delivered service, and that's why it was an enhanced section, because the other two sections are home and community-based delivery only, which we take issue with because we do individual therapy in those settings as well in the clinic. And that's a home and community-based service offered there. But the concern is, with respect to the facility requirements set forth in section one thousand and three specifically subsection, c. On page seventy-one. This section applies the facility requirements on all CSPS that are going to be enhanced, which would have to require those agencies that provide a built rehab date now, and page seventy-one subsection, c. Imposes a facility requirement that requires every client to have an individual bed and have that furnishing a lockable door. These are requirements that are only appropriate for those people who reside in the facility, and that isn't the case for those clients who receive services. Yeah, it only through Rehab day they are in it. It looked to me as though some of that section was appropriate when he was talking about requiring hot water requiring air conditioning, requiring no foul odors. Those things that aren't overnight oriented appear to be appropriate to us; but the ones that are aimed at overnight stays and residential adult Rehab day is not a residential service. We don't think it belongs in the enhanced section at all for this reason, but it certainly doesn't need to have the imposition of residential type physical requirements when that's the only service being delivered in the enhanced suite of services. I am concerned that if this isn't changed, there are adult rehab day programs that will stop providing services and that will create a gap in the service continuum that doesn't presently exist. Like I said, we have a number of other concerns with these rules as well, and some questions as well. We'll be setting for those in written submitted comments in the days ahead, but I wanted to make it. I wanted to put an exclamation point next to this facilities section because it's one of the biggest concerns that we have. Thank you.

Response: Adult Rehabilitative Day Service will remain under the CSSP Enhanced certification due to the location of the service being limited to facility settings. The CSSP Certification manual will be updated to indicate the regulations related to treatment programs in which the client is provided with treatment twenty-four (24) hours per day and seven (7) days per week.

Ada Sochanska, MPAS, PA-C
President Elect, Arkansas Academy of Physician Assistants

Comment: The Arkansas Academy of Physician Assistants (ARAPA), on behalf of over 150 Physician Assistants (PAs) throughout Arkansas, appreciates the opportunity to provide comments on amendments associated with Rules for the Division of Developmental Disabilities Services Community

and Employment Support (CES) Waiver Providers. By including PAs in the updated section, this will continue to encourage PAs to practice with clients with high needs and continue their recognition as providers in a healthcare team. These updates will also align with PAs current scope of practice and ensure we are not excluding PAs from important rules or amendments pertaining to medical care and allow for improved quality of care across the state of Arkansas.

We would like to draw your attention to Section(s) 292. 471, 210.160, 211.200, 252.111-252.119, 252.111-252.119, 252.121-252.123 and 255.001 and respectfully ask that the Department update terminology in these sections to include PAs.

In section 292.471 "Behavior Health Screen" the language mentions "Physician's Assistant" however, ARAPA would recommend updating the language from "Physician's Assistant" to the official legal title of "Physician Assistant" as PAs are referred to by the Arkansas State Medical Board.

Response: Thank you for your comment. We are currently in the process of adding physician assistants as rendering providers and will review all codes and rates at that time.

Comment: In section 210.160 "Treatment Plan", ARAPA would recommend the inclusion of Physician Assistants as a new subsection, in addition to the current subsections C and D which include Advanced Practice Nurse (APN) and Physician, respectively.

Response: Thank you for your comment. We are currently in the process of adding physician assistants as rendering providers and will review all codes and rates at that time.

Comment: In section 211.200 "Staff Requirements", ARAPA would recommend that the chart include Physician Assistants and specifications into licensing. Licenses would include "Certified Physician Assistant" and "State Certification Required would include "Must be employed by a certified Behavioral Health Agency, or Community Support System Agency", similar to the APNs and Physicians, while "Supervision" would entail "Delegation Agreement"

Response: Thank you for your comment. We are currently in the process of adding physician assistants as rendering providers and will review all codes and rates at that time.

Comment: In section(s) 252.111 "Individual Behavioral Health Counseling", 252.112 "Group Behavioral Health Counseling", 252.113 "Marital/Family Behavioral Health Counseling with Present " 252.114 "Marital/Family Behavioral Health Counseling without Present Client", 252.115 "Psychoeducation"

252.116 "Multi-Family Behavioral Health Counseling" , 252.117 "Mental Health Diagnosis" , 252.118 "Interpretation of Diagnosis", 252.119 "Substance Abuse Assessment", 252.121 "Pharmacologic Management", 252.122 "Psychiatric Assessment", 252.123 "Intensive Outpatient Substance Abuse Treatment", and 255.001 "Crisis Intervention": ARAPA would recommend ensuring that language that incorporates "allowable performing providers" to include PAs along with the current listed providers of Physicians and Advanced Practice Nurses.

Response: Thank you for your comment. We are currently in the process of adding physician assistants as rendering providers and will review all codes and rates at that time.

Comment: ARAPA would kindly ask that in any other sections that have excluded PAs as healthcare providers that render services, Physician Assistants be included to accurately reflect our role in the healthcare team.

Thank you for your attention to these details and comments. ARAPA welcomes the opportunity to provide further clarification of the role of PAs or be of any further assistance.

Response: Thank you for your comment. We are currently in the process of adding physician assistants as rendering providers and will review all codes and rates at that time.

DeAnna Doherty, Executive Director
Advantages of Southeast Arkansas, Inc.

Comment Section 303 (2)(B)(ii)-Why is care planning for individuals with ASD required for all staff? If their client has a Cerebral Palsy diagnosis, ASD care planning training is not relevant. Please note that not all IDD clients are ASD.

Response: It is unclear which manual you are commenting on. The Community Support System Provider (CSSP) is a provider type designed to provide care to clients with IDD, BH, or both needs. Data is showing us that often, children and adults with Autism were not diagnosed prior to the PASSE program and have historically been treating by behavioral health services. We believe the misdiagnosis is lack of diagnosis is prevalent enough to focus a module specifically on this disability. The training modules were promulgated under CSSP and have been in place since January of 2021 when this new provider type was established and available for application.

As for CES Waiver Providers, the approved CMS waiver only requires: employees must pass a drug screen, a criminal background check, a child maltreatment registry check, an adult maltreatment registry check, AND have a high school diploma, GED or equivalent, and have at least one (1) year of experience OR complete the training sessions outlined in the CES provider licensure manual.

We will internally discuss making the change in the CES Waiver certification manual to specify that the twelve (12) hours of training is required if the staff member does not have one year of experience working with persons with developmental disabilities. However, we do not think twelve (12) hours of training is overly burdensome and will continue to require it for CSSP.

Comment: Section 303 (2)(B)(iv)-Why is behavioral modification or prevention training required for all staff? If their client does not have behaviors or a PBSP, then this training is not relevant. Please note that not all IDD clients have behaviors.

Response: While not all clients with IDD have significant behaviors, it is imperative that clients with IDD with behaviors have highly trained staff available to prevent institutionalization. Under the 2023 Agreement between DHS and the PASSEs, each PASSE will utilize a Risk Mitigation Screen for each member that will analyze all risk factors, not just behavioral health needs. If a member is identified as having a low level of risk of BH, a Behavioral Prevention and Intervention Plan will be required. If a high level of risk of BH is identified, a more robust clinical Positive Behavioral Support is required. We believe this is best practice to support all members.

Comment: Section 303 (c)(2)(A)-Why do providers have to train on the PCSP, we do not create it, and we do not always get a copy of it from the care coordinator, even after asking for it multiple times.

Response: Please see comment above regarding the twelve (12) hours of training requirements and the required modules. Also, even if a provider does not receive the member's overall PCSP, a provider's treatment plan is incorporated into the member's PCSP. Training will ensure that staff understand the federal requirements associated with a Person-Centered Service Plan.

Comment: Section 305 (b)(4)-Providers should not be responsible for maintaining name, phone number, and email address of the client's assigned care coordinator as they change FREQUENTLY and without notice to clients and providers. Typically to find a care coordinator we have to reach out to a supervisor to find the correct care coordinator.

Response: Thank you for your comment and we will discuss this comment internally and determine if the language should be amended.

Comment: Section 305 (c)(1)-As stated previously, providers are not always given copies of PCSPs that are written by care coordinators, and therefore it is more than difficult to maintain current copies.

Response: Thank you for your comment and we will discuss this comment internally and determine if the language should be amended.

Comment: Section 305 (c)(4)-Again, behavioral prevention and intervention plans are not necessary for every IDD client. This should read, behavioral prevention and intervention plan; if applicable.

Response: Thank you for your comment and we will discuss this comment internally and determine if the language should be amended.

Comment: Section 502 (B)(ii)-Should read current Treatment Plan, as again, providers do not write PCSPs and are not always given, even after requesting, current PCSPs.

Response: Thank you for your comment and we will discuss this comment internally and determine if the language should be amended.

Comment: Section 601 (d)(1)-Should read, a provider must maintain a medication log for each client to document the administration of all prescribed and over the counter medications, IF the client is prescribed medication or routinely takes over the counter medications and does not elect to self-administer. There is no reason for a provider to have to maintain a medication log for a client that elects to self administer or for a client that takes no medications.

Response: Thank you for your comment. The language in the approved CES Waiver can be found on page 130 or 183.

Comment: Section 602 (a)-Providers should not be responsible for the development of a written behavioral health plan, as this is a care coordination duty and was (pre PASSE) a case management duty. The state determined there to be a conflict when providers provided both case management and waiver staffing duties; therefore determining the need for PASSE care coordination. And these plans, developed

by care coordinators and implemented by providers are only necessary for clients that exhibit behaviors. Again, not all IDD clients have behaviors.

Response: We disagree that there is a conflict, and this is different from the federal Conflict Free Case Management Rule. Supportive living providers are in the home and are responsible for writing, training and implementing a member's Behavioral Prevention and Intervention Plan. You can bill for this service under Consultation.

Comment: Section 602 (2)(A)-Again, providers should not be responsible for developing these plans. Implementing, yes, but not developing.

Response: Thank you for your comment.

Comment: Section 806 (a)- Which department receives the monetary penalties? What are those funds used for?

Response: Funds are used in accordance with state law.

James Scott

Comment: It is evident by the many, many mentions of behavioral health that CES Waiver providers were not invited to the table to give input regarding these rules. My comment is that providers work in the field daily with IDD clients and it is in the best interest of all parties to utilize providers as stakeholders and value their input when creating rules.

Response: This promulgation contains changes to ten (10) manuals, primarily behavioral health services. The Community Support System Provider (CSSP) type was promulgated and available to providers to apply back in January of 2021. The base level services are historic IDD services and were not altered for IDD providers. The CES Waiver certification manual was sunsetted in 2018 under the assumption that the PASSE would be taking over licensure/certification of their PASSE providers. However, prior to the PASSE taking over full risk, it was determined that this was not feasible. For that reason, DDS asked the PASSEs to place the sunsetted CES waiver licensure standards in their provider manuals and as providers sign agreements to be in network with PASSEs, they also agree with that signature to abide by the PASSE provider manual. This has not been ideal, and we are now standing back up a CES Provider certification manual to bring clarity to the rules. The certification manual nearly mimics the language in the approved Community and Employment Supports Waiver that also went through public comment earlier this year and has been approved by CMS.

Kathy Weatherl, Director of Compliance

BOST

Comment: Page 2 – Complex Care Home – who determines if the person meets qualifications for Complex Care Home? Provider or passe or state? Is there a certain assessment tool that needs to be used to make this determination? Will there be extra funding since you are setting ratios of 1:4 for a complex care home?

Please clarify that current group homes will not fall under the category of complex care home unless a provider chooses to request certification for that group home, and it meets the requirements.

Response: The PASSEs will determine medical necessity for Complex Care Homes similar to how they determine medical necessity for the other services they pay for. We agree that a rate still needs to be established for Complex Care Homes because additional requirements are associated with this service.

As for current group homes, they will continue to be grandfathered in.

Comment: Page 9 302 b1 – A provider must meet any minimum staff to client ratio included in a clients treatment plan. Is this the provider treatment plan or the passe PCSP?

Response: This is referring to the Treatment Plan for the service you are providing. Also note that we changed Consultation to include Treatment Plan so IDD can be paid for Treatment Plans to be consistent with allowing BH providers to be paid for Treatment Plans.

Comment: Page 10 – 1E – Added Arkansas Sex offender registry check upon hire and every 2 years. Please confirm that you will only be requiring an ARKANSAS sex offender registry check and not a national registry check.

Response: Thank you for your comment. Section 302(c)(1)(E) only requires an Arkansas Sex Offender Central Registry search.

Comment: Page 10 2(d)2 – Employees must have HS diploma or GED – Didn't they take this out of the waiver application? It was taken out of ADDT standards. What do we do for employees who did not have to have this during the Covid exception period? This will impact our ability to hire staff and in our current staffing crisis this rule does not make sense. A high school diploma or GED does not qualify a person to do these jobs or assure quality care will be provided.

Response: Please see response above concerning language in the CMS approved CES Waiver that was also state promulgated earlier this year. Concerns around employee language at that time, and when filing Covid policies did not discuss High School or GED. The discussion was around the required years of experience. We are allowing an exception for years of experience. To my knowledge, we have never waived High School Diploma or GED for CES Waiver.

Comment: Page 11 303 2(a)(b) – 12 hours of training before having contact with client and at least once every 12 months thereafter. Can this training include on the job shadowing with current staff?

Response: Yes, the twelve (12) hours can include job shadowing as long as all training requirements are met.

Comment: Page 11 - 303 2 B – Why require training on autism spectrum disorders if the staff is not working with someone who has autism? Should this not be a consumer specific training instead? If a consumer has spina bifida or Epilepsy more training should be provided in that area, not autism.

Response: Thank you for your comment. Please see response to a similar comment above.

Comment: Page 11 - 303 2C – Why can the initial required training in 303(a)(1) not be counted in the 12 hours required in 2(c)? With the staffing shortage that we all face, it does not make sense to not count those hours if you are requiring those trainings. We all want staff to be trained to provide good care, it should not be about the number of hours, but about the quality of the training and topics.

Response: Please see comments and responses above regarding training for CSSP and CES Waiver provider types.

Comment: Page 12 – 303 Employees who have not completed the required certifications cannot be counted towards staffing requirements. For recertifications are you saying if a staff is past due by a few days they cannot be counted as staff? Again, with the staffing crisis we are in that does not make sense. Consumers will be left without staffing and services. Staff know how to call 911 in emergencies and 911 operators will instruct them on care to provide and even walk them through doing CPR.

Response: The trainings are required annually. Staff should not work if any training is past due or lapsed.

Comment: Page 14 – 305 (b) (4) -Face sheet must contain name, phone number, email address of assigned passe care coordinator. CC's change frequently. Can we just note general Passe information vs specific CC info.

Response: Please see DHS' response to a similar question above.

Comment: Page 15 ©1 – PCSP must be maintained in client file – It is often very difficult to get this from the PASSE. The provider should not be held accountable for the PASSE responsibility. If we have documentation showing, we have requested the information from the PASSE multiple times is that acceptable?

Response: Please see DHS' response to a similar question above.

Comment: Page 15 C4 – Behavioral prevention and intervention plan – should state if applicable, because everyone does not need a plan.

Response: Please see DHS' response to a similar question above.

Comment: Page 18 – Financial management of client funds – e(1) states the provider must maintain separate accounts for each client -what about when there is 1 account but funds are distinguished by client? Social Security allows this for rep payee and we are required to followed rep payee guidelines. Providers who are rep payee are audited every year by Social Security to assure we are handling funds correctly.

Response: Thank you for your comment. "Separate accounts" does not mean separate commercial bank accounts. A single commercial bank account may hold multiple individual clients' funds, so long as there as separate accounts maintained for each individual client through software programs or other means that otherwise comply with these Rules.

Comment: Page 18 309 Emergency Plans and Drills – a1 emergency plans for all locations, including client residences – do you mean private homes or only provider owned homes, please clarify.

Response: Thank you for your comment. This requirement applies to provider owned and/or controlled homes/apartments.

Comment: Page 19 – 309(a1) – Are you stating that the provider must have a written emergency plan for all private residences where clients live (family home), or are you just referring to the provider owned homes?

Response: Thank you for your comment. This requirement applies to provider owned and/or controlled homes and apartments.

Comment: 309 2(a) Fire drills must be conducted monthly in provider owned homes or leased residential settings – We need procedures for all emergencies but only required to do fire drills – am I understanding that correctly?

Response: Thank you for your comment. This requirement applies to provider owned and/or controlled homes and apartments.

Comment: Page 19 310 Infection Control – (b)1 Will Covid fall under this? If yes, what about when we have families who say they still want their staff to work and just wear a mask and staff wants to work. We have families who must work to support their family. Ultimately providers should be following CDC guidelines, and those change. We think it would be appropriate for wording to be that provider follows CDC guidelines in place at the time.

Response: Yes. During Covid, the Arkansas Department of Health followed the CDC guidelines.

Comment: Page 21 401 – There are specific requirements for complex care homes to meet under 402 but there are no site-specific requirements for current group homes or provider owned apartment complexes. Are you considering all current group homes and provider owned apartments to be complex care homes? Or will these standards also apply to group homes and apartments already in place? My assumption is that only 42 CFR 441.301 © (4)-(5) will apply to current group homes and apartment complexes that are provider owned but please clarify.

Response: Complex Care Homes is a new service with different requirements. Please previous response to group home comment above.

Comment: Page 26 502 Exits and Transitions – (b) A provider must document the exit of all clients regardless of reason – Please elaborate on what you mean by document the exit.

Response: Thank you for your comment. This would depend on the reason the client exits. Documenting a client exit due to a client's voluntary request to change provider would be different than an exit due to a client death. Specifics are not listed to allow providers maximum flexibility in documenting and demonstrating how and why a client exits its program.

Comment: Page 27 502 Exits and transitions -502 C - Needs to put WRITTEN request by client for records.

Response: Thank you for your comment. Section 502(c)(3)(C) of the Rules for the Division of Developmental Disabilities Services Community and Employment Support (CES) Waiver Providers will be changed to add the word "written" between the words "a" and "request".

Comment: Page 27 (d) 1 and 2 – If a client or their family refuses to allow us to provide services during the transition period how can the provider be responsible for the health, safety, or welfare of the client. We have encountered this very situation on several occasions.

Response: Thank you for your comment. While transition from one provider can be contentious, the health and safety of the individual must be assured in accordance with waiver regulations. The agency is willing to provide technical assistance on a case by case basis as warranted

Comment: Page 29 Mediations – (a)2(A) goes beyond CDCA requirements. We need to stick to CDCA requirements and do the self-administration form that individual and/or family sign off on but it does not require that meds be listed.

Response: Please see Appendix G of the Waiver. We will mimic this language. The current CES waiver does not include self-direction as part of the operational components of this program. Each state that offers Consumer Directed Care as part of its operational allowances varies depending on the state and state defined Nurse' Practices Act. See below for guidance regarding this from the Consumer Directed Care amendment to the Arkansas Nurse Practices Act of 2005
CONSUMER DIRECTED CARE 1. 2. 3. 4. 5. 6. 7. 8. Health maintenance activities may be provided by a designated care aide for a competent adult at the direction of the adult or for a minor child or incompetent adult at the direction of a caretaker. Caretaker means a person who is directly and personally involved in providing care for a minor child or incompetent adult, and the parent, foster parent, family member, friend, or legal guardian of the minor child or incompetent adult receiving care. Designated care aide means the person hired by the competent adult or caretaker to provide care for the competent adult, minor child, or incompetent adult. Health maintenance activities mean activities that the minor child or adult is unable to perform for himself or herself. The attending physician, advanced practice nurse, or registered nurse must determine a designated care aide under the direction of a competent adult or caretaker can safely perform the activity in the minor child's or adult's home. Home shall not include nursing home, assisted living facility, residential care facility, an intermediate care facility, or hospice care facility. Health maintenance activities that are not exempted by the Consumer Directed Care Act of 2005 include: a. Physical, psychological, and social assessment which requires nursing judgment, intervention, referral, or follow-up; b. c. d. e. f. Formulation of the plan of nursing care and evaluation of the client's response to the care rendered; Tasks that require nursing judgment or intervention; Teaching and health counseling; Administration of any injectable medications (intradermal, subcutaneous, intramuscular, intravenous, intraosseous, or any other form of injection) or intravenous therapy. Receiving or transmitting verbal or telephone orders. The designated care aide must demonstrate the ability to safely perform the health maintenance activity.

Comment: Page 29 – 2b – when you say other health care professionals authorized to administer medications are you referring to those trained according to CDCA? This should be more specific as far as what authorizes a person to administer medications.

Response: This is a scope of practice question. However, please Appendix G of the approved CES Waiver, we outline regulations around medications. We will mimic this language.

Comment: Page 30 I – Med errors are reported on incident reports as required by DHS regulations, not on the MAR.

Response: Thank you for your comment. We will internally review to see if language should be amended.

Comment: Page 32 – 602 Behavior plans

602 (a)- Is this referring to the providers risk assessment or something the PASSE will be doing? 602 (a)(1) and 2(A) who determines the risk level?

We have concerns if this is based off PASSE risk mitigation plan since we often do not get copies of the PASSE plan or get invited to the individual's PCSP meeting. How can a provider be held accountable for requirements of the PASSE?

Will there be a specific risk mitigation plan that will be used by all PASSES so determination of a Tier is the same across all PASSES?

The requirements for who can do these plans, especially positive behavior support plans are concerning. There is a staffing crisis in this state and the training through Partners requires 5 days of training, that's 5 days that most managers do not have time to be out of the office as they are often serving as Direct Support staff right now or trying to find and train direct care staff so daily supports can be provided to individuals.

The licensed individuals who you have on the list will want to do behavior plans their way according to their training and license, so it will be difficult to find licensed professionals who will want to do these plans as you have them defined. We have run into this issue in the past when behavior plans had to be done by licensed professionals. Plus, licensed mental health professionals and board-certified behavior analysts are hard to find in this staffing crisis. This service will not be a priority for them.

Response: Thank you for your comment. Please see previous responses on this topic. DHS is working with the PASSEs to develop one risk assessment tool. We amended the definition in Consultation and expanded the clinicians who can develop a Positive Behavioral Support Plan for this very reason.

Comment: Page 37-43 Regarding specific waiver services it states the provider must maintain documentation in the client service record: date ordered, name of CC who ordered, and other info based on each specific service, etc. The Passe does not provide all this information to the provider, so how can the provider be held accountable for it? Will documentation showing our attempts to get the information be enough?

Response: The provider is responsible for their information. Please see other responses regarding these sections and the role of the care coordinator.

Comment: Page 41 – PBSS- States that the person must be trained by Partners to write the plans. Why is there only 1 entity able to do this training? Will the state require Partners to offer this training so many times a year in all regions of the state so there are enough trained PBSS? Will the state assist with funds to get staff trained to do these plans?

Response: Thank you for your comment. We will discuss internally. PBS can write a Positive Behavioral Support Plan. We agree this should not mandate one provider offer the training if other providers are available to provide this training.

Comment: Page 47 Incident Reporting- 703 B Provider must maintain documentation evidencing notification to guardian of incident – Is the notification section on the IR enough for this documentation?

Response: Yes.

Comment: Page 52 901 Closure – (a) 2B – this would be the role of the PASSE CC not the current provider.

Response: The standards are for providers so if a provider is closing their business, then it is the provider's responsible to follow what is outlined under this section.

Comment: Medicaid Manual

220.310 Complex care home – Who will make the determination that a person qualifies for a complex care home? Will that be the provider? The PASSE? Is there an assessment tool we'll need to use?

Will there be extra funding since you are setting ratios of 1:4 for a complex care home?

Please clarify that current group homes will not fall under the category of complex care home unless a provider chooses to request certification for that group home, and it meets the requirements.

N under 220.340 – Positive Behavior Support Plan for higher level risk consumers can be done by PBSS or licensed MH.

***On N - Concerned that only partners can provide the training for PBSS. Will the state require them to offer the training so many times per year in each region so there are enough PBSS who have been trained to do these plans?*

Response: Please see responses above to similar questions.

Pam Edison, Director of Home and Community Based Services
Shana Fryar, Director of Quality Assurance
Pathfinder, Inc.

Comment: On the waiver portion (page 14), it states we need the PASSE care coordinator information (name, address, email, phone number) in our client service record. All of the information required on the client service record is on our Face Sheet, except the care coordinator information. This is something

we would need to add to our Face Sheet. It should be noted we have a difficult time keeping care coordinator information updated due to high turnover in the PASSE's.

Pages 37 - 45 states the Provider must maintain the following documentation in our files: Specialized Medical, Adaptive Equipment, Environmental Modifications, Supplemental Supports. Unfortunately, some of those documents go directly from the PASSE to a vendor so we never see the documents and cannot maintain a copy for our files. The only time we have this documentation is if we (the Provider) pays for something as a pass-thru. In addition, we have trouble getting copies of the PCSP from some of the care coordinators.

(Also see attached exhibit A)

EXHIBIT A.pdf

Response: Thank you for your comment. We will review this language based on public comments.

Bess Heisler Ginty, Chief Executive Officer
Kids for the Future, (Pediatric Day Centers, Counseling Services, Therapy Group, Inc.)

Comment: I have grave concerns about the way some of it is written that it does not allow for true diagnostics. For example, I think adding the word "suspected and / or qualifying disability" could open doors for initial testing.

(Also see attached exhibit B)

EXHIBIT B.pdf

Response: Thank you for your comments in the PDF. We will look at clarifying this language.

David Ivers, J.D., VP for External Affairs & General Counsel
Easterseals Arkansas

Comment: The proposed rules are causing a lot of confusion among providers. We believe more work is needed to make the rules clear and understandable. We urge the Department to go back and convene a workgroup with providers to get more input from those of us who have to provide services under these rules.

We understand DDS is taking the CES licensure role back from the PASSEs through these proposed rules. Will there also be a Provider Manual again? We ask because this promulgation includes a Provider

Manual for “Home and Community-Based Services for Clients with Intellectual Disabilities and Behavioral Health Needs” that contains services provided through the PASSEs.

Response: Please see responses above about CES certification standards and what has been in place since 2018. We are running a Provider manual in this packet entitled Home and Community Based Services for Clients with Intellectual Disabilities and Behavioral Health Needs that outlines the HCBS under the PASSE program. That manual is applicable to Outpatient Behavioral Health Agencies, CES Waiver Providers, and Community Support System Providers. The certification manuals for those provider types (CES Waiver and CSSP) outline what services may be performed under those provider certifications.

Comment: 103. Definitions-“Adverse action” – This definition does not take into account the Medicaid Fairness Act. The MFA applies to actions, including “(g) Desk audits; (h) Field audits and onsite audits; and (i) Inspections or surveys.” “To constitute an adverse decision, an agency decision need not have a monetary penalty attached but must have a direct monetary consequence to the provider.” Thus, if a DDS decision under these rules results in a monetary penalty or is an action such as no new admissions, suspension or termination of license that would have a direct monetary consequence, that action would fall under the MFA. 20-77-1702(2).

Response: Thank you for your comment. It was not our intention to bifurcate or go around the standard appeal process. We will review this language. We elaborate more on this topic below in the public comments.

Comment: 103. Definitions- “Change of Ownership” – What is the meaning of the qualifier “within a twelve (12) month period”?

Response: Thank you for your comment. All transactions within the prior twelve (12) month period are aggregated for purposes of determining whether there has been a fifty percent (50%) or greater ownership change. In other words, the fifty percent (50%) threshold cannot be circumvented by using multiple transactions spread out over a short time period.

Comment: 103.Definitions-“CES Waiver Service” – Since the waiver is amended from time to time, we would recommend just reference the list in the approved 1915(c) waiver as it may be amended.

The approved 1915(c) waiver being referenced in this promulgation is called the Community and Employment Support Waiver. The name has changed once in the past ten years and there are no plans to amend the name. The Department administers several 1915(c) waivers and want to state the specific name.

Comment: 103. Definitions- “Complex Care Homes” -- What if a group home has individuals who meet this criteria of having an IDD diagnosis and a co-occurring deficit. Does that automatically make them a complex care home or do they have to self-designate, and if so how? Has DHS provided additional funding to the PASSEs for this model?

Response: Please see previous responses to this question.

Comment: 103. Definitions-"Licensed professional" – What does "general contractor" in this list mean?

Response: Thank you for your comment. You are correct. General contractor should be removed from this list.

Comment: 302. Employee and Staffing Requirements-In regards to 302 b.1 regarding minimum staffing requirements. Is this reg stating that we must staff what's in the treatment plan? What happens if we cannot due to the staffing crisis? Will we be held accountable or penalized because we cannot staff a position even though it may be out of our control? Also, some family staff member (e.g. parent/guardian) may use this to assert that they must be paid for hours that are in the service plan but are intended for alternate staff. This is already becoming a complex area to navigate without this added language.

Response: The treatment plan is intended to outline what service the provider is providing and for what duration and time. If ratio's change, the treatment plan should be amended or outline what will occur if staffing ratios cannot be met.

Section 302.d.2 – Employees must have a high school diploma or a GED. – In light of the workforce shortage, can qualified experience can be accepted in lieu of a HS diploma or GED?

Response: Please see previous responses on this topic.

Comment: 309. Emergency Plans and Drills- Are all items, drills, procedures and reporting listed required for an individual's home? Some may be unnecessary in a private residence.

Response: Please see previous responses on this topic.

Comment: 501. Request to Change Provider-Section (b) Says that a provider remains responsible for delivery of services until such time as the client's transition to the new Provider is complete. There should be a deadline on the PASSE to complete this process, otherwise there is no incentive to make it happen timely, and the client is left in a situation where the provider has already determined they cannot meet the client's needs.

Response: Please see previous response on this topic.

Comment: 502. Exits and Transitions- Section (d)(1) says a provider remains responsible for the health, safety and welfare of an existing client until all transitions to the new provider are complete. However, the reason the transition is occurring is because the current provider CANNOT ensure health, safety and welfare. Also, often clients will not cooperate to let the current provider continue. Please reword to accommodate these realities.

Response: Please see previous response on this topic.

Comment: 503. Refusal to Serve- What office at DDS does the provider notify of a refusal to serve?

Response: Notification of unable to serve may be submitted to DDS CES Waiver Member Support Unit via email at dhs.dds.southeast@arkansas.gov .

Comment: 601 Medications-(b)(2) This section says a provider can administer medications only through a licensed nurse or "other healthcare professionals authorized to administer medication." However, under the Consumer-Directed Care Act (Arkansas Code Ann. 17-87-103(12) and the ASBN Rules, Chapter 5, Delegation) authorize individuals or caregivers to delegate certain medication administration and other health maintenance activities to unlicensed direct care aides. Considering reviewing the old DDS waiver certification rules that had a section on the CDCA.

(c)(2)(C)– Is this stating the plan must give a physical description of the medication or what description is it referring to? This may need to be worded differently as to state what the medication is primarily treating, otherwise if they are wanting a physical description of the medication this can change with each pharmaceutical company and there will not be any consistency in this circumstance.

(c)(2)(D) -- This may need to be more clear to state route of administration i.e. by mouth, inhalation, per tube, etc..... versus delivery.

(c)(2)(E) – Is this stating we need to indicate on the plan that it will be charted on a Med Log?

(c)(2)(F) – Potential side effects are numerous for most drugs. Why not require client-specific side effects unless said individual is starting a new medication and does not know if there will be side effects from this particular med. And then, we suggest limit to most common or the list will be way too long.

(d)(2)(B) -- This should be indicated on the med management plan not the med log -- there is only so much room on a medication log, and the DSPs are not medical professionals and do not perform assessments, unless it is pertaining to a PRN drug that is only used for certain symptoms and that will be listed on the original pill bottle/container.

(d)(2)(H) **–** Regarding transfer of meds from original container into individual dosage containers by the guardian **--** Will this need to be indicated on a med log even if the individual administers their own medication?

Response: Please see other responses on this topic.

Comment: 602. Behavior Management Plans--This section has become extremely complicated and may prove difficult for staff to implement. The rules make it sound as though every client has to have some type of behavior plan. Many clients do not need a behavior plan. Can you clarify this?

602. What is the difference between a "behavioral management plan", "behavioral prevention and intervention plan", and a "positive behavioral support plan"?

602.a.1. If a client is "low risk," why would you write a behavior plan? It seems different wording is needed. Who is qualified to develop a "low risk" behavior plan?

602a.1.C – Does this mean the person writing the behavior plan must be qualified or certified in the areas listed in, I, ii, and iii? This may limit who can write behavior plans.

Response: Please see previous responses on this topic.

Comment: 604. Supported Living--We have no problem with daily progress notes, but (b)(5) seems excessive – having to describe every day the relationship of the service to the treatment objectives. That changes much less frequently than every day and should be addressed in the treatment plan.

Response: Thank you for your comment. We will review this internally and determine if an amendment to the language can or should be made.

Comment: 607. Specialized Medical Supplies; 608 Adaptive Equipment; 609 Community Transition Services; 610 Consultation; 611 Environment Modifications; 612 Supplemental Support

The Department seems to be saying PASSE care coordinators will now be fully responsible for handling and ordering these services instead of the direct service provider? Is that what the Department intends? Although providers would welcome this, the Department should be aware that in many instances this is not current practice.

Response: We disagree that those sections are insinuating that the PASSE care coordinator is solely responsible. Those definitions were pulled from the approved CES Waiver.

Comment: 700. Incidents to be Reported**--**702.a.2 – This say submit reports of all other incidents within 48 hours of the event. -- Does this mean if an incident occurs on a Friday, it must be reported by Sunday, or will the following Monday suffice?

Response: Thank you. We will discuss internally and check the language in the approved waiver.

Comment: 803. Enforcement Actions--This section should reference the Medicaid Fairness Act for adverse actions that fall under that Act. (See comment under "Adverse Action" definition.)

Response: Please see previous response above on this topic.

Comment: 1002 Appeal of Regulatory Actions**--**(a)(1) Says the appeals under Medicaid Fairness Act are those "related to the payment of Medicaid service claims." However, as explained above, the wording of the statute is broader than that.

Response: Thank you for your comment. Section 802(a)(1) of the Rules for the Division of Medical Services Licensure Manual for Community Support System Providers shall be changed to read "A CSSP Agency may administratively appeal any adverse regulatory action to the DHS Office of Appeals and Hearings (OAH) except for provider appeals governed by the Medicaid Fairness Act, Ark. Code Ann §§ 20-77-1701 to -1718, which shall be governed by that Act."

Section 1002(a)(1) of the Rules for the Division of Developmental Disabilities Services Community and Employment Support (CES) Waiver Providers shall be changed to read "A Provider may administratively appeal any adverse regulatory action to the DHS Office of Appeals and Hearings except for Provider appeals covered by the Medicaid Fairness Act, Ark. Code Ann. §§ 20-77-1701 to -1718, which shall be governed by that Act."

David Ivers, J.D., VP for External Affairs & General Counsel
Easterseals Arkansas

Comment: We support the Department's goal of breaking down silos between IDD and behavioral health. However, these proposed rules are extremely confusing and raise many questions. While well intentioned, they contain provisions that all but shut out IDD provider organizations from obtaining a CSSP license. We strongly urge the Department to pull these proposed rules down and convene a workgroup with IDD providers to work out the problems identified below.

Which services? Please clarify which services a CSSP agency can provide that a CES Waiver provider cannot. (The "HCBS for Clients with IDD and Behavioral Health Needs" says that CES Waiver providers can provide the services in that manual. There is no indication they have to obtain a CSSP license. However, the Counseling Services Manual is limited to various BH provider types or CSSP. It sounds like that is the only service that a CSSP agency can provide that a CES Waiver provider cannot, but please clarify.)

Response: All services listed under the Intensive Level, all services except Complex Care Homes for IDD listed under the Enhanced Level, and all services listed in the Base Level that are contained in the 1915i state plan amendment for behavioral health are not allowed to be performed with a CES Waiver provider certification. The CSSP type was implemented in January of 2021. CES Waiver providers could have chosen to become a Base level CSSP and provide more services than they can under the CES Waiver provider type. However, only two CES Waiver providers applied and enrolled as CSSP. This is not a mandatory provider type. CES waiver providers can remain a CES waiver provider type only. The services you are licensed to provide are outlined in the CES waiver certification manual or the CSSP certification manual. All HCBS and service descriptions are listed in the HCBS for Clients with IDD and Behavioral Health Needs manual.

Comment: Which individuals? Can CSSP providers provide any medically necessary service listed under their level of CSSP certification to *any eligible individual regardless of whether the individual has a diagnosis of IDD only, BH only, or IDD with behavioral health needs*?

Response: Please refer to the service descriptions in the manual mentioned above but yes, HCBS under the PASSE is based upon functional deficits not diagnosis.

Comment: Barriers for IDD organizations. The requirements for CSSP Base Level certification do not appear to provide any significant new service that an IDD provider cannot offer now through their CES Waiver license. And the requirements imposed for a provider to offer Intensive or Enhanced level services, including Counseling, require a CEO with a behavioral health degree or related field, a Certified Peer Support Specialist on staff and other provisions that basically shut out IDD organizations from becoming a CSSP Agency. This is a major problem that must be addressed for CSSP to work as intended.

Response: There are additional services available under the Base Level that can be performed without clinical oversight. These include Adult Life Skill Development, supportive housing, support life skill development (individual or group), and therapeutic host homes. We have several IDD providers who are planning to become Intensive level CSSP providers. Remember that you can contract with the required staff. They do not have to be full time employees. Further, the services outlined in Intensive and Enhanced are intended to have clinical oversight due to the nature of the service being provided.

Comment: 103. Definitions--Adverse Agency Action -- This definition does not take into account the Medicaid Fairness Act. The MFA applies to actions, including “(g) Desk audits; (h) Field audits and onsite audits; and (i) Inspections or surveys.” “To constitute an adverse decision, an agency decision need not have a monetary penalty attached but must have a direct monetary consequence to the provider.” Thus, if an adverse decision under these rules results in a monetary penalty or is an action such as no new admissions, suspension or termination of license that would have a direct monetary consequence, that action would fall under the MFA Ark. Code Ann. 20-77-1702(2).

Response: Please see previous response.

Comment: 103.Definitions--CSSP Location **–** This term is used frequently but not defined and its meaning not clear.

Response: Thank you for pointing this out. The current version defines CSSP location and it appears we missed defining in this promulgation. A CSSP location is a physical location of a program that falls under the Enhanced level of CSSP.

Comment: 103. Definitions--Base Services, Enhanced Services, Intensive Services –

Here it says that Counseling Services require an Enhanced level certification. But at 902(3) [numbering is off, should be 5?] it says Counseling Services come under Intensive level.

Response: Thank you for pointing this out. You are correct that Counseling Services are allowed under Intensive Level. It appears that Intensive and Enhanced are out of order in the definition section which may be causing some confusion. The progression is BASE-more than base-Intensive-more than intensive-Enhanced. The requirements continue to grow as you lead up to Enhanced.

Comment: Under which level of certification does Pharmacological Counseling by RN go?

Response: It is located under Base with the understanding that you would need to contract or hire an RN to do perform this service, but it does not require the clinical oversight requirements found in Intensive or Enhanced.

Comment: Home and Community-Based Services – This definition seems overly broad. There are many services that can be obtained through the PASSE Provider Manual that are not HCBS since the PASSEs cover all Medicaid services except the six excluded ones to any individual who meets the medical necessity criteria.

Response: The services and descriptions can be located in provider manual also in the promulgation packet. We agree that PASSEs pay for services beyond home and community based. We do agree that the wrong manual is cited in (r) under the definitions. We need to reference the new HCBS manual in this promulgation packet. We will make that change.

Comment: Licensed Professional – There are many types of licensed professionals who have nothing to do with healthcare. It seems like some narrowing of the definition is needed.

Response: Thank you for your comment.

Comment: Qualified Community Support Provider – This section is confusing. The terminology used elsewhere in the promulgation is "Qualified Community Support Staff" not "Qualified Community Support Provider." Staff is less confusing for this purpose. Can you identify which services such staff may perform? Is it any service that does not require a licensed professional to perform?

Response: A Community Support Staff is defined as an employee who provides direct care services or assistance to clients. The manual has been corrected to be consistent in terminology.

Comment: In criterion #3 are you saying that every QSSS must be an Arkansas Certified Peer Support provider or is that simply a voluntary alternative to item #2, i.e, someone working under the direct supervision of a Mental Health Professional or as part of a multidisciplinary team under a licensed professional?

Also, this definition says every QSSS must work under a MHP or License Professional. Does this mean that staff must become a CSSS and work under a mental health professional in order to bill any service under CSSP even if the service is a traditional IDD service for someone with IDD?

Response: Criterion 3 has been removed for clarity. Peer Support Specialist requirements are addressed elsewhere in the manual. Yes, for Intensive and Enhanced CSSP Levels.

Comment: 201. Certification Requirements. (c) and (d) appear to be duplicates.

Accreditation requirements**.**

> Paragraph 201(e) says "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."
>
> Paragraph 201(f) says: A CSSP Agency must demonstrate its accreditation or accreditations cover each
> home-Home and community-based service the CSSP offers or intends to offer.

Please clarify this section. It appears to contradict informal guidance we have received that any CARF accreditation "in the HCBS arena" will suffice. CARF accreditation categories do not line up exactly with the HCBS service list. Please clarify which CARF accreditations will suffice for which HCBS and Counseling services. This will be a major obstacle to CES providers getting into CSSP if it is not relaxed.

Also, if the accreditation language is not modified then another dilemma is created: CARF requires a provider to provide a service for at least 6 months before it will accredit the organization. But these rules require the accreditation prior to issuing a license. Please explain how this catch-22 will be resolved if the accreditation requirement is not modified.

Response: As stated above, the CSSP type has been in existence since January of 2021, and we are not requiring that providers become a CSSP. If a provider would like to become a CSSP, you can remain in your current provider type while you become accredited. The accreditation is in the area of home and

community-based services. We will review the above and determine if the language should be amended for clarity.

Comment: 302. Employees and Staffing Requirements-(a) and (b) regarding minimum staffing requirements. Is this reg stating that we must staff what's in the treatment plan? What happens if we cannot due to the staffing crisis? Will we be held accountable or penalized because we cannot staff a position even though it may be out of our control?

(c) and (d) appear to be redundant with (e) and (f), regarding requirement for maltreatment and criminal background checks.

(g) says employees must be at least 18 and have a high school diploma or GED. In light of the workforce shortage, can experience or training substitute for the diploma/GED requirement? Suggested wording "or have additional certifications required for Qualified Community Support Providers in Definitions (dd)."

Response: Thank you for your comments and please see previous responses to these topics above.

Comment: 303. Employee Training--(b) requires 12 hours of training before having contact with client and at least once every 12 months thereafter. Can this training include on the job shadowing with current staff?

(c) says the 12 hours in (a) cannot count toward the 12 hours in (b). Why impose this hurdle? With the staffing shortage that we all face, it does not make sense to not count those hours if you are requiring those trainings. We all want staff to be trained to provide good care, it should not be about the number of hours, but about the quality of the training and topics.

(e) says employees who have not completed the required certifications cannot be counted towards staffing requirements. For recertifications are you saying if a staff is past due by a few days they cannot be counted as staff? Again, with the staffing crisis this does not make sense. Consumers will be left without staffing and services. Staff know how to call 911 in emergencies and 911 operators will instruct them on care to provide and even walk them through doing CPR.

Response: Please see previous responses to these similar questions above.

Comment: 304. Employee Records-Please define searches and timeline for searches if this is not part of annual and continuing background checks.

Response: Thank you for your comment. Section 304(a)(2) through (6) is referring to those required checks, searches, etc. set out in Section 302.

Comment: 309. Emergency Plans and Drills-This section says providers must have emergency plans for all locations, including client residences – do you mean private residences, provider-owned homes, or only congregate residential sites where services are provided? This may be overkill for private residences. Section (b) seems to recognize this, but does not say specifically which procedures and which drills are required in which type of setting. Can you clarify?

Response: Please see previous response above.

Comment: 312. Emergency Response Services-These requirements seem to reflect traditional 24-hour emergency response services required for OBHAs. Not all HCBS services would seem to warrant this level of emergency staffing and services. This may deter many providers from becoming CSSP agencies.

Also, can telehealth be used in place of in-person contact?

Response: Thank you for You Comment. Yes, telehealth may be used in place of in person contact.

Comment: 313 Restraints and Seclusions-- This section seems to be written from a BH standpoint. CES Waiver providers are not allowed to use seclusion. This may need clarification as to which HCBS services a seclusion can be used for, if any.

Response: Thank you for your comment.

Comment: 402. Exits**--**This section says a provider remains responsible for the health, safety and welfare of an existing client until all transitions to the new provider are complete. However, the reason the transition is occurring is because the current provider CANNOT ensure health, safety and welfare. Also, often clients will not cooperate to let the current provider continue. Please reword to accommodate these realities.

Response: Please see previous response to this question above.

Comment: 501 Incidents to Be Reported-With regard to items (6) and (7), why are they 1 hour here but 2 hours in CES Waiver?

Response: Thank you. We will discuss internally and ensure that the language is consistent with the approved waiver.

Comment: 502. Reporting Requirements-With regard to the 48-hour reporting requirement, please clarify what happens when the deadline would fall on a weekend or holiday.

Response: Thank you. We will discuss internally and ensure that the language is consistent with the approved waiver.

Comment: Subchapter 9. Intensive Level Services

As an organization considering CSSP, the service we are most interested in providing for our clients that we cannot provide as a CES Waiver provider would be Counseling, and perhaps Family Support Partners, both of which this section says requires an Intensive Level Certification. But in order to obtain this certification, it says the CEO must have a degree in *behavioral health management* or a related filed and experience. Also, we would have to have a full-time Clinical Director who must be a MHP, even though

our mix of clients may not justify a FTE. It also says we must have a Certified Peer Support Specialist. If this section is not modified, it it seems unlikely that any CES Waiver provider will provide any service they are not providing today. In other words, no silos will be broken down.

(Also, why is this level called Intensive and the higher level Enhanced. The common meaning of those words would indicate the reverse.)

Response: The services under the Intensive level of certification require the provision of services focused on behavioral issues and require professional oversight the agency must meet the requirements to obtain certification and deliver services. Providers who are not interested in providing services to address symptoms of a behavioral health condition can apply to become a CSSP Base level provider or remain a CES waiver provider.

Comment: Subchapter 10. CSSP Enhanced Certification

Since this level requires the provider to meet both Base and Intensive level requirements as well, the same problems arise as listed under Subchapter 9 Intensive.

Response: Agree. See previous response that these services are in the wrong location in the definition section.

Comment: 1002(b) seems to be describing Complex Care Homes for IDD. Why is the name not used? Or is it intended for any group setting of IDD?

Response: Yes, you are correct and this needs to be amended.

Comment: Section (b)(1) states that a Therapeutic Communities or Community Reintegration program can house no more than 16 individuals, but (b)(2)(8) says no more than 8. Please explain the rationale for the difference. It still seems like these are siloed approaches for IDD and BH.

Response: Therapeutic Communities and Community Reintegration are behavior health programs approved under the 1915i state plan amendment and must remain sixteen (16) beds or less to avoid the designation of Institution for Mental Disease. CMS only approved Complex Care Homes for IDD being eight (8) person maximum. Members who live in a Complex Care Home must be IDD and need supportive living which is the primary service in this setting.

Comment: At various places in this subchapter, there are requirements that a “CSSP Location” must meet, but it is not clear if that applies to Complex Care Homes for IDD as well as TC and CI.

Response: Please see previous response on this topic. Yes, a CSSP location is an enhanced physical location.

Comment: Section (b) say a CSSP facility housing one or more CES Waiver clients can house more than 4 clients if the requirements are met (for a Complex Care Home). This is extremely confusing. What about clients with IDD who are being served through 1915(i)/wait list. And does this mean that all existing group homes must now meet this requirement if they want to serve more than 4 under the recent waiver amendment that increased maximum size to 8.

Response: There is no definition for group home in the approved CES Waiver. Prior "group homes" will be grandfathered in. The only addition to the CES Waiver was the service of Complex Care Homes that definition can be found in the service description under Supportive Living.

Comment: (c) says males and females cannot share a bedroom. What if they are adults?

Response: We disagree. Thank you for your comment.

Comment: 1005. General Nutrition and Food Service Requirements

Sections (b)(9) and (10) refer to a licensed professional being on site or on call and available within certain time frames. Is this in the wrong section?

Response: Thank you. You are required. It appears that those sections are in the wrong location and need to be relocated in the appropriate section of the manual.

Comment: 1006 Medications

Why is this section limited to Enhanced Certification? The Consumer-Directed Care Act (Arkansas Code Ann. 17-87-103(12) and the ASBN Rules, Chapter 5, Delegation) authorize individuals or caregivers to delegate certain medication administration and other health maintenance activities to unlicensed direct care aides. In light of that, it would seem this needs to be under the Base certification, and the CDCA provisions should be addressed.

(b)b. [numbering glitches?] This section says a provider can administer medications only through a licensed nurse or "other healthcare professionals authorized to administer medication." However, under the Consumer-Directed Care Act (Arkansas Code Ann. 17-87-103(12) and the ASBN Rules, Chapter 5, Delegation) authorize individuals or caregivers to delegate certain medication administration and other health maintenance activities to unlicensed direct care aides. Considering reviewing the old DDS waiver certification rules that had a section on the CDCA.

(c)(h)(iii)– Is this stating the plan must give a physical description of the medication or what description is it referring to? This may need to be worded differently as to state what the medication is primarily treating, otherwise if they are wanting a physical description of the medication this can change with each pharmaceutical company and there will not be any consistency in this circumstance.

(c)b.(v) – Is this stating we need to indicate on the plan that it will be charted on a Med Log?

(c)b.(vi) – Potential side effects are numerous for most drugs. Why not require client-specific side effects unless said individual is starting a new medication and does not know if there will be side effects from this particular med. And then, we suggest limit to most common or the list will be way too long.

(d)b.(iii) -- This may need to be more clear to state route of administration i.e. by mouth, inhalation, per tube, etc..... versus delivery.

(d)(b)(ii)-- This symptom to be addressed should be indicated on the med management plan not the med log -- there is only so much room on a medication log, unless it is pertaining to a PRN drug that is only used for certain symptoms and that will be listed on the original pill bottle/container.

(d)b.(vii) **–** Regarding transfer of meds from original container into individual dosage containers by the guardian **--** Will this need to be indicated on a med log even if the individual administers their own medication?

Response: Please see other responses on this topic.

Comment: 1007 Daily Service Logs-We have no problem with daily service longs, but (b)(5) seems excessive – having to describe every day the relationship of the HCBS service to the treatment objectives. That changes much less frequently than every day and should be addressed in the individual treatment plan.

Response: Please see previous response on this topic.

Comment: 801 Reconsiderations and 802 Appeals--These sections also should reference the Medicaid Fairness Act for adverse actions that fall under that Act. (See comment under "Adverse Action" definition above.)

Response: Please see previous response on this topic above.

David Ivers, J.D., VP for External Affairs & General Counsel
Easterseals Arkansas

Comment: We agree with the Department's efforts to find a way to break down silos in order to meet the needs of individuals with complex needs. However, the proposed manual is extremely confusing. The service descriptions continue to reflect the input of behavioral health providers but little if any input from intellectual and developmental disability providers. We believe the proposed manual needs to be pulled back and addressed with a workgroup of IDD providers who can help the Department to supplement the service descriptions with appropriate language that will benefit individuals whose primary diagnosis is IDD but who have behavioral health needs as well.

Which providers/which services? Also, it is not clear which providers can bill which services for which clients. For instance, can CES Waiver providers bill any service in this manual provided it is medically necessary? If so, does it matter whether the client qualifies under 1915(i) or CES Waiver? If they cannot bill any services in the list, which services are CES providers limited to? What services can OBHA providers bill and for which clients? Can CSSP agencies bill any service under their level of certification for any client regardless of whether the client qualifies under CES or 1915(i)? If not, please explain.

Response: Thank you for your comment and the state believes that services and levels of certification have been added to address the needs of the behavioral health population as well as individuals with IDD that have symptoms of a behavioral health condition. Service descriptions for the majority of services did not change and instead were moved from a PASSE manual to a new HCBS manual to work in concert with the 3 levels of CSSP certification. Also see previous responses above.

Comment: Accreditation issues. Finally, the proposed CSSP Rules state that a CSSP agency must have accreditation to provide any HCBS service. Does that mean CES Waiver providers also must have

accreditation to provide any HCBS service in this list? If so, which ones? And which CARF accreditation sections will suffice for which services?

Response: Accreditation is required for CSSP at this time. It is not a requirement in the CES Provider certification manual.

Comment: What is the status of the state's 1915(i) State Plan Amendment? We could not locate a copy online.

Response: It is with CMS waiting for approval.

Comment: Section 202.000 Participation Requirements. This says the individual must tier at a level 2 or 3. Hasn't a Tier 4 been added?

Response: Thank you for your comment. Tier IV is not an eligibility determination and therefore was not included.

Comment: Section 203.00 Provider Certification Requirements. This section says participating providers must be certified under as either OBHA, CES, or CSSP. Many of the services taken from the proposed 1915(i) SPA pertain solely to behavioral health needs or to a mixture of BH and DD needs? In the August 2, 2022 promulgation of 1915(i), the Department removed CES Waiver providers as eligible providers for these services. *Are you saying that CES providers can provide any service in this manual?* That would seem to allow CES Waiver providers to provide any of these services without having to meet the heightened requirements of CSSP. Is that what was intended? What would be the need to become a CSSP Agency if so?

Response: No, see previous responses to this question above.

Comment: 210.000 Home and Community-Based Services Under ABHSCI**.** Elsewhere in this promulgation the Department proposes to repeal ABHSCI. Thus, we are confused as to how this section can be limited to ABHSCI.

Response: ABSCHI will be replaced with Behavioral Health Adults receiving HCBS services outside of the PASSE.

Comment: 220.000 Home and Community-Based Services Under PASSE**.** 220.100 Behavior Assistance – Is this limited to clients whose primary diagnosis is BH? The wording indicates it is ("rehabilitative and restorative in nature," children and adolescents at risk of out of home placement after return form residential placement, "offending behaviors, aggressions, and oppositional defiance." etc.) If it were reworded, it could be useful for clients with IDD who have challenging behaviors.

Response: Services have not been reworded due to the ability of each PASSE to authorize services based on the member's individual needs.

Comment: 220.110 Crisis Stabilization – Is this limited to clients whose primary diagnosis is BH? Also, the last two sentences appear to be a section of the CMS template that was left in.

Response: This service is used to address a behavioral health crisis. Each PASSE may authorize services to meet the member's need regardless of diagnosis.

Comment: 220.120 Assertive Community Treatment – Is this limited to clients whose primary diagnosis is BH? The wording says it is typically targeted to individuals who have "a serious mental illness or co-occurring disorders, multiple diagnoses, and the most complex and expensive treatment needs."

Response: Please see above. All HCBS under the PASSE model will have the same response.

Comment: 220.130 Intensive In-Home for Children – Is this limited to clients whose primary diagnosis is BH? The wording is heavily BH-oriented.

Response: Please see responses above.

Comment: 220.140 – Adult Rehabilitative Day Service -- Traditionally, this service has been for individuals with chronic mental illness, and the wording still reflects that. Is there a comparable service for individuals with intellectual and developmental disabilities who have complex, higher needs that cannot be met easily in the traditional waiver HCBS setting?

Response: Adult Developmental Day Treatment.

Comment: 220.150 Peer Support – Is this limited to clients whose primary diagnosis is BH? Again, the wording is BH-oriented.

Response: Please see responses above.

Comment: *220.160 Family Support Partners ("intensive" CSSP level) – Thank you for specifically referencing "developmental disabilities" in this description. The service should prove helpful. However, why is it limited to "*Intensive Services*" certification under CSSP if a CES Waiver provider can offer the same service without meeting any additional requirements?

Response: Thank you for your comment.

Comment: *220.170 Pharmacological Counseling by RN – Thank you for including this service since this could apply to individuals with both IDD and BH needs. Does this mean CES Waiver providers can now provide this service to any client or only those under 1915(i)?

Response: No, please see responses above. The specific services for each provider type are outlined in the certification manuals. A CES Waiver provider would need to be enrolled as a CSSP to provide this service since it is a 1915i and not available under the CES Waiver provider type.

Comment: 220.180 Respite – This is a much-needed services. However, unless the reimbursement rate is increased above current levels, providers will not be able to afford to provide to any significant extent. Families definitely need relief. Please re-evaluate whether the rates being paid are sufficient to meet access requirements.

Response: Thank you for your comment.

Comment: *220.190 Supportive Life Skills Development – Thank you for including “or habilitative plan.” However, please clarify how this service differs from Adult Life Skills? From Supported Living under CES Waiver? From Personal Care?

Response: Supportive Life Skills Development is a service for transition aged youth that have experienced behavior issues that have prevented them from obtaining skills for adulthood.

Comment: 220.200 Child and Youth Support Services – Is this limited to clients whose primary diagnosis is BH? The wording indicates yes. Along with “symptoms of illness” we would suggest adding “challenging behaviors” or words to that effect.

Response: Please see previous responses above in regards to HCBS and who can receive the service.

Comment: 220.210 Supportive Employment – Why is there a separate CES Supported Employment? We are not opposed to that but are confused as to whether we are blending service lines or not and if so, how.

Response: While supported employment is focused on helping clients with IDD, supportive employment under the 1915i is focused on helping address behavioral health concerns in the workplace or community. Again, the PASSE can determine which HCBS to approve for the member.

Comment: 220.220 Supportive Housing –Is it limited to clients whose primary diagnosis is BH? It seems to be taken from substance abuse services (“transitional housing” and “chemical free living,”).

Response: Please see previous responses above in regards to HCBS and who can receive the service.

Comment: 220.230 Partial Hospitalization –The wording is heavily BH-oriented – is it limited to clients whose primary diagnosis is BH?

Response: Please see previous responses on why we did not reword service descriptions.

Comment: *220.240 – Therapeutic Host Homes – Thank you for including and for referencing “developmental disability needs.” Without some sort of certification/inspection process, providers may be reluctant to refer clients to a host home and families may be reluctant to utilize.

Response: Thank you.

Comment: 220.270 Therapeutic Communities –Is this limited to clients with a primary diagnosis of BH? The wording indicates that it its, but we have heard from various parties of the need to provide this type of service to individuals with IDD with complex needs.

Response: Please see previous responses regarding who can utilize HCBS under the PASSE.

Comment: 220.280 Residential Community Reintegration Program -- Can this be revised to better accommodate individuals with IDD? For instance, the first sentence says it is an intermediate level of care between inpatient psychiatric care and outpatient behavioral health services. Individuals with IDD who have behavioral challenges make transitions from various settings as well.

Response: Please see previous responses regarding who can utilize HCBS under the PASSE.

Comment: 220.290 to 220.300 and 220 through 220.380 CES Supported Employment; Supported Living; Adaptive Equipment; Community Transition Services; Consultation; Environmental Modifications; Supplemental Support; Respite; Specialized Medical Supplies –These services are taken from the CES Waiver. Are they limited to members whose primary diagnosis is IDD. Why would a provider bill under this program rather than under CES? It seems like we are maintaining most of the same silos since the services continue to be defined differently for BH and IDD.

Response: No, any PASSE member may receive an HCBS under the PASSE if the PASSE authorizes the service to meet a member's functional need.

Comment: 220.130 Complex Care Homes for IDD – Thank you for including this service (see our comments on the CES Waiver seeking more clarification).

** indicates the only 4 services that are not in CES Waiver that seem by their wording to be written to include individuals whose primary diagnosis is IDD.*

Response: Thank you for your comment.

Comment: REIMBURSEMENT**.** This section seems to pre-date the decision to repeal AHSCI. Can you clarify?

Response: ABHSCI will be replaced with Behavioral Health Adults receiving HCBS services outside of the PASSE Program.

<u>David Ivers, J.D., VP for External Affairs & General Counsel</u>
<u>Easterseals Arkansas</u>

Comment: 211.200. Staff Requirements. For Non-Independently Licensed Clinicians, Physician, etc. – please add "or contracted with" after "employed by."

Response: Thank you for your comment. We will review internally.

Comment: 212.000 Scope. Shouldn't "or CSSP Agency" be included as an eligible provider type along with a BH provider?

Counseling Services definition – shouldn't allowable settings include "outpatient-based setting" as in 214.000 since new providers who are not BH agencies may not fit within the other named locations.

Response: Allowable location codes are attached to each service and should be used for all eligible provider types.

Comment: 213.000 Counseling Services Program Entry--This section says, "The intake assessment, either the Mental Health Diagnosis, Substance Abuse Assessment, or Psychiatric Assessment, must be completed prior" to starting Counseling. Does this mean any one of those three suffice as an intake assessment? Section 252.122 Psychiatric Assessment says it is NOT required to receive Counseling Services.

Response: Yes, any of those three assessments can be used to establish a diagnosis and begin counseling services. A specific psychiatric assessment is not required.

Comment: 214.100 Parent/Caregiver & Child (Dyadic treatment). It says providers must be certified by DAABS to provide this service. Earlier the manual says they can be a CSSP provider for the services in this manual.

Response: Dyadic treatment requires a separate certification for the rendering provider.

Comment: 217.100 PCP Referral--Shouldn't the third sentence in the second paragraph say no services except Crisis Intervention may be provided without a PCP referral "after the initial ten (10)?

Response: Crisis Intervention service definition has been updated for clarification.

Comment: 216.100 Documentation--Daily documentation is understandable, but "F" seems excessive – having to describe every day the relationship of the services to the treatment regimen described in the treatment plan. That changes much less frequently than every day and should be addressed in the treatment plan.

Response: Thank you for your public comment.

Comment: 229.000 Medicaid Client Appeal Process--Where is the section for Provider Appeals, which should reference the Medicaid Fairness Act?

Response: Thank you for your comment and please see other DHS responses pertaining to the appeal language and needed amendments.

Comment: 202.110 Counseling Level Services--This appears to be a heading for all the services descriptions that follow, not a separate section in and of itself.

Why is CSSP Agency site not mentioned in the allowable settings under each service?

Response: CSSP is not a setting, it is a provider type. Provider would use the applicable location code.

Comment: 252.121 Pharmacological Management-How does Pharmacological Management here differ from Pharmacological Management by an RN in the HCBS Manual?

Response: Pharmacological management in this manual is a service provided by a licensed physician or APN to prescribe and monitor medications. Pharmacological Management by an RN is a HCBS service provided by an RN to assist with medication compliance.

James Atkins, Pediatrician

Comment: My name is James Atkins, and I am a pediatrician in Monticello. Integrated behavioral health matters to me due to inaccessible mental health care for children in our state, especially the rural area of our state. Pediatricians, like many providers, are caring for children and youth experiencing the current behavioral health crisis. Screening, assessing, and treating children for emotional and behavioral needs in real time in the primary care setting is an effective way to remove barriers to access and ensure quick action for children and youth in crisis. I support the concept of integrated behavioral health and applaud the rule changes that have been proposed to permit employment of licensed therapists in physician offices. In particular, I support activating payment for depression screenings and maternal/caregiver depression screenings in the pediatric primary care setting, which aligns with American Academy of Pediatrics recommendations. I do my best to provide the best possible care to my patients and closely follow AAP recommendations. I have screened numerous mothers of infants and diagnosed them with postpartum depression. I spend time screening and finding them assistance so it would be nice to receive reimbursement for my services. We would love to be able to provide time-limited, preventive counseling or psychoeducation services without a diagnosis to prevent escalation of risk factors as well.

Response: Thank you.

Jared Sparks, PhD, LCSW, CHC, Vice President of Quality & Compliance
Arisa Health

Comment: Why is the state of Arkansas rejecting the successful and nationally recognized Certified Community Behavioral Health Center model for Behavioral Health in favor of this one designed for Intellectual and/or Developmental Disability populations? We know the PASSEs serve approximately 55,000 beneficiaries, only 6,000 who are IDD. Why design a system based on 11% of the total population?

Response: Thank you for your comment. It is unclear from the question if you are referring only to the additions made to the Community Support System Provider (CSSP) Certification manual and if that is the case the original CSSP certification and provider type was created and promulgated in January of 2021. Updates to this manual include the addition of a new level of certification to provide professional oversight of services delivered to individuals with a behavioral health diagnosis or an intellectual disability and symptoms of a behavioral health condition. The system has been designed to support the rural workforce in AR in the delivery of HCBS across all populations and enabling new providers to provide HCBS to broad or narrow populations within the PASSE.

Comment: There are no new published daily rates for Community Support System Providers. This prevents planning for sustainable service delivery.

Response: Rates are not published for provider types and instead published separately for services. Rates are not included in AR Medicaid service or certification manuals.

Comment: Page 5. 103. Definitions (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 (3) Adult Rehabilitation Day Treatment and 1003. Specific Requirements (c) CSSP Agency Enhanced owned or leased facility must provide each client with:

(1) An individual bed…bedroom furnishings…

In this manual there is no provision for Rehabilitation Day Treatment to be provided outside of an Enhanced level or Intensive level of care. Rehabilitation Day Treatment Services are an essential component of treatment for those clients with functional deficits due to qualifying illnesses and disabilities. In a state where 41% of the population live in rural counties, access to a day program enables more service for a broader geographic region than would be possible through individual services, especially given the nationwide shortage of behavioral health workers. Making this available only for residential clients creates a gap in care that cannot be filled by other services or a combination of services. Can these level of care and facility requirements be removed for Rehabilitation Day Treatment, so that Rehabilitation Day Treatment can be provided in the CSSP Base Services?

Response: Adult Rehabilitative Day Service will remain under the CSSP Enhanced certification due to the location of the service being limited to clinic settings. The CSSP Certification manual will be updated to indicate the regulations related to treatment programs in which the client is provided with treatment 24 hours per day and 7 days per week.

Comment: Page 7. 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 development disability services needs

In the past there has been confusion about whether the BHA manual, OBHS manual, and Therapeutic Communities manual governed CSSP TC providers services. What manuals govern services in the CSSP manual?

Response: The CSSP is a certification manual for an AR Medicaid enrolled provider type. The Outpatient Behavioral Health Agency manual is a certification manual for an AR Medicaid enrolled provider type. The OBHA provider is certified to provide the professional services now contained in the Counseling Services manual and the 1915 (i) services contained in the new HCBS for Clients with Intellectual Disabilities and Behavioral Health Needs. The CSSP certified provider can provide services in both manuals as well depending on their level of certification-Enhanced, Intensive or Base.

Comment: Are clients who have Medicaid Spend Down eligible for HCBS services under the PASSE manual in Therapeutic Communities? Previously these services were only available under the Adult Behavioral Health Services for Community Independence.

Response: ABHSCI will be replaced with Behavioral Health Adults receiving HCBS services outside of the PASSE Program.

Comment: Page 15. Certification Process. Will there be a grandfathering of current BHAs to CSSPs?

Response: All Outpatient Behavioral Health Agencies (OBHA) in good standing can be grandfathered as a CSSP Intensive level provider if they wish. The OBHA certification is not being sunset.

Comment: Page 19. 303. Employee Training. **T**raining requirements of “all employees” is excessive. Can this be limited to direct service providers?

Response: The intention of the state was to require training of direct service providers only. Language will be added to clarify.

Comment: Page 27**.** 308. Financial Safeguards-- a. … or the CSSP otherwise has the *legal authority* to limit a client’s use or access of their own funds…”.

Does “legal authority” mean only as approved as payee by the Social Security Administration? What is the definition of legal authority?

Response: Legal authority would be an individual or governmental entity that has the authority to dictate the use of a client’s funds or other assets. Social Security Administration could be an example as it pertains to a client’s social security funds. A court and legal guardian would be others.

Comment: Page 30**.** 310.a(3) – Employees and clients must wash their hands with soap before eating, after toileting, and as otherwise appropriate to prevent the spread of infectious disease. Is alcohol-based hand sanitizer permitted in place of soap?

Response: We believe best practice is to use soap and water but understand if sometime hand sanitizer is used instead. We will look at clarifying the language.

Comment: Page 32**.** 3112 Emergency Response Services**--**Emergency Response Services: Applicants/providers must establish, implement and maintain a site-specific emergency response plan, which must include:

3. Direct access to a mental health professional within fifteen (15) minutes of an emergency/crisis call and face to face crisis assessment withing two hours. Please clarify that telehealth may be used to provide access and assessment in the above requirement.

Response: We agree and will clarify the language.

Comment: Page 52. 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.. Please clarify that incidents and accidents to be reported are incidents and accidents that occur only at the CSSP site and/or during the delivery of a CSSP service.

Response: Correct.

Comment: (7) Any situation where services to the client are interrupted for more than one (1) hour…

This is too broad of a category. Please provide some clarity on how this can be meaningfully applied, as it occurs on a regular basis for multiple reasons related to health, emotional lability, family issues, etc.

Response: Thank you for your comment. We will discuss internally and provide additional clarifications and guidance around incident reporting requirements.

Comment: (10) Any act or admission that jeopardizes the health, safety, or quality of life of a client. This is too broad of a category. Please provide some clarity on how this can be meaningfully applied.

Response: Thank you for your comment. We will discuss internally and provide additional clarifications and guidance around incident reporting requirements.

Comment: (11) Motor vehicle accidents involving a client**.** Please clarify that this is only during the time a client is transported by CSSP employees.

Response: Correct.

Comment: Page 54.DPSQA shall monitor a CSSP Agency to ensure compliance with these standards:

(a) Cooperation required under these standards…with respect to investigations, surveys, site visits, reviews, an other regulatory actions taken by DPSQA or any third-party contracted.

Over the past several years, the third party contracted to conduct audits has provided reports that are inconsistent with the content of the provider manuals, and there has not been timely feedback on inspections or reconsiderations. This creates an unnecessary administrative burden on providers. Can audit tools be made public as required? In these tools, can intent statements for ambiguous standards be created/made public so that there is some consistency between auditors and audits?

Response: Thank you for your comment. DPSQA is working with the vendor to ensure the tools they use are correct in accordance with the certification standards.

Comment: Page 64. Employees and Staffing Requirements. Multidisciplinary Team Leader (Individual who has licensure and training applicable to the treatment of the individual client indicated in the individualized plan of care) Is the individualized plan of care referenced in the CSSP manual developed by the CSSP provider or PASSE?

Response: The plan is developed by the provider.

Comment: There is no individualized treatment plan identified in this manual as it was in the previous CSSP manual. Outside of any medication management plan and behavior management plan, are there

any specific requirements for a treatment plan and/or plan of care? For example, what is the review period, who develops, and who signs?

Response: Service providers develop treatment plans outlining the service you are providing the client. Treatment plans are incorporated into the member's overall PCSP if the person is in a PASSE.

Comment: Page 68. General Requirements. (a) (1) A CSSP Agency Therapeutic Community or Community Reintegration Program can house no more than sixteen (16) clients

Currently, Therapeutic Communities do not always have clients at one address. Some have 16 beds at one site. Others have individual homes or other residences that are geographically separated. Please clarify that this requirement allows for separate addresses that together house no more than 16 clients - to be connected to one certification.

Response: Thank you for this comment. We will discuss this internally and make amendments to clarify.

Comment: Page 71-1003 Specific Requirements**--**(13) A kitchen with equipment, utensils, and supplies necessary to properly store, prepare, and service three (3) meals a day.

(2) …a shower or bathtub

A CSSP offering only Base service does not need a kitchen or shower/bathtub. Can you clarify what specific requirements apply to a CSSP providing only Base services?

Response: The requirements you listed above pertain to the Enhanced level if a client is living in a CSSP location.

Comment: Page 71. 1003. Specific Requirements-(c) CSSP owned or leased facilities must provide each client with (5) One (1) or more windows that can open and provide an outside view. This eliminates the option for interior bedrooms, increasing the cost significantly of the facility.

Additionally, this is not advisable for some clients who are under court order, and the setting exceptions and variations in 1004 does not take into consideration facility structures designed to accommodate these clients. Can this be removed as a requirement?

Response: Thank you for your comment. We will need to discuss this more internally.

Comment: Page 74. 1005. General Nutrition and Food Service Requirements. a. (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…

This eliminates the option to contract with local restaurants for meals and snacks. Can this be modified to allow for contracting with local restaurants?

Response: Thank you for your comment. We will need to discuss this more internally.

Haley Thomas MRC, LPC, Director of Clinical Operations
Families, Inc. Counseling Services

Comment: 217.100 Primary Care Physician Referral

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.

We would like to see the Arkansas Department of Human Services reconsider requiring PCP referrals for Counseling Services. Many ,if not most insurance companies, don't require these referrals, as they prolong the time it takes to get clients into services. They also add additional barriers to mental health treatment. Often the wait to see a Primary Care Physicians is weeks if not longer with the current shortage. The manual does allow for 10 visits at the beginning of treatment before a referral is needed but doesn't allow for that when the referral expires and an additional one is needed. Also, the manual requires in 224.000 that 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." One would argue that this oversight is enough to ensure appropriateness of clients into services. Not requiring a PCP referral would not only remove a barrier and ensure continuity of care but would also save money as the extra service provided by the PCP wouldn't be needed.

Response: Thank you for your comment. AR Medicaid enrolled physicians need to be part of the discussion to change this requirement.

Comment: In the Diagnostic and Evaluation Services Manual: 202.000

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 has begun mental health counseling services, can receive a psychological evaluation to confirm the diagnosis in order to guide continued behavioral health counseling services.

We would like to see the Arkansas Department of Human Services reconsider requiring that a client " has begun mental health services." Often providers for evaluation services have clients who receive counseling services at another provider. It would cause an undue hardship to have to confirm these services. If providers decide to not take outside referrals for evaluation, then the very small pool of providers of evaluation would further shrink for the Medicaid clients who need these services. Furthermore, there are many legitimate reasons that clients may want evaluation services before any counseling services are provided (ie... to determine if medication only services will effectively treat the diagnosis). Clients also deserve the autonomy to have a diagnosis confirmed regardless on their choice of how to treat it.

Response: Psychological testing for individuals with Behavioral Health issues is being used for the clarification of diagnosis and to inform treatment planning of existing clients when a Diagnostic Assessment and Psychiatric Assessment have not clarified diagnosis and appropriate course of treatment.

Comment: 220:100

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.

On 220:100, we would like to recommended that the Arkansas Department of Human Services reconsider the requirement for a PCP referral for ASD evaluation. Often clients are referred from their Mental Health Professional and/or Psychiatrist , both of whom are trained to identify symptoms of Behavioral Health Diagnosis as well as symptoms of Autism. To then ask for an additional referral from a PCP provides a barrier to the service as well as additional cost to the system.

Response: We agree that this should be amended to reflect the statute.

Comment:

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

Lastly, We would like to recommend that the Arkansas Department of Human Services reconsider excluding LPE(I)s from the accepted list of clinicians who can evaluate for ASD. They are well trained and currently providing the service. The wait list in Arkansas for ASD evaluation is already very lengthy due to a small pool of evaluators. If you exclude LPE(I)s you will be effectively limiting the pool of evaluators and creating even longer wait times. This is detrimental, as it is well known, that early intervention produces the best outcomes for those diagnosed with ASD.

Response: We agree. A LPE may evaluate if it is within their scope of practice under a licensed psychologist.

Craig Cloud, Chief Executive Officer
Friendship Community Care

Comment: Thank you for the opportunity to provide public comment/ feedback on these proposed rules. All changes presented are extensive and represent significant changes that must be implemented by our provider network. Implementing these rules without fully reviewing and vetting the changes and the related impact only creates dysfunction. Friendship Community Care is committed to the provision of services to individuals with specialized and complex needs. Friendship supports these efforts to ensure proper access to services for individuals served

These changes and rules were not developed nor fully discussed with the providers, stakeholders, and consumers. As a provider that will be charged with implementing these new rules it is important the impact of said changes be communicated and understood by the provider network. Failure to ensure proper coordination between DHS, the PASSE, and providers on these changes only creates dysfunction for the consumer and our service system as a whole. I respectfully request that DHS hold on the approval and implementation of said rules until such coordination, communication, and education can occur.

Response: Thank you for your comment. We are taking all public comments very seriously and will be making adjustments based on these comments. Due to the short timeframe, we cannot postpone the promulgation package at this time.

Comment: Subchapter 1 103 Definitions--Item E Does a chemical restraint require all 3 requirements. For example, if a client has a PRN Xanax for anxiety is that considered a chemical restraint?

Response: A chemical restraint is the use of a medication outside of a client's normally prescribed, daily medication routine that is used to change a client's immediate behavior.

Comment: Item E-3 What is considered to not be a standard treatment?

Response: Not standard treatment is what is described above. The medication used is not part of the client's regular daily medication and is used in an emergent situation to change the client's behavior.

Comment: Item F--Can you explain what a complex care home is within the CES waiver and the difference from a CSSP complex care home? DHS was to request a waiver from CMS to allow 6 individuals in a home setting, has this been changed to 8? These new proposed rules do not address group homes or provider owned/managed apartments/ independent living units.

Response: A complex care home can be provided by a CES Waiver provider or a CSSP provider. It was our intention to make the certification standards the same in both manuals. We did receive approval from CMS to implement Complex Care homes. It is located in the Supportive Living definition in the waiver itself. The waiver is silent on group homes, but DDS will continue to grandfather in existing group homes.

Comment: Item S Will Risk Mitigation Plans be developed with the providers input, and will this be shared with providers?

Response: We are continuing to work with the PASSEs to develop and utilize ONE Risk Mitigation Plan/Screen. We will invite IDD and BH providers to join into that discussion to provide input on the tool.

Comment: Subchapter 3 Administration. 302 Employee and Staffing Requirements- Item D Is experience no longer acceptable when no GED or HSD is available? Will current staff be grandfathered in?

Response: Please see previous response on this topic.

Comment: 305 Client Service Records. Item B-1-J This item states Medicaid Number, but no PASSE number? Item B-4 Care Coordinator information is difficult to get with turnover and no notification from PASSE.

Response: We understand. Please see previous response on this topic in regards to care coordinator information. As to Medicaid ID, Medicaid still validates claims and clients by Medicaid ID.

Comment: Item C-4 Please clarify what is the difference between Behavioral Prevention and Intervention Plan, Positive Behavior Support Plan, and Risk Mitigation Plan?

Response: Please see response on this topic above in the document.

Comment: 309 Emergency Plans and Drills. Item A-1 Does this mean we are required to have emergency plans and evacuation drills a clients private home in the community?

Response: Please see previous response on this topic.

Comment: Subchapter 5 Entries and Exits. 503 Refusal to Serve. Will DDS be developing criteria for determining a refusal to serve?

Response: Please see previous response on this topic.

Comment: Item B What is considered a reasonable effort to recruit and retain qualified personnel?

Response: Thank you for your comment. The reasonableness of efforts is determined on a case-by-case basis depending on the applicable circumstances.

Comment: Item D What is considered a legitimate client health, safety, or welfare concern? Is there a process for appeal? What are the consequences of no longer being able to serve a client?

Response: Thank you for your comment. Legitimate concerns would be determined on a case-by-case basis depending on the applicable circumstances. If there is a violation, then potential consequences and appeal rights would be the same as any other violation of the Rules as set out in Subchapter 8 and 10 respectively.

Comment: Subchapter 6 Programs and Services. 602 Behavioral Management Plans

Item A-1-C Will DDS provide a list of acceptable trainings to be able to implement and develop behavioral prevention and intervention plans?

Response: We do not plan to provide a list. It is the provider's discretion. The required modules/topics are outlined in the approved CES Waiver.

Comment: Item 2-C Will a QDDP no longer be able to be considered to implement and develop a positive behavior support plan?

Response: The definition of Consultation was amended in the CES Waiver earlier this year. That waiver was run in public comment, promulgated and approved by CMS. In the waiver it states, screening, assessing and developing positive behavior support plans, assisting staff in implementation, monitoring, reassessment and plan modifications; is required when a high level of behavioral related risk is identified in the PASSE Risk Mitigation Plan; allowable providers include psychologist, psychological examiners. PBS, BCBA, licensed clinical social workers and licensed professional counselors. QDDP, if trained, can complete a Behavioral Prevention and Intervention Plan, which we anticipate a large number of IDD clients needing.

Comment: 604 Supportive Living. Item A-4 What is considered an acceptable staffing back up plan?

Response: This would be determined on an individual basis but could include having staff on call, temporarily using natural supports, etc. The goal is to staff our clients when it has been determined in the treatment plan that staff was needed at that time.

Comment: Item B-6 Please define an acceptable narrative.

Response: A daily progress note is required for supportive living that reflects that the activities conducted that day assisted the client with acquiring, retaining, or improving a skill that has been identified as an area of need that is hindering the client.

Comment: 605 Respite. Item B-2 What are considered acceptable Respite Activities would these be the same goals and objectives used for Supportive Living services?

Response: Correct.

Comment: Subchapter 7. 701 Incidents to be Reported

Item 7 Please define unscheduled situation. For example, if a client's family comes unexpectedly and takes the client out for the day/ weekend/ week, would this be considered an incident that needs to be reported?

Response: Incidents are required to be reported if the provider is providing a service at that time.

Comment: 702 Reporting Requirements. Item A-1-C Please elaborate on what is considered an interest of the public?

Response: We will cross check the waiver to make sure this aligns with the language.

Jack Hopkins, Manager, Government Relations
Arkansas Health Plan Association Comments

Comment: In the Community and Employment Support Waiver Providers Manual, 305 (d) Should the PASSE be listed as an entity able to access the record?

Response: We can clarify. We felt that you were included in "governmental entity."

Comment: 403 (a) Settings Exceptions and Variations – states "any client need or behavior that requires a variation or exception to the requirements set out in Sections 401 or 402 must be justified in the client's PCSP."

- Recommend this to state "…must be justified in their treatment plan and supported by the PCSP" as the items listed below this section go into detail about what would be included in the treatment plan, not the PCSP.

Response: We will look at the language.

Comment: 601 (b) (1) A provider can administer medication only as: (A) provided in the client's PCSP → would recommend this be removed…care coordination should not dictate any re: medication administration

Response: We agree. It should say treatment plan which is incorporated into the member's PCSP.

Comment: 602 defines Behavioral Management Plans and Positive Behavioral Support Plans that are the responsibility of the provider based on the PASSE's Risk Mitigation Plan.

- How will certified Behavioral Health Agencies (BHA) receive reimbursement for a Positive Behavioral Support Plan? Currently this can be billed by a CES waiver or CSSP provider as consultation, but not by a BHA. Will a code/rate be established for Positive Behavioral Support Plans? What about a Behavioral Prevention and Intervention Plan?
- 602 (a) (1) (C) Who can do these plans? This is very vague → individual who has documented training on the following topics: verbal de-escalation, trauma-informed care, verbal intervention training. Stratifies low and high risk (who determines this?)

Response: Correct. Consultation is a service billable under CES Waiver and CSSP provider types. Please see other responses regarding the PASSEs responsibility to perform a Risk Mitigation Plan/Screen to determine the level of risk. That risk will trigger the type of plan needed for the member. Also note that this will not be effective until the summer of 2023 while we continue to work with the PASSEs to utilize ONE tool for Risk. Providers will be included in those discussions.

Comment: 607 and 608: care coordinators should not always be responsible for placing orders of these types of supplies. The manual reads as if this is a requirement

Response: We agree and will amend (c)(2) on page 37.

Comment: 610 Consultation: (1) administering psychological and adaptive behavior assessments. Allowing providers to perform psychological testing through this route becomes problematic when they are also Medicaid providers or in network with the PASSEs. The reimbursement rate is higher for this route (than the psych testing codes) and providers frequently attempt to bill via consultation for higher reimbursement rates of the same service.

Response: This mimics the language in the approved waiver. We will need to further discuss.

Comment: 611 (e.8) Environmental Modifications – The Care Coordinator should not be certifying at job completion that the modification is complete, the property was left in satisfactory condition and any incidental damages to the property were repaired. This should be the responsibility of the billing entity, and or the property owner. Agree, care coordinator should NOT maintain this function.

Response: We agree and will amend.

Comment: 702 (b) states "A provider must submit all reports to DDS" It doesn't state that the provider must also submit to the member's PASSE in addition to DDS. Currently the PASSE is responsible for notifying DDS of all incidents that we are notified of. Does this mean the PASSE is no longer responsible for notifying DDS of incidents? How will the PASSE be notified of our member incidents? Currently the process is for the provider to notify the PASSE and DDS.

Response: We agree and will amend.

Comment: In the Home and Community Based Services for Clients with Intellectual Disabilities and Behavioral Health Needs CBS manual for IDD/BH, Assertive Community Treatment (ACT) has been added as a service offered by the PASSE but not to ABHSCI why was ACT not added to ABHSCI?

Response: The ABHSCI manual is being sunset. ACT is an allowable services for individuals outside of the PASSE under the Home and Community Based Services for Clients with Intellectual Disabilities and Behavioral Health Needs. We will make needed amendments.

Comment: 202.000: lists only Tier II and Tier III as eligible to receive services…what about Tier IV?

Response: Tier IV is not an eligibility determination and therefore was not included.

Comment: 230.100 Method of Reimbursement: they state they have fee schedule for services provided under ABSCI (210) but no mention of fee schedule for HCBS services provided under the PASSE model (220)

Response: ABHSCI manual is being sunset and therefore there will be no corresponding fee schedule. The fee schedule would be under the corresponding manual.

Comment: In the Diagnostic and Evaluation Services Manual, 240 Reimbursement: A: providers are not allowed to accumulatively bill for spanning dates of service. Comment: sometimes evaluations and feedback are performed on two different dates of service, depending on complexity of testing and need for feedback/reporting.

The manual does not address provider types. We have current issues with provider type mismatches and psychologists not being allowed to do psych 96136/96137 and neuropsych testing codes 96132/96133.

Response: Thank you for your comment and we will discuss this comment internally and determine if the language should be amended.

Comment: In the Licensure Manual for Community Support System Providers, 103 Definitions (k) Should N and O be included in Base Services? This is Pharmacological Counseling and Therapeutic Host Home.

Response: Yes.

Comment: 103 Definitions (dd) Qualified Community Support Provider (QCSP). What is the difference between a QCSP and Community Support Staff which is defined in (h)?

Response: This has been updated to Support Staff to be consistent.

Comment: 305 Client Service Records- All of the original (c) was removed. These are still listed in the CES waiver provider manual. Please clarify why the documentation that should be included in a client's service record was removed. Agree, need minimum documentation standards for this, especially given it is brand new.

Response: Thank you for your comment and we will discuss this comment internally and determine if the language should be amended.

Comment: 501 Incidents to be Reported - #6 and #7 differ from the CES waiver manual's Incident Reporting requirements, CES waiver manual states 2 hours for items #6 and #7. Please clarify if this should be 1 hour or 2 hours?

Response: Thank you for your comment and we will discuss this comment internally and determine if the language should be amended.

Comment: 1002 General Requirements (b 2B)- Is the CSSP Facility in this section referring to the "Complex Care Home" only or all CSSP facilities such as Therapeutic Community or Community Reintegration? Is it just the "Complex Care Home that can't have more than 8 CES waiver clients or all CSSP facilities can't have more than 8 CES waiver clients even though Therapeutic Committees can house 16 members? Please clarify.

Response: This should say Complex Care Home. We will amend.

Comment: In the Physician Manual, a behavioral health screen may be administered 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.

- Is the screening billable, is it only in a physician office? If it is a billable service is there a CPT code and accompanying rate for this to be billed?

Response: Yes, is it billable, only in physician's offices and the code and rate will be published.

Josh Wilson, Ph.D, Chief Executive Officer
Independent Case Management, Inc.

Comment: Section 303(b). We request the language governing CPR and First aid requirements be clarified to reflect employees who may be required to perform direct care services to clients. This change will remove any doubt about organizations being able to hire people with physical disabilities who cannot complete CPR and First Aid training and who will not be required to perform direct care services. For instance, an organization should not be prevented from employing someone with a disability who is physically unable to perform CPR if they will never provide direct care services to clients.

Response: Thank you for your comment. The requirements of Section 303 apply to employees. Section 103(j) defines "employee" as, "…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."

Comment: Section: 503(c)(1)(2) Each PASSE is responsible for providing care coordination that includes assistance with social determinants of health. Housing is considered a social determinant of health according to the Centers for Disease Control. Therefore, we request that this language be revised to reflect the PASSE, not the provider, be responsible for the housing requirements reflected in this section.

Response: Thank you for your comment. Once selected as the supportive living provider, it is part of a provider's responsibilities to assist the client in locating and securing appropriate housing. If the client's preferred dwelling options are not available, then it is the responsibility of the supportive living provider to propose potential available alternative housing arrangements and working with the client to locate and secure an available housing arrangement acceptable to the client.

Comment: Section: 601(e)(1). We request that the language be revised to include the client being able to transfer the medication if they do not have a court-appointed guardian.

Response: Thank you for your comment. We are internally discussing if the language should read as follows: Section 601(e)(1) of the Rules for the Division of Developmental Disabilities Services Community and Employment Support (CES) Waiver Provider will be changed to read, "Kept in the original medication container unless the legal guardian, or, the client, if no legal guardian is appointed, transfers the medication into individual dosage containers;"]

Comment: Section: 602(a)(C). There is not consistency between the CES Waiver Rules and Section II of the Home and Community-Based Services for Clients with Intellectual Disabilities and Behavioral Health Needs manual concerning the qualifications of who can develop and implement a behavioral prevention and intervention plan. The CES Waiver Rules only require training in verbal de-escalation, trauma informed care, and verbal intervention, while Section II requires the individual be a Positive Behavior

Support Specialist. We request Section II be revised by removing the Positive Behavior Support Specialist requirement and only requiring the training mentioned earlier.

Response: A Behavior Management and Prevention Plan can be performed by a QDDP or other direct care staff who has been trained in the introduction to behavior management, abuse and neglect, verbal de-escalation, trauma informed care and verbal intervention. Those modules are outlined the CES Waiver. If a Positive Behavior Support Plan is needed, licensed professionals write, implement and oversee the plan. Therefore, additional training is not required. Positive Behavioral Support Plans should only be used when a high-risk level is identified in the Risk Mitigation Plan.

Comment: Section: 610(a)(11). We request this section by revised to include behavioral prevention and intervention plans.

Response: Thank you for your comment. We agree.

Comment: Section: 610(b)(13). We request that certification to become a Behavior Support Specialist be expanded to include any entity offering the certification. Limiting certification to only Partners for Inclusive Communities could greatly inhibit certification thus reducing the number of certified professionals.

Response: Thank you for your comment. See previous responses on this topic.

Comment: In the CSSP certification manual, Section: 103(l) Does certification as a CSSP Enhanced or Intensive organization permit the organization to provide the services set out in the Counseling Services Medicaid Manual?

Response: Yes

Comment: In the CSSP certification manual, Section303(d). We request the language governing CPR and First aid requirements be clarified to reflect employees who may be required to perform direct care services to clients. This change will remove any doubt about organizations being able to hire people with physical disabilities who cannot complete CPR and First Aid training and who will not be required to perform direct care services. For instance, an organization should not be prevented from employing someone with a disability who is physically unable to perform CPR if they will never provide direct care services to clients.

Response: Our intention was for this to be a requirement for direct services providers.

Comment: In the CSSP certification manual, Section: 901(2) We request that language be added to clarify that Corporate Compliance Officer, Medical Director, and Clinical Director responsibilities only

pertain to behavioral health-specific services, not other services such as those for people with intellectual and developmental disabilities.

Response: This is a requirement for Intensive and Enhanced Levels of Certification therefore agencies certified under this manual should meet all requirements as indicated.

Comment: In the CSSP Certification manual, Section: 903. We request more information pertaining to the role of a Qualified Community Support Staff including the scope of services delivered by this role, the population of people served by this role, and if and how it is different from a Direct Support Professional for people with IDD.

Response: The services allowed are outlined in the manual. The population is those individuals who have behavioral needs which may benefit from these services.

Comment: In the Counseling Services Manual, Section: 252.112. We request the home of a client be included as a location for group behavioral health counseling.

Response: Thank you for your public comment. We will continue to work with stakeholders and providers as we improve the behavioral health system. No change will be made at this time.

<u>Sabrina Woodson, CEO</u>
<u>Focus, Inc</u>

Comment: Pg.2 (f) (1) physical health need needs to be defined, for example, peg tube? Uses wheelchair? Who determines what is deemed to meet this?

Response: Thank you for your comment. The PASSE will determine if someone meets medical necessity to be in a Complex Care Home.

Comment: Pg. 9 302 a. "a provider must appropriately supervise all clients based on each client's needs" What does this mean?

Response: Thank you for your comment. Client needs can change by the month, day, hour, or even minute. Providers must always ensure each client has the level of supervision necessary based on the client's needs at that time. For example, this might mean a more enhanced supervision level than that included in a client treatment plan when the client's needs at the time warrant.

Comment: Pg. 9b 1. "a provider must meet any minimum staff-to-client ratio included in a client's treatment plan" Where is this supposed to be documented? This is not included on master treatment plan or PCSP at this time? What does this mean?

Response: Thank you for your comment. Any required staffing ratio should be included in the master treatment plan.

Comment: Pg. 11 303 (d) Basic health and safety practices means what? First aid and infection control covers this. Give examples of what is expected for health and safety practices training

Response: Thank you for your comment. specific trainings have intentionally not been listed to allow providers maximum flexibility in selecting the best and most appropriate trainings. Industry best practices and available training offerings change with such frequency that mandating specific trainings would quickly become limiting to providers.

Comment: Pg. 11 303 (f) Identification and mitigation of unsafe environmental factors. What is this? Would workplace safety cover this?

Response: Thank you for your comment. Specific trainings have intentionally not been listed to allow providers maximum flexibility in selecting the best and most appropriate trainings. Industry best practices and available training offerings change with such frequency that mandating specific trainings would quickly become limiting to providers. Presumably for CES Waiver direct care employee identification and mitigation of unsafe environmental factors trainings that focused on a residential as opposed to an office workspace would be most appropriate, but there are no specific requirements.

Comment: Pg. 11 303 (g) Emergency restraint procedures. Is this CPI traininng for all? Every staff? Who pays for this training if CPI training?

Response: Thank you for your comment. Specific trainings have intentionally not been listed to allow providers maximum flexibility in selecting the best and most appropriate trainings. Industry best practices and available training offerings change with such frequency that mandating specific trainings would quickly become limiting to providers. Training would be required for each employee. "Employee" is defined in Section 103(j) as "…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."

Comment: P. 11 303 2 A Are we going back to every 12 months, currently is every two years?

Response: Thank you for your comment. Correct, the trainings set out in Section 303 are required annually.

Comment: P. 11 303 2 B Are we going back to a designated 12 hours of training and this 12 hours exclude subsectin (a)(1), why? We got away from the hours requirement.

Response: Thank you for your comment. There are no specific hour requirements tied to the annual training mandated by Section 303(a)(1). Regardless of how much time is spent training on the topics in Section 303(a)(1), Section 303(a)(2)(A) requires an additional twelve (12) hours of annual training for each employee and Section 303(a)(2)(B) lists certain topics that are required to be covered as part of those twelve (12) hours**.**

Comment: p.11 2 B (ii)Why is EVERYONE having to have care planning for autism when a staff might not even serve a client with ASD?

Response: Please see responses to other comments on this topic.

Comment: P. 11 303 (b) CPR certification from one of the following: AHA, MFA, or ARC. What about trainings that follow AHA guidelines but not specifically AHA, for example, Pro Trainings is the certification and follows AHA. But since Pro Trainings is not listed will it be accepted?

Response: Trainings listed will be accepted.

Comment: P.12 c(1)and (2) This is repetitive of 2(a)(b). 2(a)(b) is general training for 12 hours of care planning and de-escalation techniques, behavior modification or prevention training and then we have to client specific train on this. And these training don't even count the other specific trainings staff is too receive on maltreatment, incident reporting, etc. And staff can't even work before this amount of significant training or if they are over the 12 months. This is a tremendous amount of training and needs to be consolidated at a minimum. It is taking so long now to train and get staff in that providers are losing the new staff before we can even get them started. The training and hiring has become so complicated that it is not even feasible to date. The training and requirement process is so long now that it takes almost three weeks to get a new staff to start working. Again, not feasible. And the costs keeps growing.

Response: Thank you for your comment. All time spent conducting the annual client-specific training required by Section 303 (c) may be counted toward the annual twelve (12) hour training requirement in Section 303(a)(2). See Section 303(c)(3).

Comment: P.12 c (2) a PCSP training- We again do not get the PCSP's from PASSE CC, even though we ask.

Response: Thank you for your comment. See previous responses to this topic.

Comment: P. 13 304 a 4 All required Adult AND Long-Term Care Facility Resident Maltreatment Central Registry checks. Why is all Waiver staff having to obtain a LTC Facility Resident Maltreatment when we are not in that setting? This should be and/or

Response: Thank you for your comment. These are not separate registry checks. It is just a single registry. The name of the actual registry is the "Adult and Long-term Care Facility Resident Maltreatment Central Registry" that was established and mandated by the Adult and Long Term Care Facility Resident Maltreatment Act.

Comment: p.15 305 c8 We do not get copies of all completed client assessments and evaluations? Where and who has these? What assessments and evaluations are these?

Response: Thank you for your comment. The client's PASSE should have copies of all assessments and evaluations related to a client.

Comment: p. 15 305 c10 Copies of any leases or residential agreements related to the client's care? What does this mean? Do you want this for every client that has a lease? Or what makes it applocable for their care?

Response: Thank you for your comment. Any client living in a house or apartment that is not owned by the client should occupy the dwelling pursuant to legally valid rental or lease agreement that ensures the client has all rights and benefits required pursuant to Arkansas Residential Landlord-Tenant Act and Arkansas law.

Comment: p.18 309 a1,2,3 This is impossible for all locations without in house case managers. Who does this? What is the reimbursement rate for this? And required annually is not feasible.

Response: Thank you for your comment. There are no specific requirements tied to who must develop/write the emergency plan. There is no reimbursement rate related to the preparation and evaluation of a written emergency plan.

Comment: P.23 402 Complex Care Home Specific Requirements. Are these rules for both complex and residential home setting because we do not see requirements for residential in these rules and some of the number bullets state "at the residential setting"? If so, please see comments below

P.23 402 12. A reasonably furnished living and dining area? Is the provider paying for this or is the client paying to furnish their home?

14. Have written instructions and diagrams Every 25 feet?

15. lighted exit signs in houses?

16. lockable storage containers or closets for any chemicals, toxic substances, and flammable substances that must be stored at the residential setting? This states residential setting and not complex care home so is this the same setting? We currently do not have to lock these up in the home but we have MSDS paperwork.

C 1. Bed measuring 36 inches wide?

C.1.1 Mattress 4 inches thick?

Response: Thank you for your comment. Section 402 only applies to Complex Care Homes. Section 402(a)(3), (a)(4), and (b)(16) will be changed to replace the words "residential setting" with "complex care home."

Comment: P. 26 501 (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. A timeline needs to be set for the tranistion time (30 days or 60 days or 90 days), not ongoing.

Response: Thank you for your comment. The health, safety, and welfare of client dictate the continuance of services until a transition is complete.

Comment: P. 27 503 (b) Provider must be able to demonstrate reasonable efforts to recruit and retain qualified personnel and the results of those efforts. What is the expectation of the documentation? Need form from DDS

Response: Thank you for your comment. Specific forms or requirements have intentionally not been listed to allow providers maximum flexibility in documenting and demonstrating all employee recruiting and retention efforts and the result of those efforts.

Comment: P.27 503 ©1 If a provider is unable to ensure a client's health, safety, or welfare because of adequate housing……provider must propose alternative housing arrangements….. Who is going to do this? We provider direct care services not care coordination . This is a CC's job duty.

Response: Thank you for your comment. Once selected as the supportive living provider, it is part of a provider's responsibilities to assist the client in locating and securing appropriate housing. If the client's preferred dwelling options are not available, then it is the responsibility of the supportive living provider to propose potential available alternative housing arrangements and working with the client to locate and secure an available housing arrangement acceptable to the client.

Comment: P. 27 503 © 2 Provider shall document the client ahs refused available resources. Again, the Care Coordinator should be doing this. We should not have to notify the CC, they should be completing this.

Response: Thank you for your comment. Once selected as the supportive living provider, it is part of a provider's responsibilities to assist the client in locating and securing appropriate housing.

Comment: P.28 305 (D) Whether a provider is refusing serve based on legitimate client health, safety, or welfare concerns is determined in the sole discretion of DDS. If a provider is telling DDS that they cannot serve a client of which they feel they CANNOT ensure health and safety or welfare, could DDS deny the refusal to serve and make the provider serve the client against their concerns?

Response: Thank you for your comment. DDS does retain the discretion to determine the legitimacy of a provider's refusal to serve claim. Ultimate resolution of how to handle a situation where a provider's claim was found to be illegitimate would be handled on a case-by-case basis. Providers would be free to pick and choose clients if DDS did not retain the discretion to evaluate refusal to serve claims.

Comment: p..41 610 (3) Training direct service staff or client family members in carrying out service strategies listed in the client's PCSP. We do not get these from the PASSE Care Coordinator's and we request them. We are also not being inlcuded PCSP meetings. The CC's do not communicate to us the date for most PCSP meetings and we do not get invited even though we communicate with them to invite us.

Response: Thank you for your comment.

Comment: p.46 701 a (7) Any unscheduled situation where a client's services are interrupted for more than (2) hours. Does this mean when staff calls in and there is an interruption in service? Does this mean an incident report for the client's with no staff? Does this mean when a client choose to be with natural supports we send in an incident report? What is the deifnition and examples of situation?

Response: Thank you for your comment. DDS feels the Section 701(a)(7) is written with sufficient specificity. This is the same description used across multiple Medicaid programs for incident reporting purposes. If there is doubt as to whether a particular situation is reportable, it is always recommended to err on the side of reporting.

Comment: P. 46 701 (10) Any act or admission that jeopardizes……. This is subjective and too broad, needs to be more objective.

Response: Thank you for your comment. DDS feels the Section 701(a)(10) is written with sufficient specificity. This is the same description used across multiple Medicaid programs for incident reporting purposes. If there is doubt as to whether a particular situation is reportable, it is always recommended to err on the side of reporting.

Natalie N. Burr, MD
Little Rock Pediatric Clinic

Comment: My name is Natalie Burr, and I am a General Pediatrician in private practice in Central Arkansas. I care for children and adolescents who have been affected by the current behavioral health crisis on a daily basis. Usually several of my 30-40 patients seen during the day come to the office for behavioral or mental health concerns. Being able to screen, assess, and treat children for behavioral and mental health needs in the primary care setting allows us to address these concerns in real time. These interventions are an effective way to remove some of the barriers to mental health care access and ensure quick action for patients in crisis.
I support the concept of integrated behavioral health and applaud the rule changes that have been proposed to permit employment of licensed therapists in physician offices. In particular, I support activating payment for depression screenings and maternal/caregiver depression screenings in the pediatric primary care setting, which aligns with American Academy of Pediatrics recommendations. These screenings are one of the first steps in identifying our patients' needs and risk levels and allow us to begin the process of connecting them to mental health resources.
I would love to be able to provide time-limited, preventive counseling or psychoeducation services without a diagnosis to prevent escalation of risk factors. All too often, I will see patients at multiple visits for the same mental or behavioral health concern, and, despite multiple referrals, families are unable to access mental health care due to multiple barriers to access in the community. My patients are all too often in crisis by the time they can finally access care, and this results in more stress for families and more costly interventions, such as inpatient stabilization. I feel that we could avoid some of these poor outcomes if preventative counseling or psychoeducation services were available in the primary care setting, a setting where patients and families have already established communication and trust.
Thank you for your time and your dedication to children's health.

Response: Thank you for your public comment. We will take this into consideration as we continue to work with providers in improving the behavioral health system in Arkansas.

Kimberly Baltzell, QDDP/LMSW, Crisis Intervention, Consultation, and Billing Specialist
Above and Beyond Care, Inc.

Comment: Section 602, subsection C, outlines the credentials required to develop and implement behavior management plans for waiver individuals with behavioral health needs. This amendment disallows professionals who were previously qualified to perform these services, specifically Licensed Master Social Workers. The previous minimum qualification for providing this service was a Qualified Developmental Disabilities Professional, which is a bachelor-level credential. Now, masters-level, licensed mental health professionals are being excluded from providing this service. There are already so few mental health professionals in the state with experience and availability to develop these positive-behavior support plans. This has been demonstrated by several waiver providers and PASSEs reaching out to our agency to outsource the development of these plans, as they do not have a licensed professional to do this work. This amendment will only further restrict waiver providers' access to positive behavior supports. I am a Licensed Master Social Worker with ten years of experience in the waiver field, and I will now be disqualified from providing these essential services to our members, despite my demonstration of competence and experience in this area. Not only are the qualification standards for professionals being narrowed, but the indicators for individuals requiring a behavior management plan are broadening, which is going to exacerbate the currently existing, detrimental gap in this area of need.

Response: Thank you for your comment. The list of accepted licensed professionals included in Section 602(a)(2)(C) tracks those included the CES Waiver application approved by CMS. We will consider adding licensed master social workers in the future.

Anna Strong, MPH, MPS, Executive Director
Arkansas Chapter, American Academy of Pediatrics

Comment: The Arkansas Chapter, American Academy of Pediatrics (ARAAP) represents approximately 450 member pediatricians across the state of Arkansas. We wish to submit supportive comments regarding the proposed rules for "Rebalancing Services for Clients with IDD and BH Needs."

Pediatricians, like many other types of health care providers, are impacted by the current behavioral health crisis affecting children and adolescents, which has been well-documented by the American Academy of Pediatrics and other child-focused organizations. Our members who work in primary care report that they often spend the majority of their day discussing behavioral health concerns with youth and their families, including referrals, medication management, and anticipatory guidance. They also struggle with challenges with access to behavioral health care for their patients, reporting that patients with Medicaid coverage struggle to access therapy, psychiatric care, and inpatient care in a timely way. Central Arkansas physicians report wait times of more than four months in many cases. In rural areas, waits can be even longer.

We are supportive of the array of solutions in the proposed rules that address timely access to appropriate behavioral health care, but our comments focus primarily on the changes in the rules that impact physician office settings. While co-located behavioral health care services have previously been allowed, physicians had to create new corporations to employ behavioral health providers or contract with independently licensed practitioners or agencies to offer services on-site. This prevented true integration of behavioral and physical health care, with separate medical records and challenges with oversight and communication.

Specifically, we support:

- **Integrated, team-based behavioral health care**. We strongly support the proposed rules for the physician manual that permit billing by licensed, employed behavioral health care providers in the physician office. This will allow team-based care for children and youth with a behavioral health diagnosis to receive timely physical and mental health care in a location familiar to the patient. Screening, assessing, and treating children for emotional and behavioral needs in real time in the primary care setting is an effective way to remove barriers to access and ensure quick action for children and youth in crisis, preventing delays in care that lead to costly emergency services.
    - It does appear that the outpatient hospital place of service setting is missing from the Counseling manual updates, though outpatient hospital is newly listed as an option in the Physician manual changes.
- **Behavioral health screenings.** We strongly support timely implementation of the proposed rules permitting behavioral screenings for patients and caregivers in the pediatric primary care setting and under a minor's Medicaid number, including rate-setting and payment. This aligns with American Academy of Pediatrics recommendations; perinatal depression screening recommendations are fully outlined here and the child/youth behavioral health screening periodicity schedule is here.
    - There is a small typo in section 292.741 – in the next-to-last sentence, "parent/legal guardian session" should read "parent/legal guardian screening" and there is an extra "counseling" later in that sentence.
- **Evidence-based, preventive behavioral health services**. While these rules expand access to counseling, psychoeducation, and other services in the proposed Counseling manual for children and youth who have had an intake assessment and have a mental health diagnosis, ARAAP supports an additional offering of time-limited, evidence-based, preventive services for children without a mental health diagnosis. These services will prevent escalation of risk factors or determine need for a behavioral intake assessment. A new offering of evidence-based behavioral/social/developmental screening that incorporates integrated short-term behavioral health services, such as HealthySteps, is especially important for families with children under age 4. Currently, children under age 4 can only receive dyadic, evidence-based services that require prior-authorization, a specific dyadic assessment, and a diagnosis by specially trained, licensed individuals. While these services are an incredible benefit to families impacted by adverse experiences and trauma, a preventive approach is needed to support families more easily in integrated settings.

Thank you for this opportunity to submit comments.

Response: All allowable location codes have been included in this document. "Session" will be changed to "screening"; the word "counseling" will be removed in section 292.741. Thank you for your public comment. We will take information in reference to preventative behavioral health services into consideration as we continue to work with providers in improving the behavioral health system in Arkansas.

Joel P. Landreneau, Esq., Executive Director, The Council
Arkansas Council for Behavioral Health, Inc.

Comment: ISSUE 1: FACILITIES REQUIREMENTS FOR CSSP ENHANCED:

Section 103(m) enumerates the services included in the "CSSP Enhanced" license. It includes "Adult Rehabilitation Day Treatment" as a service that can only be provided by CSSP Enhanced. The Council's understanding of the Department's reasoning in support of the placement of this service in the Enhanced section of CSSP rather than in the "Intensive" manual is that it is facility-based. The Council notes that other services provided by "Base" and "Intensive" service providers are also provided within the physical confines of the CSSP's office. For example, Individual, Family, and Group Therapy can be provided in the CSSP's certified site. This fact does not make those services "facility-based." The same is true of "Adult Rehabilitation Day Treatment."

The problem with placing Adult Rehabilitation Day Treatment in the Enhanced section of the manual is the burden imposed on Enhanced CSSP providers who must meet the physical plant requirements set forth in Section 1003. Some of these requirements do make sense for CSSP providers who Adult Rehabilitation Day Treatment. For example, it makes sense to require a physical facility that has appropriate lighting, is well-ventilated, has a running source of potable water. The Council does not object to these requirements. Likewise, the facility's structure should be in good repair, and the grounds should be free of hazards.

However, there are requirements in the facilities' section 1003 that are non-sensical as applied to CSSP's whose only "enhanced" service is Adult Rehabilitation Day Treatment. For example, these programs do not need a "kitchen with equipment, utensils, and supplies necessary to properly store, prepare, and serve three (3) meals a day" as required by Section 1003 (b)(13) when no client is on the premises long enough to need three meals per day.

Likewise, the entire section labeled 1003(c) is inapplicable to "CSSP Enhanced" providers whose only "enhanced" service is Adult Rehabilitation Day Treatment. There is no need for individual beds because clients do not sleep in these facilities. There is no need for bedroom furnishings or for an entrance that can be accessed without going through a bathroom or another person's bedroom. And for the same reason.

This is a threshold issue for the Council. Some of our members will be faced with a decision either to discontinue their Adult Rehabilitation Day Treatment programs or embark upon expensive and unnecessary physical renovations to their physical plant. As a result, this issue will bring us to the Capitol in opposition to these regulations in a way that the other issues will not, because we anticipate that imposition of these absurd requirements will create a gaping hole in the mental health service continuum that does not currently exist today. This is a dramatic step backwards. The absurdity of

imposing bedroom requirements on facilities who do not house clients on a 24-hour basis should be common sense.

The Department should amend this proposal in one of two ways: First, it should place the Adult Rehabilitation Day Treatment service in the "CSSP Intensive" section of the manual, because Rehab Day is no more a facility-based service than Individual, Family, or Group Counseling, which also take place principally within the physical confines of the CSSP providers' office. In the alternative, the Department should amend the proposed rule as follows:

b) CSSP owned or leased facilitys 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;

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(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 for those programs that provide 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; 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

Response: Please see response below.

Comment: Section 1003 (c) should be amended as follows:

(c) CSSP owned or leased facilitys which provide any CSSP Enhanced services in addition to Adult Rehabilitation Day Treatment 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.

Section 1003 (d) should be amended as follows:

(d) CSSP owned or leased facility which provides any CSSP Enhanced services in addition to Adult Rehabilitation Day Treatment 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

Response: Please see response below.

Comment: Section 1003 (e) should be amended as follows:

e) CSSP owned or leased facility which provides any CSSP Enhanced services in addition to Adult Rehabilitation Day Treatment 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.

QUESTION 1: If the Department declines to make these suggested changes, please describe the reasons for doing so, and please describe the reasons why bedroom and bathroom requirements are a sensible requirement for programs who do not house clients on a twenty-four (24) hour basis.

Response: Thank you for your comment. We will revise the CSSP manual to differentiate services provided 24/7 from Rehab day services.

Comment: ISSUE 2: Training for Paraprofessionals: Are current QBHP's grandfathered? What BH training is required for paraprofessionals whose experience is mainly in DD?

Response: Behavioral Health Agencies may voluntarily request to be grandfathered into the CSSP program. CSSP providers will be expected to comply with annual trainings as outlined in the CSSP manual as per their requested level of certification.

Comment: ISSUE 3: Incident Reporting: Incident reporting requirements are oppressive. The idea that an adult whose whereabouts are not immediately known for only an hour is a reportable event under Section 501(a)(5) is not realistic. Adults in treatment for serious mental illness should be able to leave to go into the community, and to consider that to be an "incident" is utterly inconsistent with the HCBS Settings Rule set forth in 42 CFR § 441.301(c)(4)-(5) which requires as much personal autonomy and individual choice as is appropriate for patient care. These rules lack the kind of person-centered language that is contemplated by the federal HCBS settings rule. Also, the expectation that providers should be able to predict when a matter is "of public interest" is vague. Section 502(a)(1)(C) should be deleted. It is often the case that public interest can be hard to predict, particularly if law enforcement chooses to post something on Facebook, which in and of itself creates public interest. Given the experience that Council members have had with the unreasonable enforcement of certification rules as overseen by DPSQA, the Council believes that more specific and less vague criteria for incident reporting are needed.

Response: Thank you for your comment and we will discuss this comment internally and determine if the language should be amended.

Requires any modification under 42 CFR 441.301(c)(4)(VI)(A) through (D) must be supported by a specific assessed need and justified in the person-centered service plan.

Comment: ISSUE 4: Peer Support: Peer Support should be encouraged, but not required. It is not clear that the inclusion of "Peer Support" in the suite of services set forth in Section 103(o)(1) is elective for the CSSP Intensive provider, or whether it is mandatory. This needs to be clarified. There is great concern that the workforce to comply with this as a requirement does not even exist at present, particularly on the behavioral health side. The Council believes that trainings for Peer Support are much too infrequent to remedy this shortfall at this time.

Response: Criterion 3 will be removed for clarity. Peer Support Specialist requirements are addressed elsewhere in the manual.

Comment: QUESTION 2: Are Peer Support Specialists a required service to be provided by CSSP Intensive agencies? If so, will the training and available workforce meet this mandate?

Response: We will remove this as a requirement for certification.

Comment: ISSUE 5: Medication Storage: More flexibility would be desirable with the requirement that medication should be kept in the original container unless the transfer is done by custodian or guardian. This is often not practical, as the custodian or guardian is sometimes several states away. When this is the case, and the custodian is not available, the client will be forced to go to evening dinner with the entire inventory of their medication. This practice is burdensome and unnecessary, and introduces the possibility that the client will lose the entire inventory of their medications if the custodian or guardian is not available.

A sensible alternative would be for the rule to allow for a nurse in the facility to transfer medications away from the original container when the custodian or guardian is not available. Remember: the federal HCBS rule requires you to maximize client autonomy. The following suggested rule change to proposed Section 1006 (d)(b)(vii) would remedy this issue:

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 or the facility's nursing staff;

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.

Response: Thank you for your comment and we will discuss this comment internally and determine if the language should be amended.

Comment: ISSUE 6: Seclusion/Restraint: There is concern about which settings this provision applies. By "CSSP location" does this refer to Enhanced only? Does it apply in the patient's own home? If so, how is placing a client in restraint in their own home consistent with HCBS settings rule?

Response: Yes, this would refer to secure Enhanced CSSP locations. No, it does not apply to patient's own home.

Comment: Issue 7: Emergency Drills: The Council has a similar concern with Section 309. This requires a CSSP to 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 facility." Section 309(c) goes on to state that "When a CSSP is providing home and community based services to a client in a CSSP location, a CSSP must conduct emergency fire drills at least once per month. Section 309(c)(2)(A).

QUESTION 3: Do the foregoing sections require a CSSP to enter the home of a client and conduct emergency fire drills in that client's home once per month? If so, what is the rationale for this level of invasive intervention into the client's own home?

Response: No, this section does not require a CSSP to enter the home of a client and conduct emergency drills in the home.

Comment: Issue 8: Background Checks: Are CSSP agencies required to conduct a check of the adult maltreatment registry if the worker only works with children? Council members have the same question in reverse if they only work with adults. In that case, are they required to conduct a check of the child maltreatment registry?

Response: CSSP agencies are required to conduct both adult and child maltreatment registry checks without regard to the population being served.

Comment: Issue 9: Employee Searches: Section 202 sets forth the requirements for what constitutes a complete application for certification to become a CSSP. Section 202(b)(5) includes that in order for an application to be deemed compete, the application must include "Documentation of all required registry checks and searches for employees and contractors." What is an employee search referenced on page 15? We have questions about what registry checks are required depending on our client based, but where is there a requirement for an employee search? This language is a new insertion into the existing language, so we must ask:

QUESTION 4: Where is the requirement for an employee or contractor search in addition to registry checks described in Section 202(b)(5), and what kind of search of employees is required?

Response: Thank you for your comment and we will discuss this comment internally and determine if the language should be amended.

Comment: Issue 10: Settings Variations: In Section 1004, it is required that "any client need or behavior that requires a variation or exception to the setting requirement set out in Sections 401 or 402

must be justified in the client's PCSP. It is not clear who has the authority to authorize these. Also, spend down clients do not have a PCSP.

QUESTION 5: Which CSSP staff have the authority to authorize settings variations described in Section 1004? How does this requirement apply to spend down clients for whom there is no PCSP?

Response: Thank you for your comment and we will discuss this comment internally and determine if the language should be amended.
The PCSP is developed by the PASSE care coordinator in cooperation with the client, family, guardian, and provider as applicable and variations would be approved based on the client needs as set forth in the approved plan.

All clients receiving services under the 1915i must have a Person-Centered Service Plan.

Comment: Issue 11: Mobile Crisis: Why is this section stricken?

Response: Providers are required to operate under their scope of practice, ethical standards, and as per their accreditation standards to ensure the safety of their clients.

Comment: Issue 12: Client Records: Section 402(c)(2) sets forth the list of persons to whom a client's record is available. This list does not include the client themselves. It is conceivable that it might not be appropriate to provide a client with a copy of their record, but it seems that this should be demonstrated by particularized circumstances, and that the default position should be to make records available to the people about whom the records are compiled, absent a showing of circumstances why that would not be appropriate.

QUESTION 6: Is this intentional? Are clients not required to be provided a copy of their own record?

Response: Please see below.
"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."

Comment: ISSUE 13: Application for Certification by Existing BHA's These rules do not describe the process for how an existing BHA will communicate their decision to elect to be grandfathered into CSSP Intensive. What is that process? Must the BHA apply anew? How will those who wish to transition to CSSP Intensive achieve this seamlessly by January 1, 2023?

Response: Agencies wishing to become a CSSP agency must submit application for certification to DPSQA.

Comment: ISSUE 14: Monitoring: Council members have had difficult issues with DPSQA regarding their monitoring practices in conducting Inspections of Care. A particularly vexing problem is when small agencies are contacted by DPSQA with no notice, and the small provider, whose entire staff is a

single therapist, has to cancel an entire day's worth of appointments in order to babysit an inspector from AFMC.

These rules do not address this problem. What notice, if any, is required before a routine monitoring visit is conducted pursuant to Section 601? At least 24 hours' notice should be provided for non-emergency enforcement actions.

Thank you for your consideration in this matter.

Response: The DPSQA may conduct routine monitoring without notification. CSSP agencies should employ sufficient staff to allow for the operation of the agency.

Laura Prondzinski, CEO
Hometown Behavioral Health Services of Arkansas, Inc.

Comment: Comments regarding manual proposals:

Counseling manual:

Is the attestation letter really necessary?

Response: Thank you for your comment. We will review this recommendation internally.

Comment: Quality Assurance committee meetings were removed. I do not see where anything similar was put in place anywhere else. Was this the intention?

Section217.100 – You can provide 10 visits without a pcp referral, but no services except crisis should be performed without a pcp referral. I am not sure this was really the intent, but if it is, that is not really helpful.

Also regarding crisis for a person who is not yet a client. It is not a billable service if the client does not complete an intake assessment within 7 days.

Response: Yes, the Quality Assurance Committee was removed intentionally.

We agree, the language referring to PCP referrals has been updated.

Comment: 224.000 what constitutes a "relationship?"

The language has been updated to clarify the role of the Primary Care Physician.

Can a LADAC practice as ILP?

Response: Yes.

Comment: Is it correct to say that there are no more IOCs and only retrospective reviews? If there are no more IOC and no one to site P&P, how does recoupment work?

Response: Please refer to the Retrospective Review Process noted in the manual for processes.

Comment: Since psych testing has been removed from counseling manual and moved to it's own manual, is int of dx still a billable service for LP?

Response: Yes.

Comment: 252.121 "Place of service (When ninety-nine (99) is used for telemedicine, specific locations of the beneficiary" Can you use 99 for telemedicine still?

(10) telehealth client home is not listed as a POS in the new manual

Response: No, 99 is no longer an allowable telemedicine POS. This has been removed from the manual.

Comment: Physician/Independent Lab/CRNA/Radiation Therapy Center Manual

Can counseling services in a physicians office be provided the same day as a physicians appointment?

Response: This is a billing process question and is not part of the promulgation of this manual.

Comment: Rules for the Division of Medical Services Licensure Manual for Community Support System Providers Manual

This manual references the PASSE manuals, which won't exist if I looked at the proposed PASSE manual correctly.

202 #4 – Are state and national background checks required for everyone or just those that have not lived in Arkansas for 5 years?

Response: The CSSP Manual has been revised to remove PASSE.

Comment: Did the 40 hour training for QBHPs really reduce to 12 hours for CSSP providers?

Response: Training requirements are individualized to the level of CSSP certification.

Comment: Page 51 – the CSSP provider is responsible for the client until they find new providers? I need clarification on how this works, especially on the BH side.

Response: The provider assumes the same responsibility for all clients receiving Home and Community-Based Services.

Comment: Page 74 – Medical Director qualifications: must participate in QA meetings, but it appears QA section has been removed.

Response: We will update the manual to remove the requirement.

Comment: Financial safeguard section:

Incidents to be reported on Page 52 - #6, 7, 11, 12 and 13 – are these meant to say incidents to be reported if the incident happens while in the CSSP setting?

Response: Though there is no CSSP setting, incident reporting requirement still apply.

Comment: CSSP Manual

202.001 ABSCI manual will not exist

Can someone be in CSSP program without being in counseling level service program? If so, please explain how they enter the program.

Response: Individuals become eligible for BH HCBS services through the referral and completion of an BH Independent Assessment.

Division of Medical Services
P.O. Box 1437, Slot S401, Little Rock, AR 72203-1437
P: 501.682.8292 F: 501.682.1197

October 12, 2022

Mrs. Rebecca Miller-Rice
Administrative Rules Review Section
Arkansas Legislative Council
Bureau of Legislative Research
#1 Capitol, 5th Floor
Little Rock, AR 72201

Dear Mrs. Rebecca Miller-Rice:

Re: Rebalancing Services for Clients with Intellectual and Developmental Disabilities and Behavioral Health Needs

Please arrange for this rule to be reviewed by the ALC-Administrative Rules Subcommittee. If you have any questions or need additional information, please contact Mac Golden, Office of Rules Promulgation at 501-320-6383 or by emailing Mac.E.Golden@dhs.arkansas.gov.

Sincerely,

Elizabeth Pitman
Director

EP:jet

Attachments

QUESTIONNAIRE FOR FILING PROPOSED RULES AND REGULATIONS WITH THE ARKANSAS LEGISLATIVE COUNCIL

DEPARTMENT/AGENCY Department of Human Services
DIVISION Division of Medical Services
DIVISION DIRECTOR Elizabeth Pitman
CONTACT PERSON Mac Golden
ADDRESS P. O. Box 1437, Slot S295 Little Rock, AR 72203-1437
PHONE NO. 501-563-7634 **FAX NO.** 501-404-4619 **E-MAIL** Mac.E.Golden @dhs.arkansas.gov
NAME OF PRESENTER AT COMMITTEE MEETING Elizabeth Pitman
PRESENTER E-MAIL Elizabeth.pitman@dhs.arkansas.gov

INSTRUCTIONS

A. Please make copies of this form for future use.
B. Please answer each question completely using layman terms. You may use additional sheets, if necessary.
C. If you have a method of indexing your rules, please give the proposed citation after "Short Title of this Rule" below.
D. Submit two (2) copies of this questionnaire and financial impact statement attached to the front of two (2) copies of the proposed rule and required documents. Mail or deliver to:

Jessica C. Whittaker
Administrative Rules Review Section
Arkansas Legislative Council
Bureau of Legislative Research
One Capitol Mall, 5th Floor
Little Rock, AR 72201

****

1. What is the short title of this rule? Rebalancing Services for Clients with Intellectual and Developmental Disabilities and Behavioral Health Needs

2. What is the subject of the proposed rule? Ten manuals have been either created, amended, or repealed to offer more home and community-based services for clients with behavioral health or intellectual disabilities

3. Is this rule required to comply with a federal statute, rule, or regulation? Yes ☐ No ☒
   If yes, please provide the federal rule, regulation, and/or statute citation. __________

4. Was this rule filed under the emergency provisions of the Administrative Procedure Act?
   Yes ☐ No ☒

   If yes, what is the effective date of the emergency rule? __________

   When does the emergency rule expire? __________

   Will this emergency rule be promulgated under the permanent provisions of the Administrative

Procedure Act?

Yes ☐ No ☐

5. Is this a new rule? Yes ☒ No ☐
If yes, please provide a brief summary explaining the regulation.

New rules include:
- Home and Community-Based Services for Clients with Intellectual Disabilities and Behavioral Health Needs Manual
- Diagnostic and Evaluation Manual

Does this repeal an existing rule? Yes ☒ No ☐
If yes, a copy of the repealed rule is to be included with your completed questionnaire. If it is being replaced with a new rule, please provide a summary of the rule giving an explanation of what the rule does.

Rules that are being repealed include:
- Independently Licensed Practitioner Certification Manual—The repeal will allow ILP's to enroll in Medicaid with proof of their clinical license. This is consistent with how Medicaid treats other professionals.
- School-Based Mental Health Manual—These services are contained in other programs.
- Adult Behavioral Health Services for Community Independence Manual—these services are now outlined in the new Home and Community-Based Services for Clients with Intellectual Disabilities and Behavioral Health Needs Manual.

Is this an amendment to an existing rule?
Yes ☒ No ☐
If yes, please attach a mark-up showing the changes in the existing rule and a summary of the substantive changes. **Note: The summary should explain what the amendment does, and the mark-up copy should be clearly labeled "mark-up."**

Rules being amended include:
- Community Support Systems Provider Certification Manual
- PASSE Manual
- Physician's Manual
- Outpatient Behavioral Health Services Manual will become the Counseling Services Manual

6. Cite the state law that grants the authority for this proposed rule? If codified, please give the Arkansas Code citation. Arkansas Code §§ 20-48-1003, 20-76-201, 20-77-107, and 25-10-129.

7. What is the purpose of this proposed rule? Why is it necessary? See Attached.

8. Please provide the address where this rule is publicly accessible in electronic form via the Internet as required by Arkansas Code § 25-19-108(b).

https://humanservices.arkansas.gov/do-business-with-dhs/proposed-rules/

9. Will a public hearing be held on this proposed rule? Yes ☒ No ☐
If yes, please complete the following:

Date: October 27, 2022

Time: 10:30 a.m.

Zoom:
https://us02web.zoom.us/j/81309686433

Place: ______________________________

10. When does the public comment period expire for permanent promulgation? (Must provide a date.)

November 13, 2022

11. What is the proposed effective date of this proposed rule? (Must provide a date.)

January 1, 2023

12. Please provide a copy of the notice required under Ark. Code Ann. § 25-15-204(a), and proof of the publication of said notice. See Attached.

13. Please provide proof of filing the rule with the Secretary of State as required pursuant to Ark. Code Ann. § 25-15-204(e). See Attached.

14. Please give the names of persons, groups, or organizations that you expect to comment on these rules? Please provide their position (for or against) if known. Independently Licensed Practitioners, Outpatient Behavioral Health Agency providers, providers who provide Community and Employment Supports Waiver services, physicians, Community Support Systems Providers, Provider-led Arkansas Shared Savings Entities (PASSEs). (Against).

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:

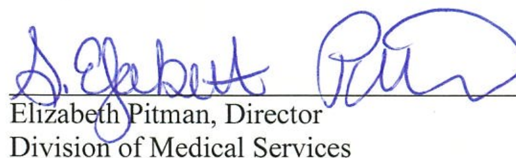
The Director of the Division of Medical Services amends ten (10) manuals and related State Plan pages. There are three (3) new manuals: Community and Employment Support (CES) Waiver Certification Manual, Home and Community-Based Services for Clients with Intellectual Disabilities and Behavioral Health 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

Jack Tiner

From: legalads@arkansasonline.com
Sent: Wednesday, October 12, 2022 6:38 AM
To: Jack Tiner
Cc: Mac Golden; Simone Blagg (DHS); Elaine Stafford; Lakeya Gipson; Kate Chagnon
Subject: Re: FULL RUN AD--Rule-210

[EXTERNAL SENDER]
Jack,

This will run Fri 10/14, Sat 10/15, and Sun 10/16.

Thank you.

Gregg Sterne, Legal Advertising
Arkansas Democrat-Gazette
legalads@arkansasonline.com

From: "Jack Tiner" <jack.tiner@dhs.arkansas.gov>
To: legalads@arkansasonline.com
Cc: "Mac Golden" <Mac.E.Golden@dhs.arkansas.gov>, "Jack Tiner" <jack.tiner@dhs.arkansas.gov>, "Simone Blagg, DHS" <Simone.A.Blagg@dhs.arkansas.gov>, "Elaine Stafford" <elaine.stafford@dhs.arkansas.gov>, "Lakeya Gipson" <Lakeya.Gipson@dhs.arkansas.gov>, "Kate Chagnon" <Kate.Chagnon@dhs.arkansas.gov>
Sent: Monday, October 10, 2022 1:37:18 PM
Subject: FULL RUN AD--Rule-210

Please run the attached Notice of Rulemaking in the *Arkansas Democrat-Gazette* on the following days:

- Friday, October 14, 2022
- Saturday, October 15, 2022
- Sunday, October 16, 2022

I am aware that the print version will only be provided to all counties on Sundays.

Invoice to: **AR Dept of Human Services**
P.O. Box 1437
Slot S535
Little Rock, AR 72203
ATTN: Elaine Stafford

Or email invoices to: dms.invoices@arkansas.gov

Jack Tiner

From: Jack Tiner
Sent: Wednesday, October 12, 2022 9:02 AM
To: register@sos.arkansas.gov
Cc: Mac Golden; Simone Blagg (DHS); Jack Tiner; Eric Collins; Lakeya Gipson; Kate Chagnon
Subject: DHS/DMS--Proposed Filing--Rebalancing Services for Clients with Intellectual and Developmental Disabilities and Behavioral Health Needs (Rule 210)
Attachments: Proposed Filing Packet-Rule 210.pdf

Please find attached the proposed filing packet for rule titled: *Rebalancing Services for Clients with Intellectual and Developmental Disabilities and Behavioral Health Needs*

The public notice will run in the Arkansas Democrat-Gazette October 14 through 16, 2022. The public comment period ends November 13, 2022.

Please let me know if you have any questions. Thank you.

JACK TINER
OFFICE OF RULES PROMULGATION
DHS/DMS MEDICAL ASSISTANCE MANAGER

P: 501.320.6112
F: 501.404.4619
700 Main St., Slot S295
Little Rock, AR 72203
Jack.Tiner@dhs.arkansas.gov

humanservices.arkansas.gov

This email may contain sensitive or confidential information.

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FINANCIAL IMPACT STATEMENT

PLEASE ANSWER ALL QUESTIONS COMPLETELY

DEPARTMENT Department of Human Services

DIVISION Division of Developmental Disabilities Services

PERSON COMPLETING THIS STATEMENT Jason Callan

TELEPHONE (501) 320-6540 **FAX** ________ **EMAIL:** Jason.callan@dhs.arkansas.gov

To comply with Ark. Code Ann. § 25-15-204(e), please complete the following Financial Impact Statement and file two copies with the questionnaire and proposed rules.

SHORT TITLE OF THIS RULE Rebalancing Services for Clients with Intellectual and Developmental Disabilities and Behavioral Health Needs

1. Does this proposed, amended, or repealed rule have a financial impact? Yes ☒ No ☐

2. Is the rule based on the best reasonably obtainable scientific, technical, economic, or other evidence and information available concerning the need for, consequences of, and alternatives to the rule? Yes ☒ No ☐

3. In consideration of the alternatives to this rule, was this rule determined by the agency to be the least costly rule considered? Yes ☒ No ☐

   If an agency is proposing a more costly rule, please state the following:

   (a) How the additional benefits of the more costly rule justify its additional cost;

   ____

   (b) The reason for adoption of the more costly rule;

   ____

   (c) Whether the more costly rule is based on the interests of public health, safety, or welfare, and if so, please explain; and;

   ____

   (d) Whether the reason is within the scope of the agency's statutory authority; and if so, please explain.

   ____

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

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

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

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

Current Fiscal Year		Next Fiscal Year	
General Revenue	$99,330	General Revenue	$198,660
Federal Funds	$250,670	Federal Funds	$501,340
Cash Funds		Cash Funds	
Special Revenue		Special Revenue	
Other (Identify)		Other (Identify)	
Total	$350,000	Total	$700,000

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

Current Fiscal Year	Next Fiscal Year
$ 0.00	$ 0.00

6. What is the total estimated cost by fiscal year to state, county, and municipal government to implement this rule? Is this the cost of the program or grant? Please explain how the government is affected.

Current Fiscal Year	Next Fiscal Year
$ 99,330	$ 198,660

7. With respect to the agency's answers to Questions #5 and #6 above, is there a new or increased cost or obligation of at least one hundred thousand dollars ($100,000) per year to a private individual, private entity, private business, state government, county government, municipal government, or to two (2) or more of those entities combined?

Yes ☒ No ☐

If YES, the agency is required by Ark. Code Ann. § 25-15-204(e)(4) to file written findings at the time of filing the financial impact statement. The written findings shall be filed simultaneously with the financial impact statement and shall include, without limitation, the following:

(1) a statement of the rule's basis and purpose;

This rule includes ten (10) manuals and several accompanying State Plan pages. The manual amendments, enactments, and repeals are all focused on shifting away from a fee for payment methodology for our clients with high needs (IDD or BH), lessening administrative burden on our providers, supporting the workforce (both paraprofessional and clinical) that are employed to provide services to IDD and BH clients, and raising the quality of the care with evidence based and/or recognized service models.

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

The manual amendments, enactments, and repeals are all focused on shifting away from a fee for payment methodology for our clients with high needs (IDD or BH), lessening administrative burden on our providers, supporting the workforce (both paraprofessional and clinical) that are employed to provide services to IDD and BH clients, and raising the quality of the care with evidence based and/or recognized service models.

(3) a description of the factual evidence that:

(a) justifies the agency's need for the proposed rule; and

This rule includes a large amount of policy work aimed to position both our provider types and service array to provide more home and community-based services to our clients with IDD and BH.

(b) describes how the benefits of the rule meet the relevant statutory objectives and justify the rule's costs;

This rule includes a large amount of policy work aimed to position both our provider types and service array to provide more home and community based services to our clients with IDD and BH.

(4) a list of less costly alternatives to the proposed rule and the reasons why the alternatives do not adequately address the problem to be solved by the proposed rule;

There are no less costly alternatives.

(5) a list of alternatives to the proposed rule that were suggested as a result of public comment and the reasons why the alternatives do not adequately address the problem to be solved by the proposed rule;

N/A

(6) a statement of whether existing rules have created or contributed to the problem the agency seeks to address with the proposed rule and, if existing rules have created or contributed to the problem, an explanation of why amendment or repeal of the rule creating or contributing to the problem is not a sufficient response; and

N/A

(7) an agency plan for review of the rule no less than every ten (10) years to determine whether, based upon the evidence, there remains a need for the rule including, without limitation, whether:

(a) the rule is achieving the statutory objectives;
(b) the benefits of the rule continue to justify its costs; and
(c) the rule can be amended or repealed to reduce costs while continuing to achieve the statutory objectives.

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

Statement of Necessity and Rule Summary
Rebalancing Services for Clients with Intellectual and Developmental Disabilities and Behavioral Health Needs

Statement of Necessity

This rule includes ten (10) manuals. The manual amendments, enactments, and repeals are all focused on shifting away from a fee-for-service methodology for our clients with high needs (IDD or BH), lessening administrative burden on our providers, supporting the workforce (both paraprofessional and clinical) that are employed to provide services to IDD and BH clients, and raising the quality of the care with evidence-based and recognized service models.

Summary

The following manuals are affected by this rule:

New Manuals:

- Home and Community-Based Services for Clients with Intellectual Disabilities and Behavioral Health Needs Manual
  Changes based on Public Comments:
  - Clarified the name of the 1915i state plan outside the PASSE program because it is no longer named the Adult Behavioral Services for Community Independence.
  - Added the word Intervention to the service Crisis Stabilization Intervention because that is the actual name.
  - Added Assertive Community Treatment to the 1915i state plan outside the PASSE because it was inadvertently left off of the service list.
- Diagnostic and Evaluation Manual
  - Sets for criteria to determine eligibility for the Division of Development Disabilities Services and treatment planning and diagnostic clarification for the Division of Aging, Adult, and Behavioral Health Services.

  Changes based on Public Comments:
  - Based on public comment, language has been amended under the Autism section and under the Institutional Level of Care section to specifically ensure that the clients PCP is involved and makes the referral for the additional evaluations.
  - Under Evaluator Requirements for Autism testing, we mimicked the requirements for the other sections to allow LPEs and LPEIs, under their scope of practice, to perform the evaluations.

Amended Manuals:

- Community Support System Provider Certification Manual—Changes include:
  - Adds an Intensive Level to this provider type
  - Adds an intermediate level between base and enhanced
  - Adds two new services to this provider type
  - Changes the term “beneficiary” to “client” throughout the document
  - Changes the CSSP “licensure” to “Agency Certification” throughout the document

- Clarifies that the CSSP is the CSSP Agency, not the specific provider, by updating terminology
- Makes technical changes as necessary

Changes based on Public Comments:

- Most changes were to formatting for clarity purposes or just to correct formatting mistakes pointed out in public comment.
- Minor changes to adverse action definition and appeal process based on public comment.
- Removed definitions for which defined terms were not used elsewhere within document.
- Several changes within Section 103 "Definitions" to retain alphabetical order after term changes based on public comment.
- Several new definitions were added for clarity purposes.
- "Employee" definition changed based on public comment.
- Specific criminal background, maltreatment, drug screen, and registry check requirements were included in Section 302 for clarity purposes based on public comment.
- Section 303 "Employee Trainee" had multiple changes based on public comment.
- Section 305 "Client Service Records" had multiple changes based on public comment and for clarity purposes.
- Section 309 "Emergency Plans and Drills" was moved to become the new section 501 based on public comment and for clarity purposes.
- Section 311 "Compliance with State and Federal Laws, Rules, and Other Standards" was simplified for clarity purposes based on public comment.
- Section 312 "Emergency Response Services" was moved to become the new Section 1003 "Behavioral Health Crisis Response Services" for clarity purposes and simplified based upon public comment.
- The new Section 312 "General Nutrition and Food Service Requirements", Section 313 "Medications" and Section 314 "Service Logs", were moved from Subchapter 10 "Enhanced CSSP Agency Certification" because these standards needed to apply to Base CSSP Agency certification home and community-based service providers and not just Enhanced CSSP Agency certification providers.
- New Section 315 "Behavioral Management Plans for IDD Clients" was added due to its unintentionally being left out of the original proposed Rule.
- New Subchapter 5 "Settings Requirement" was added for clarity purposes based on public comment to create a standalone section applicable to home and community-based service settings. All section in this subchapter were pulled from other portions of the proposed document (primarily the former Subchapter 10 Enhanced CSSP Agency) with slight revisions based on public comment.
- Subchapter 9 (now 10) was revised and simplified based on public comment.
- Dozens of other minor typo corrections, terminology corrections, capitalization corrections, and changes for consistency purposes were made throughout.

- PASSE Manual—Removes home and community-based specialty services sections (This information is included in the new HCBS for Clients with IDD and BH Needs Manual. No changes based on public comments.
- Physician's Manual
  - Section 203.270 modifies PCP referral policy for some behavioral health services if place of service is not the physician's office.

- Renames Section 205.100 as Physician's Supervision in the Provision of Behavioral Health Counseling Services, and adds Hyperlinks to the new Counseling Services provider manual and the new Diagnostic and Evaluation provider manual.
- Removes Section 248.000, Psychotherapy and Psychological Testing.
- Renames Section 292.740 Counseling Services, and modifies rule regarding who can provide these services to clients and where counseling may occur.
- Renames Section 292.741 Behavioral Health Screen, and adds screening services
- Removes Section 292.742, Family/Group Psychotherapy.
- Updates term psychotherapy to behavioral health counseling in Sections 205.100 and 292.740

Changes based on Public Comments:

- 205.100—Added reference to PCCM program.
- 292.740—Added limitations for Place of Service Codes for counseling services.
- 292.741—Added that the emotional/behavioral assessment is "standardized".

- Outpatient Behavioral Health Services Manuals is amended and will become the Counseling Services Manual
    - Updates term Outpatient Behavioral Health Services to Counseling Services throughout the manual.
    - Changes staff requirements for providers.
    - Clarifies the physician's role in the relationships with Counseling Services providers.
    - Requires prior authorization for certain counseling services for beneficiaries under the age of four (4).
    - Limits individuals solely licensed as Licensed Alcoholism and Drug Abuse Counselors (LADAC) to only provide services to individuals with a primary substance use diagnosis
    - Adds Licensed Alcoholism and Drug Abuse Counselor Master's to allowable performing providers list for specific procedure codes.
    - Updates minimum documentation requirements for specific procedure codes.
    - Adds services, service descriptions, and minimum documentation requirements for Intensive Outpatient Substance Abuse Treatment and Crisis Stabilization Intervention.
    - Updates minimum documentation requirements for Acute Crisis Units and Substance Abuse Detoxification.

  Changes Based on Public Comments:

    - Section 202.200 Providers with Multiple Sites: Removed this section. No longer applicable due to end of moratorium and changes to Behavioral Health system.
    - Section 211.200 Staff Requirements: Language updated to include individuals who are contracted by a certified Behavioral Health Agency or Community Support System Agency.
    - Section 213.000: Order of paragraphs changed to be consistent with program entry.
    - Section 217.100 Primary Care Physician (PCP) Referral: Duplicative language was removed.
    - Section 224.000 Physician's Role: Clarify the responsibility of Counseling Services providers to communicate with PCPs.
    - Section 226.100: Removed Item C. and edited item D.

    - Section 252.121 Pharmacological Management: Removed language inconsistent with changes to delivery of services under current telemedicine policy.
    - Section 255.000: Crisis Stabilization Intervention: Duplicate language removed. Staff requirements included in Section 211.200
    - Section 255.001 Crisis Intervention: Added language to clarify no PCP referral is required for Crisis Intervention.
    - Section 255.001 Crisis Intervention: Duplicate language removed. Staff requirements included in Section 211.200

Repealed Manuals:

- Independent Licensed Practitioner Certification Manual—The repeal will allow ILP's to enroll in Medicaid with proof of their clinical license. This is consistent with how Medicaid treats other professionals.
- School-Based Mental Health Manual—these services are contained in other programs.
- Adult Behavioral Health Services for Community Independence Manual—these services are now outlined in the new Home and Community-Based Services for Clients with Intellectual Disabilities and Behavioral Health Needs Manual.

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

CONTENTS

200.000 GENERAL INFORMATION
- 201.000 Introduction
- 202.000 Arkansas Medicaid Participation Requirements for Home and Community-Based Services
- 203.000 Provider Certification Requirements

210.000 HOME AND COMMUNITY-BASED SERVICES UNDER ABHSCI
- 210.100 Partial Hospitalization
- 210.110 Adult Rehabilitative Day Service
- 210.120 Supportive Employment
- 210.130 Supportive Housing
- 210.140 Adult Life Skills Development
- 210.150 Peer Support
- 210.160 Treatment Plan
- 210.170 Aftercare Recovery Support (for Substance Abuse)
- 210.180 Therapeutic Communities
- 210.190 Assertive Community Treatment

220.000 HOME AND COMMUNITY-BASED SERVICES UNDER PASSE
- 220.100 Behavioral Assistance
- 220.110 Crisis Stabilization Intervention
- 220.120 Assertive Community Treatment
- 220.130 Intensive In-Home (IIH for Children)
- 220.140 Adult Rehabilitative Day Service
- 220.150 Peer Support
- 220.160 Family Support Partners
- 220.170 Pharmacologic Counseling by RN
- 220.180 Respite
- 220.190 Supportive Life Skills Development
- 220.200 Child and Youth Support Services
- 220.210 Supportive Employment
- 220.220 Supportive Housing
- 220.230 Partial Hospitalization
- 220.240 Therapeutic Host Homes
- 220.250 Aftercare Recovery Support (for Substance Abuse)
- 220.260 Substance Abuse Detox (Observational)
- 220.270 Therapeutic Communities
- 220.280 Residential Community Reintegration Program
- 220.290 CES Supported Employment
- 220.300 Supportive Living
- 220.310 Complex Care Homes for IDD
- 220.320 Adaptive Equipment
- 220.330 Community Transition Services
- 220.340 Consultation
- 220.350 Environmental Modifications
- 220.360 Supplemental Support
- 220.370 Respite
- 220.380 Specialized Medical Supplies

230.000 REIMBURSEMENT
- 230.100 Method of Reimbursement
- 230.200 Fee Schedules

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 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

Home and Community Based Services are limited to the following populations: PASSE members and Behavioral Health Adults receiving 1915i HCBS services outside of the PASSE.

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.

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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:

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- 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

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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

210.190 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-

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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.

220.000 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 Intervention 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

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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

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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-pharmacological 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

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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,

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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.

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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.

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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;

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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

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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

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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

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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.

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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 Behavioral Health Adults receiving HCBS services outside of the PASSE 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.

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

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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 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

Home and Community Based Services are limited to the following populations: PASSE members and Behavioral Health Adults receiving 1915i HCBS services outside of the PASSE.

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.

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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:

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- 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

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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

210.190 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-

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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.

220.000 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 Intervention 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

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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

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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-pharmacological 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

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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,

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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.

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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.

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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;

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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

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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

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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

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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.

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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 Behavioral Health Adults receiving HCBS services outside of the PASSE 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.

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SECTION II - DIAGNOSTIC AND EVALUATION SERVICES

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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 have a DMS-693 prescription specifying an Autism diagnosis from their primary care provider or attending licensed physician and 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 either have a diagnosis of a developmental or intellectual disability or display symptoms of a qualifying developmental or intellectual disability and have a referral from their primary care provider or attending licensed physician who require an adaptive behavior and/or intellectual assessment to either establish or confirm that the diagnosis meets the criteria for Institutional Level of Care.

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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;

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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 DMS-693 prescription specifying an Autism diagnosis from their primary care provider or attending licensed physician and displays symptoms 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 Psychologist (LP)
2. A Licensed Psychological Examiner (LPE)
3. A Licensed Psychological Examiner-Independent (LPEI)
24. 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);

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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 of the following developmental disabilities and an evaluation(s) is neededIn order to confirm Institutional Level of Care for clients with IDD, the client has a diagnosis of the following developmental disabilities and an evaluation(s) is needed:

1. Epilepsy
2. Cerebral Palsy
3. Down Syndrome
4. Spina Bifida
5. Autism Spectrum Disorder

B. In order to establish Institutional Level of Care for clients with IDD, Tthe client displays symptoms of the following qualifying intellectual disabilities and has a referral or DMS 693 prescription from their primary care provider or attending licensed physician and an evaluation(s) is needed:

1. Intellectual Disability or related condition

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:

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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.

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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.

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SECTION II - DIAGNOSTIC AND EVALUATION SERVICES

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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 have a DMS-693 prescription specifying an Autism diagnosis from their primary care provider or attending licensed physician and 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 either have a diagnosis of a developmental or intellectual disability or display symptoms of a qualifying developmental or intellectual disability and have a referral from their primary care provider or attending licensed physician who require an adaptive behavior and/or intellectual assessment to either establish or confirm that the diagnosis meets the criteria for Institutional Level of Care.

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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;

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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 DMS-693 prescription specifying an Autism diagnosis from their primary care provider or attending licensed physician and displays symptoms 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 Psychologist (LP)
2. A Licensed Psychological Examiner (LPE)
3. A Licensed Psychological Examiner-Independent (LPEI)
4. 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);

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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. In order to confirm Institutional Level of Care for clients with IDD, the client has a diagnosis of the following developmental disabilities and an evaluation(s) is needed:

1. Epilepsy
2. Cerebral Palsy
3. Down Syndrome
4. Spina Bifida
5. Autism Spectrum Disorder

B. In order to establish Institutional Level of Care for clients with IDD, the client displays symptoms of the following qualifying intellectual disabilities and has a referral or DMS 693 prescription from their primary care provider or attending licensed physician and an evaluation(s) is needed:

1. Intellectual Disability or related condition

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**.

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1. Date of Service;

PROPOSED

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.

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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.

PROPOSED

Arkansas Department of Human Services

Behavioral Health Independently Licensed Practitioners Certification Manual

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www.arkansas.gov/dhs/dhs

~~ARKANSAS DEPARTMENT OF HUMAN SERVICES~~

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~~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:

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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)

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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

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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.

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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.

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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.

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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;

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~~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;~~

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~~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~~

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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.

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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

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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

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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;

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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

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~~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.~~

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SECTION II - SCHOOL-BASED MENTAL HEALTH SERVICES

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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.

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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.

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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.

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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

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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

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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:

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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

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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:

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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.

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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.

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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

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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

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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

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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	

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• 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

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• 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**

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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

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	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

272.160 Individual Behavioral Health Counseling 2-1-22

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CPT®/HCPCS PROCEDURE CODE	PROCEDURE CODE DESCRIPTION	
View or print the procedure codes for 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)**	

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• 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

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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

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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	

MARK-UP

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.

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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.

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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.

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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.

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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.

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SECTION – ADULT BEHAVIORAL HEALTH SERVICES FOR COMMUNITY INDEPENDENCE

CONTENTS

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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

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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.

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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

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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.

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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.

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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.

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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,

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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**

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<table>
<tr><td colspan="2">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.</td><td colspan="2">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</td></tr>
<tr><th colspan="2">NOTES</th><th>UNIT</th><th>BENEFIT LIMITS</th></tr>
<tr><td colspan="2">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.</td><td>Per Diem</td><td>DAILY MAXIMUM THAT MAY BE BILLED: 1

YEARLY MAXIMUM OF DAYS THAT MAY BE BILLED (extension of benefits can be requested): 40</td></tr>
<tr><th colspan="2">APPLICABLE POPULATIONS</th><th colspan="2">SPECIAL BILLING INSTRUCTIONS</th></tr>
<tr><td colspan="2">Adults – Ages 18 and Above</td><td colspan="2">A provider may not bill for any other services on the same date of service.</td></tr>
<tr><th colspan="2">ALLOWED MODE(S) OF DELIVERY</th><th colspan="2">TIER</th></tr>
<tr><td colspan="2">Face-to-face</td><td colspan="2">Rehabilitative</td></tr>
<tr><th colspan="2">ALLOWABLE PERFORMING PROVIDERS</th><th colspan="2">PLACE OF SERVICE</th></tr>
<tr><td colspan="2">Partial Hospitalization must be provided in a facility that is certified by the Division of Behavioral Health Services as a Partial Hospitalization provider</td><td colspan="2">11, 49, 52, 53</td></tr>
<tr><th colspan="4">EXAMPLE ACTIVITIES</th></tr>
<tr><td colspan="4">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.</td></tr>
</table>

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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

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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

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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	

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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

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<table>
<tr><td colspan="2">View or print the procedure codes for ABHSCI services.</td><td colspan="2">Self-help/peer services, per 15 minutes</td></tr>
<tr><td colspan="2">SERVICE DESCRIPTION</td><td colspan="2">MINIMUM DOCUMENTATION REQUIREMENTS</td></tr>
<tr><td colspan="2">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 colspan="2">NOTES</td><td>UNIT</td><td>BENEFIT LIMITS</td></tr>
<tr><td colspan="2"></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 colspan="2">APPLICABLE POPULATIONS</td><td colspan="2">SPECIAL BILLING INSTRUCTIONS</td></tr>
<tr><td colspan="2">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 colspan="2">ALLOWED MODE(S) OF DELIVERY</td><td colspan="2">TIER</td></tr>
<tr><td colspan="2">Face-to-face</td><td colspan="2">Rehabilitative</td></tr>
<tr><td colspan="2">ALLOWABLE PERFORMING PROVIDERS</td><td colspan="2">PLACE OF SERVICE</td></tr>
<tr><td colspan="2">• 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="4">EXAMPLE ACTIVITIES</td></tr>
<tr><td colspan="4">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>
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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

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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

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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

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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	

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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

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Rules for the Division of Medical Services

Licensure Manual for Community Support System Providers

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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.

~~(b)~~(c) Providers certified and enrolled as a Base CSSP Agency or an Outpatient Behavioral Health Agency that meet the certification requirements of Intensive CSSP Agency certification or Enhanced CSSP Agency certification, can receive provisional Intensive CSSP Agency certification or Enhanced CSSP Agency certification until July 1, 2023, by executing a provisional certification attestation from DPSQA.

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 beneficiariesclients 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:

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(1) A~~a~~ denial of ~~a~~ CSSP ~~licensure~~ Agency ~~C~~certification;

(2) ~~and a~~Any enforcement action taken by DPSQA pursuant to ~~S~~sections 703 through 707; and~~803 801 to 807~~802.

(3) Any other adverse regulatory action or claim covered by the Medicaid Fairness Act, Ark. Code Ann §§ 20-77-1701 to -1718.

(b) "Applicant" means an applicant for a CSSP Agency Certification.

~~(b)~~

~~(c) "Applicant" means an applicant for a CSSP license or CSSP license enhancement.~~

~~(d)~~

~~(1)~~(c) "Change of ownership" means ~~any change in greater than~~ fifty percent (50%) or greater change of the financial interests, governing body, operational control, or other operational or ownership interests of ~~the~~a CSSP within a twelve (12) month period~~ 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.~~

(d) "Approved accrediting organization" means:

(1) ~~t~~The Commission on Accreditation of Rehabilitation Facilities ~~(CARF)~~;~~,~~

(2) ~~t~~The Joint Commission;~~,~~

(3) ~~t~~The Council on Accreditation ~~(COA),~~; and

(4) ~~t~~The Council on Quality and Leadership ~~(CQL)~~.

(e) "Base CSSP Agency certification" means a CSSP that has been certified by DPSQA to perform the following services each as defined in the Home and Community-Based Services for Clients with Intellectual Disabilities and Behavioral Health Needs Medicaid manual:

(1) Adult life skills development;

(2) Supportive Housing;

(3) Supportive Employment;

(4) Supportive Life Skills Development (individual and group);

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(5) Respite;

(6) Supported Employment;

(7) Supportive Living;

(8) Specialized Medical Supplies;

(9) Adaptive Equipment;

(10) Community Transition Services;

(11) Consultation;

(12) Environmental Modifications;

(13) Supplemental Support;

(14) Pharmacological Counseling; and

(15) Therapeutic Host Homes.

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

"Client" means any person for whom a CSSP Agency furnishes, or has agreed or undertaken to furnish, receiving or who has received one (1) or more home and community-based CSSP Agency services from a CSSP.

(f)

"Compliance" means conformance with:

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.

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g. Accreditation standards and requirements

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

(1) Is administered to manage a beneficiaryclient's behavior in a way to reduce the safety risk to the beneficiaryclient or others;

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

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

(f) "Community support staff" means an employee who provides direct care services or assistance to beneficiariesclients, including drivers and attendants. .

(h) "Complex care home" means a CSSP owned, leased, or controlled residential setting where each client residing in the home has been diagnosed with an intellectual or developmental 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.

(i) "CSSP" means an entity that:

(1) Has received CSSP Agency certification; and

(2) Is enrolled with DMS as a Community Support System provider.

(j) "CSSP -Agency Ccertificationlicense" means one of the followinga community support system provider that has been certificationsed issued by DPSQA to provide services included within these standardsa non-transferable license issued by DPQSA

(1) Base CSSP Agency certification;

(2) Intensive CSSP Agency certification; or

(3) Enhanced CSSP Agency certification.

(g)

(k) "DHS" means the Arkansas Department of Human Services.

"CSSP Agency Base Certification" means a CSSP Agency certified by DPSQA to perform CSSP Agency Base Services;

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"CSSP Agency license enhancementBase Services" means one of the following services each as defined in Home and Community-Based Service for Clients with Intellectual Disabilities and Behavioral Health Needs 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

Adult life skills development;

Supportive Housing;

Supportive Employment

Supportive Life Skills Development (individual and group);

Respite;

Supported Employment;

Supportive Living;

Specialized Medical Supplies;

Adaptive Equipment;

Community Transition Services;

Consultation;

Environmental Modifications; and

Supplemental Support.

Pharmacological Counseling

Therapeutic Host Homes

"CSSP Agency Enhanced Certification" means a CSSP Agency certified by DPSQA to perform:

CSSP Base Services;

CSSP Intensive Services; and

CSSP Enhanced Services.

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~~Services set out in the Counseling Services Medicaid Manual~~

~~"CSSP Agency Enhanced Services" means one of the following services each as defined in the Home and Community Based Service for Clients with Intellectual Disabilities and Behavioral Health Needs Medicaid Manual:~~

~~Therapeutic Communities;~~

~~Residential Community Reintegration Program;~~

~~Adult Rehabilitation Day Treatment;~~

~~Substance Abuse Detox (Observational);~~

~~Partial Hospitalization;~~

~~Outpatient Acute Crisis Units; and~~

~~Residential Complex Care Homes for IDD that house up to eight (8) unrelated settingFacilities housing more than four (4) CES Waiver clients diagnosed with an intellectually disability and a significant co-occurring deficit.~~

~~"CSSP Agency Intensive Certification" means a CSSP Agency certified by DPSQA to perform:~~

~~CSSP Base Services; and~~

~~CSSP Intensive Services.~~

~~Service set out in the Counseling Services Medicaid Manual~~

~~"CSSP Agency Intensive Services" means:~~
~~One of the following services each as defined in the Home and Community Based Service for Clients with Intellectual Disabilities and Behavioral Health Needs Medicaid Manual:~~

~~Assertive Community Treatment;~~

~~Peer Support;~~

~~Aftercare Recovery Support (Substance Abuse);~~

~~Intensive In Home Services;~~

~~Behavioral Assistance;~~

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~~Child and Youth Support;~~

~~Family Support Partners; and~~

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

(1) Provides training to ~~assist~~ a CSSP ~~Agency in~~to correct noncompliance~~ying~~ with these standards~~ and correcting deficiencies~~;

(2) ~~Includ~~Establishes 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

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(5) Is approved by DPSQA.

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

(n) "DPSQA" means the Arkansas Department of Human Services, Division of Provider Services and Quality Assurance.

(o) "Employee" means an employee, owner, independent contractor, or other agent of a CSSP Agency 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..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:

The independent contractor does not assist in the date to day operations of the CSSP Agency; and

(I) 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.

(p) "Enhanced CSSP Agency certification" means a CSSP that has been certified by DPSQA to perform:

(1) All services available under Base CSSP Agency certification;

(2) All services available under Intensive CSSP Agency certification;

(3) All services available under the Counseling Services Medicaid manual; and

(4) The following services each as defined in the Home and Community-Based Services for Clients with Intellectual Disabilities and Behavioral Health Needs Medicaid manual:

(A) Therapeutic Communities;

(B) Residential Community Reintegration;

(C) Adult Rehabilitation Day Treatment;

(D) Substance Abuse Detox (Observational);

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(E) Partial Hospitalization; and

(F) Complex care homes.

~~(n)~~ "~~Home-~~Home- and community-based services" means services that are available under the Home and Community-Based Services for Clients with Intellectual Disabilities and Behavioral Health Needs Medicaid ~~M~~manual. ~~for Medicaid clients who have behavioral health, intellectual disability, or developmental disability service needs :~~

(q)

~~(1) Adult Behavioral Health Services for Community Independence (ABHSCI) program for Medicaid beneficiaries~~clients ~~who have complex behavioral health needs; and~~

~~(2) The Provider-led Arkansas Shared Savings Entity (PASSE) program for Medicaid beneficiaries~~clients ~~who have complex behavioral health, intellectual disability, or developmental disability service needs.~~

(r) "Intensive CSSP Agency certification" means a CSSP that has been certified by DPSQA to perform:

(1) All services available under Base CSSP Agency certification;

(2) All services available under the Counseling Services Medicaid manual; and

(3) The following services each as defined in the Home and Community-Based Services for Clients with Intellectual Disabilities and Behavioral Health Needs 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.

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~~(o) "ITP" means a beneficiary~~client~~'s individualized treatment plan, which is a written, individualized service plan for a CSSP beneficiary~~client ~~to improve or maintain the beneficiary~~client~~'s condition.~~

~~(p)~~

(s) "Licensed professional" means a person who holds ~~possesses~~ an Arkansas ~~a~~ professional license in good standing in Arkansas operating within the scope of practice of their license~~to provide a service or provide oversite of a service provided to a population served~~.

~~(1) "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)~~

(t)

(1) "Market~~ing~~" means the accurate and honest advertisement of a CSSP ~~Agency~~ that does not also constitute an attempt to solicit~~ation~~.

(2) "Market~~ing~~" includes without limitation:

(A) Advertising using traditional media;

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

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(C) Conducting tours of ~~the~~a CSSP ~~Agency~~ to interested ~~beneficiaries~~clients and their families;

(D) Mentioning services offered by ~~the~~a CSSP ~~Agency~~ in which the ~~beneficiary~~client or ~~his or~~ their family might have an interest;

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

(u) "Mechanical restraint" means the use of any device attached or adjacent to the ~~beneficiary~~client~~'s body~~ that:

(1) ~~t~~The ~~beneficiary~~client cannot easily remove; and ~~that~~

~~(r)~~(2) ~~r~~Restricts the ~~beneficiary~~client's freedom of movement ~~or normal access to the beneficiaryclient's body~~.

~~(s) "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.~~

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

(1) ~~the l~~Loss of medication;~~,~~

(2) ~~u~~Unavailability of medication;~~,~~

(3) ~~f~~Falsification of medication logs;~~,~~

(4) ~~t~~Theft of medication;~~,~~

(5) ~~m~~Missed dose~~s~~ of medication;~~,~~

(6) ~~i~~Incorrect medications administered;~~,~~

(7) ~~i~~Incorrect dose~~s~~ of medication administered;~~,~~

(8) ~~i~~Incorrect time of administration;~~,~~

(9) ~~i~~Incorrect ~~method~~route of administration;~~,~~ and

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

~~(u)~~

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(1) "Mobile crisis service" means a short-term, on-site, face-to-face therapeutic response to beneficiariesclients experiencing a behavioral health crisis for the purpose of assessing, treating, and stabilizing a beneficiaryclient and reducing the immediate risk of danger to the beneficiaryclient or others.

(2) "Mobile crisis service" includes without limitation:

(A) Assessment;

(B) Interventions as needed, including psychiatric consultation and psycho-pharmacological interventions; and

(10) Referrals and other linkages to all medically necessary services, including home- and community-based services and behavioral health services.

(w) "Mental health professional" or "MHP" means a person who holds an Arkansas professional license in good standing to provide one or more of the services set out in the Counseling Services Medicaid manual.

(x) "Multidisciplinary team" means a team of individualsemployees lead by a licensedmental health professional who are responsible for the development of a client's treatment plan and the monitors and supervises the delivery of all home and community-based services in accordance with the treatment plancontained 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)

(y) "PASSE" means a client's assigned Provider-led Arkansas Shared Savings Entity.

(z) "PCSP" means a client's person-centered service plan, which is a written, individualized service and support plan developed by the client's PASSE care coordinator, which sets out the home and community-based services to be received by the client.

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

(1) Provides the steps a CSSP must take to correct noncompliance with these standards;

(2) SetsEstablishes a timeframe for each specific action provided in the plan; and

(3) Is approved by DPSQA.

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

(3)

"Professional service encounter" means any home- and community-basedprofessional 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.

(bb) "Provider" means an entity that is certified by DHS and enrolled by DMS as a CSSP Agency.

"Qualified Community Support Staff" means a person who:

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

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;

Has successfully completed prescribed and documented courses of initial and annual training sufficient to perform all tasks assigned through the IPOC;

(w) Acknowledges in writing that all qualified community support staff services are controlled by the client's individualized plan of care and provided under the direct supervision of a licensed professional.

(x) "Residence" means the address county where a beneficiaryclient is listed as residing in the Arkansas Medicaid Management Information System.

(y)

(cc)

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

(2) "Restraint" does not include:
(2)

(A) Briefly holding, without undue force, a beneficiaryclient in order to calm or comfort the beneficiaryclient; or

(B) Holding a beneficiaryclient's hand to safely escort a residentthe client from one area to another.

(B)

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

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~~(z)~~(ee) "Seclusion" means the involuntary confinement of a ~~resident~~client alone or in a room or an area from which the ~~resident~~client is physically prevented from leaving.

~~(aa)~~(ff) "Serious injury" means any injury to a ~~beneficiary~~client that:

(1) May cause death;

(2) May result in substantial permanent impairment;

(3) Requires hospitalization; and

(4) Requires the attention of:

(A) ~~a~~An emergency medical technician;~~,~~

(B) ~~a~~A paramedic;~~,~~ or

~~(3)~~(C) -An emergency room~~a doctor; or~~

~~(4) Requires hospitalization.~~

~~(bb)~~

(gg)

(1) "Solicit~~ation~~" means when ~~the~~a CSSP intentionally initiat~~es~~~~ion of~~ contact with a ~~beneficiary~~client (or ~~his or~~ their family) ~~by a CSSP when the beneficiaryclient~~that is currently receiving services from another provider and the CSSP is attempting to convince the ~~beneficiary~~client or ~~his or~~ their family to switch to or otherwise use the services of ~~soliciting~~ the CSSP~~'s services~~.

(2) "Solicit~~ation~~" includes without limitation the following acts to induce a ~~beneficiary~~client or ~~his or~~ their 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~~ their 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~~ their family regarding the quality of services performed by another service provider;

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

(F) Giving a ~~beneficiary~~client or ~~his or ~~their 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 ~~their family; or

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

(hh) "Treatment plan" means a CSSP's written, individualized service plan for a client, outlining the specific method, schedule, and goals for home and community-based service(s) delivery by the CSSP.

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Subchapter 2. ~~Licensing~~Certification.

201. ~~License~~ Certification Requirements.~~d.~~

~~(a)~~

~~(1)~~

(a) A CSSP must have ~~a CSSP license~~ one of the following certifications issued by DPSQA pursuant to these standards:

(1) Base CSSP Agency ~~Base C~~certification;

(2) Intensive CSSP Agency ~~Intensive C~~certification; or

~~(A)~~(3) Enhanced CSSP Agency ~~Enhanced C~~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~~its CSSP Agency ~~license~~certification.

(b)

(c) A CSSP ~~Agency~~ must comply with all requirements of these standards for all home and community-based services included within its ~~provided by the~~ CSSP Agency certification.

~~(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 demonstrate accreditation~~ed~~ 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)~~

MARK-UP

~~(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) 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)~~(e) A CSSP ~~Agency~~ must comply with all requirements of its accreditations.

~~(4)~~(f) A loss of a CSSP Agency's~~'s~~ accreditation constitutes a violation of these standards.

~~(d)~~

~~(1)~~(g) 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)~~(h) 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 CSSP Agency 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, Child Maltreatment Registry Check, and Adult Maltreatment Registry Check for employees and operatorscontractors;~~

~~(5)~~(4) Documentation of all ~~required C~~drug screens~~,~~ and criminal background, maltreatment, and other ~~hild Maltreatment Rregistry checks, and~~ searches ~~Adult~~

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Maltreatment Registry checks registry checks and searches required pursuant to section 302(c);for employees and operatorscontractors;

(6)(5) Documentation demonstrating compliance with these standards for a CSSP license; and

(7)(6) 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 PProcess.

(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 Ssection 202(a);

(2) DPSQA determines that all employees and operators have successfully passed all required drug screens and criminal background, and maltreatment, and other registry checks and searches required pursuant to section 302(c); 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

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~~(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 ~~S~~section 202;

(2) DPSQA determines that all employees and operators have successfully passed all ~~required~~ drug screens and criminal background, ~~and~~ maltreatment, and other registry checks and searches required pursuant to section 302(c); and

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

~~(d)~~(c) A CSSP ~~licenses and CSSP license enhancements~~Agency certification~~s~~ does not expire until terminated under these standards.

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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)~~

(b)

(1) 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) 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)~~

(c)

(1) A CSSP ~~Agency~~ cannot transfer its CSSP Agency c~~license~~ ertification ~~or CSSP license enhancement~~ to any person or entity.

(2) A CSSP ~~Agency~~ cannot change its ownership unless DPSQA approves the application of the new ownership pursuant to sections 202 and 203.

(3) A CSSP ~~Agency~~ cannot change its name or otherwise operate under a different name than the listed on ~~the~~its 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.

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302. Employees and Staffing Requirements.

(a)

(1)(a) A CSSP Agency must appropriately supervise all beneficiariesclients based on each beneficiaryclient's needs.

(2) An Agency CSSP must have enough employees on-site to supervise beneficiariesclients in a CSSP location.

(b) A CSSP Agency must meet the minimum staffing-to-beneficiaryclient ratio for each beneficiaryclient as provided in each beneficiaryclient's treatment planITP 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.

(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) At least a five (5) panel drug screen both prior to hiring and as required thereafter by Ark. Code Ann. §20-77-128(b); 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, criminal background and registry checks and searches prescribed in subsection (c)(1) of this part are not required for any licensed professional.

(2) 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

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requirements under the standards including without limitation requirements related to criminal background checks and adult and child maltreatment checks.

(d)

(1) A CSSP Agency must conduct child maltreatment, adult maltreatment, and criminal background checks for all employees as required by law.

(2) 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 beneficiariesclients 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)

(d)

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

(2) andEmployees must have a:

(A) hHigh school diploma; or

(1)(B) aA 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.

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

(3) A beneficiaryclient'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 beneficiaryclient.

~~(f)~~

~~(1)~~(f) A CSSP ~~Agency~~ must document all scheduled and actual employee staffing, including without limitation employee names, job title or credential, shift role, shift days, and shift times.

~~(2) 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 direct services~~ employees ~~of a CSSP Agency~~ ~~must receive the following training on the following topics p~~Prior to having any direct contact with clients, all employees must meet each of the following~~, and at least once every twelve~~ ~~within thirty (30~~12) ~~calendar days after beginning employment~~months thereafter:

(1) Have at least one (1) year of experience working with persons with:

(A) Developmental disabilities; or

(B) Behavioral support needs; and

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(2) Receive training on the following topics:

(A) The Health Insurance Portability and Accountability Act (HIPAA), and other applicable state and federal laws and regulations governing the protection of medical, social, personal, financial, and electronically stored records;

(A) Emergency and evacuation proceduresIdentification 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) Verbal intervention; and

(G) De-escalation techniques.Identification and mitigation of unsafe environmental factors;

(B) Emergency restraint procedures; and

(C) Reporting incidents and accidents as required in these standards and other applicable law or ruleClient financial safeguards under Section 308.

(b)

(1) All direct services employees must receive client-specific training in the amount necessary to safely meet the client's individualized needs prior to providing services to those clients.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

(2) Every employee's client-specific training must at a minimum must include training on the client's:

(A) Treatment plan;

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(B) Diagnosis and medical records;

(C) Medication management plan, if applicable;

(D) Positive behavioral support plan, if applicable;

(E) Behavioral prevention and intervention plan; if applicable;

(F) Permitted interventions; if applicable; and

(G) Setting-specific emergency and evacuation procedures.

(3)

(A) Appropriate client-specific training on the additional topics listed in (3)(B) below are required for employees performing home and community-based services:

(i) Available under Intensive CSSP Agency certification;

(ii) Available under Enhanced CSSP Agency certification;

(iii) In a complex care home; and

(iv) Available under the Counseling Services Medicaid manual.

(B)

(i) Home and community-based service record keeping;

(ii) Appropriate relationships with a client;

(iii) Group interaction;

(iv) Listening techniques;

(v) Confidentiality;

(vi) Community resources available to individuals within community settings;

(vii) Cultural competency;

(viii) Direct care ethics; and

(ix) Childhood development, if serving a child or adolescent client.

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(c) All employees must receive appropriate refresher training on the topics listed in subsections 303(a)(2) and 303 (b) at least once every calendar year

~~Time spent training on the topics listed in subsection (a) cannot be counted towards the training prescribed in this subsection (b).~~

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

~~Care planning for individuals with intellectual and developmental disabilities;~~

~~Care planning for individuals with autism spectrum disorders;~~

~~De-escalation techniques;~~

~~Behavioral health illnesses; and~~

~~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)

(1) All ~~direct services~~ employees must obtain and maintain in good standing the following credentials when performing home and community-based 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

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(iii) American Red Cross.

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

(b)

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:

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

PCSP;

Medication management plan, if applicable;

Behavioral support needs;

Behavioral prevention and intervention plan or Positive Behavioral Support Plan;

Permitted interventions, if applicable; and

Setting-specific emergency and evacuation procedures.

Client-specific training pursuant to this subsection (fc) 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;

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~~(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)~~(e) A~~n employee who is a~~ licensed professional is not required to receive the training prescribed in this section 303~~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.~~

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(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;

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~~(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 required trainings and certifications ~~required in Section 303~~;

~~(10)~~

~~(A)~~ Documentation demonstrating that the employee obtained and ~~maintained in good standing all certifications required in Section 303;~~

~~(B) If the employee was excepted from any certifications required in Section 303, documentation demonstrating that the employee was excepted from such certifications.~~

(11) ~~Documentation demonstrating that the employee obtained and~~ maintained in good standing all professional licens~~ur~~es, certifications, or credentials ~~for the employee or the service the employee is performing that are~~ required for the employee or the home and community-based service the employee is performing; and

(12) 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 personnel records for five (5) years from the date an employee ~~is no longer an employee~~ceases providing services to ~~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 (5)-year period.

305. ~~Beneficiary~~Client Service Records.

~~(a)~~

(a)

(1) A CSSP ~~Agency~~ must maintain a separate, updated, and complete service record for each ~~beneficiary~~client documenting the home and community-based services provided to the ~~beneficiary~~client and all other documentation required under these standards.

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

(1) The ~~beneficiary~~client's:

~~(1)~~ (A) ~~f~~Full name;

~~(2)~~ (B) ~~The beneficiary~~~~client~~~~'s a~~Address and county of residence;

~~(3)~~ (C) ~~The beneficiary~~~~client~~~~'s t~~Telephone number and email address, if available;

~~(4)~~ (D) ~~The beneficiary~~~~client~~~~'s d~~Date of birth;

~~(5)~~ (E) ~~The beneficiary~~~~client~~~~'s p~~Primary language;

~~(6)~~ (F) ~~The beneficiary~~~~client~~~~'s d~~Diagnoses;

~~(7)~~ (G) ~~The beneficiary~~~~client~~~~'s~~ M~~m~~edications, dosage, and frequency, if applicable;

~~(8)~~ (H) ~~The beneficiary~~~~client~~~~'s k~~Known allergies;

~~(9)~~ ~~(I)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)~~ (J) ~~The beneficiary~~~~client~~~~'s~~ Medicaid number;

(K) ~~The beneficiary~~~~client~~~~'s c~~Commercial or private health insurance information, if appliable; and

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

(2) The date client begam receiving home and community-based services from the CSSP;

(3) The date client exited from the CSSP, if applicable;

~~(13)~~

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~~(14)~~(4) The name, address, phone number, and email address, if available, of the ~~beneficiary~~client's legal guardian ~~or custodian~~, if applicable; and

~~(15)~~(5) The name, address, and phone number of the ~~beneficiary~~client's primary care provider (PCP)~~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.~~

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

(1) Client PSCP;

(2) The treatment plan developed by CSSP for the client;

(3) All home and community-based service authorizations;

(4) Positive behavioral support plan, as applicable;

(5) Behavioral prevention and intervention plan, as applicable;

(6) Service logs or other documentation for each home and community-based service;

(7) Medication management plan, if applicable;

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(8) Medication logs, if applicable;

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

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

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

(d)

(d)

(1) A CSSP Agency must ensure that each beneficiaryclient service record is kept confidential and available only to:

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

(B) Persons or entities who need to know the information contained in the beneficiaryclient service record in order to provide services to tThe beneficiaryclient's assigned PASSE;

(C) DPSQA and any governmental entity with jurisdiction or other authority to access the beneficiaryclient's service record;

(D) The beneficiaryclient's legal guardian, if applicable or custodian; and

(E) Any other individual authorized in writing by the client or, if applicable, the client's legal guardian or custodian.

(2)(E)

(2)

(A) A CSSP Agency must keep beneficiaryclient service records in a file cabinet or room that is always locked.

(B)

(B)

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

(ii) A CSSP Agency that uses electronic records must take reasonable steps to backup all electronic records and reconstruct a

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~~beneficiary~~client's service record in the event of a breakdown in the CSSP's electronic records system.

(e) 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 (5)-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)

(1) A client ~~shall~~must have full use and access to a client's own funds or other assets.~~, and~~

(2) ~~a~~A CSSP may not limit a client's use or access to a client's own funds or other assets, unless:

(A) ~~t~~The client or, if applicable, the client's legal guardian~~, or custodian~~ provides informed written consent; or

(B) ~~t~~The CSSP otherwise has the legal authority~~ to limit a client's use or access of the client's own funds or other assets~~.

(3) A CSSP is deemed to be ~~L~~limit~~at~~i~~o~~ng ~~of~~ a client's use or access to the client's own funds includes without limitation the following:

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

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

(C) ~~l~~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 when:

(1)

(A) The~~for the benefit of the~~ client, or, if applicable,~~ and only then if~~ the client's legal guardian,~~ or custodian~~ provides informed written consent; or

(B) ~~t~~The CSSP otherwise has the legal authority~~ to use, manage, or access the client's funds or other assets~~.

(2) A CSSP is deemed to be managing, using, or accessing a client's funds or other assets when:~~The management, use, or access to a client's funds or other assets includes without limitation~~

(A) ~~s~~Serving as a representative payee of a client;~~,~~

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

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

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

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

(5) 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.

(6) A CSSP must safeguard client funds ~~or~~and other assets whenever a CSSP manages, uses, or has access to a client's funds or other assets.

(c)

(1) A CSSP must maintain financial records that document all uses of ~~the~~a client's funds or other assets.~~ and comply~~

(2) Financial records for client funds must maintained in accordance with generally accepted accounting practices ~~whenever the CSSP manages, uses, or has access to a client's funds or other assets.~~

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(3) A CSSP must, upon request, make client financial records available to a client or a client's legal guardian upon requestor custodian all financial records related to a client.

(d)

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

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.

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.

A CSSP must evaluate all written emergency plans at least annually and update as needed.

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.

When a CSSP is providing home and community-based services to a client in a CSSP location,

The written emergency plan must include at least:

Designated relocation sites and evacuation routes;

Procedures for notifying legal guardians and custodians of relocation;

Procedures for ensuring each client's safe return to the CSSP community facility or residence;

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Procedures to address the special needs of each client;

Procedures to address interruptions in the delivery of home and community-based services;

Procedures for reassigning employee duties in an emergency; and

Procedures for annual training of employees regarding the emergency plan.

A CSSP must conduct emergency fire drills at least once a month.

A CSSP must conduct other emergency drills as required by the CSSP's accreditation.

A CSSP must document all emergency drills completed and include at least:

The date of the emergency drill;

The type of emergency drill;

The time of day the emergency drill was conducted;

The number of clients participating in the emergency drill;

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

Notes regarding any aspects of the emergency procedure or drill that need improvement based on the performance of the emergency drill.

30910. 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.

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~~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.~~

~~A client who becomes ill while at a CSSP location must be separated from other clients to the extent possible.~~

(b) If applicable, ~~The~~a CSSP must notify a client's legal guardian ~~or custodian~~ if the client becomes ill ~~while at a CSSP location~~.

310~~1~~. Compliance with State and Federal Laws, Rules, and Other Standards.

(a) A CSSP must comply with all applicable local, state, and federal laws, regulations, and rules~~-~~, and a violation of any applicable local, state, or federal law, regulation, or rule constitutes a violation of these standards~~including without limitation:~~.

~~The Americans with Disabilities Act of 1990 (ADA);~~

~~The Disability Rights Act of 1964;~~

~~The Health Insurance Portability and Accountability Act (HIPAA);~~

~~The Privacy Act of 1974; and~~

~~All applicable laws and rules governing the protection of medical, social, personal, financial, and electronically stored records.~~

~~A CSSP location must comply with all:~~

~~Building codes and local ordinances;~~

~~Fire and safety inspections and requirements of the State Fire Marshal or local authorities;~~

~~ADH requirements including without limitation requirements regarding water, plumbing, and sewage;~~

~~Arkansas Department of Labor and Licensing requirements including without limitation requirements regarding water heaters and boilers; and~~

~~Other federal, state, or local requirements applicable to the CSSP location, property, and structures.~~

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A CSSP must maintain documentation of compliance with applicable state, local, and federal laws, rules, codes, and standards.

A violation of any applicable state, local, or federal laws, rules, codes, or standards constitutes a violation of these standards.

(b)

(1) In the event of a conflict between these standards and other applicable local, state, local, or federal laws, rules, or standardsregulation, the stricter requirement shall apply.

(2) In the event of an irreconcilable conflict between these standards and another applicable local, state, local, or federal laws, rules, or standardsregulation these standards shall govern to the extent not governed by local, state, or 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; Face-to-face may be met through telehealth.

4. Response strategies based upon:

a. Time and place of occurrence;

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

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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)

6063113. 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 when:

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

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

~~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:

(A) Treatment plan;

(B) ~~b~~Behavioral prevention and intervention ~~management~~ plan, if applicable; and

(C) Positive behavior support plan, if applicable;

(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.

312. General Nutrition and Food Service Requirements.

(a)

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(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, Arkansas Department of Health (ADH) requirements, and other applicable laws and regulations.

(2) In the event of a conflict between these standards and U.S. Department of Agriculture guidelines, ADH requirements, or other applicable laws or regulations related to nutrition and food service, the stricter requirement shall apply.

(b) All pre-prepared food obtained or purchased by a CSSP from outside sources for client consumption must be:

(1) From restaurants and other food service providers approved by ADH and transported per ADH requirements; or

(2) In individual, commercially pre-packaged containers.

(c)

(1) A CSSP must ensure that food provided to clients meet 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 by an employee 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 ensure all surfaces used by employees to prepare or serve food to clients are clean and in sanitary condition.

(5) A CSSP must serve food to clients 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 refrigerators used for food storage are maintained at a temperature of forty-one (41) degrees Fahrenheit or below.

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(B) A CSSP must ensure that freezers used for food storage are maintained at a temperature of zero (0) degrees Fahrenheit or below.

313. Medications.

(a)

(1) A client, or, if applicable, the client's 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 CSSP can administer medication only as:

(A) Provided in the client's treatment plan; or

(B) Otherwise ordered by:

(i) A physician; or

(ii) Other health care professional authorized to prescribe or otherwise order the administration of medication.

(2) A CSSP must administer medication in accordance with the Nurse Practice Act and the Consumer Directed Care Act.

(c)

(1) A CSSP must develop a medication management plan for any prescribed medication and routinely administered over-the-counter medication that is not self-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;

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

(D) How each medication will be administered, including without limitation time(s) of administration, dose(s), route of administration, and persons who may lawfully administer each medication;

(E) A list of the most common potential side effects caused by each medication; and

(F) The consent to the administration of each medication by the client or, if applicable, the client's legal guardian.

(d)

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

(2) A medication log must be available at each location a client 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 route of medication administration;

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

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

(E) If an over-the-counter medication administered for a specific symptom, the specific symptom addressed and the effectiveness of the medication;

(F) Any adverse reaction or other side effect from the medication;

(G) Any transfer of medication by an employee that is not self-administered from its original container into individual dosage containers by the client, or, if applicable, the client's legal guardian;

(H) Any error in administering the medication; 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.

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(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.

(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 CSSP must be:

(1) Kept in the original medication container unless the client, or, if applicable, the client's 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 CSSP is no longer to be administered to the client, then the medication must be:

(1) Returned to a client's legal guardian, if applicable;

(2) Destroyed; or

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

314. Service Logs.

(a)

(1) A CSSP must document the delivery of each home and community-based service to a client.

(2) The documentation requirement may be satisfied by a daily service log or other electronic or paper documenting method.

(b) The service log or other documentation of home and community-based service delivery by a CSSP must include at least:

(1) The specific home and community-based service performed;

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(2) The date the home and community-based service was performed;

(3) The beginning and ending time of the home and community-based service;

(4) The name, title, and credential of each person performing the home and community-based service for each date and time;

(5) The relationship of the home and community-based service to the goals and objectives described in the client's treatment plan; and

(6) Progress notes that describe each client's status and progress toward the client's goals and objectives.

(c)

(1) Each service log entry must be signed by the employee responsible for the performance of the home and community-based service.

(2) Each service log entry must be included in the client's service record.

315. Behavioral Management Plans for IDD Clients.

(a) The requirements of this section 315 apply only to clients with a diagnosed intellectual or developmental disability as defined in Ark. Code. Ann. § 20-48-101.

(b)

(1)

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

(B) A behavioral prevention and intervention plan must address:

(i) Behavior shaping and management to reduce inappropriate behaviors; and

(ii) How the client will safely remain residing in the community and avoid an acute placement.

(2)

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(A) A CSSP must develop a positive behavioral support plan if a client's risk mitigation plan identifies the 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.

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

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

(e)

MARK-UP

(1) A CSSP 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:

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

(ii) The duration of each intervention;

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

(iv) 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.

~~**308. Financial Safeguards.**~~

~~(a)~~

~~(1) A beneficiary~~client shall have full use and access to a ~~beneficiary~~client's own funds or other assets, and a CSSP may not limit a ~~beneficiary~~client's use or access to a ~~beneficiary~~client's own funds or other assets, unless the ~~beneficiary~~client or the ~~beneficiary~~client's legal guardian or custodian provides informed written consent or the CSSP otherwise has the legal authority to limit a ~~beneficiary~~client's use or access of the ~~beneficiary~~client's own funds or other assets.~~

~~(2) Limitation of a beneficiary~~client's use or access includes without limitation designating the amount a ~~beneficiary~~client may use or access, limiting the amount a ~~beneficiary~~client may use for a particular purpose, and limiting the timeframes during which a ~~beneficiary~~client may use or access the ~~beneficiary~~client's funds or other assets.~~

~~(b)~~

MARK-UP

(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.

MARK-UP

(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 beneficiaryclient's safe return to the CSSP community location or residence;

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

(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.

MARK-UP

(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 beneficiariesclients 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.

MARK-UP

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.

MARK-UP

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;

MARK-UP

~~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;~~

MARK-UP

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;

MARK-UP

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;

MARK-UP

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.

(c) 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;

MARK-UP

(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;

MARK-UP

(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.

MARK-UP

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.

MARK-UP

(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.

MARK-UP

~~Subchapter 5. Entries and Exists.~~

~~501. Entries.~~

~~(a) A CSSP may enroll and provide home- and community-based services to a beneficiary~~client ~~who is eligible to receive the home- and community-based services provided.~~

~~(b) A CSSP must document the enrollment of all beneficiaries~~clients ~~in its program.~~

~~502. Exits.~~

~~(a) A CSSP may exit a beneficiary~~client ~~from its program if the beneficiary~~client ~~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 beneficiaries~~clients ~~from its program.~~

~~(c) A CSSP must provide reasonable assistance to all beneficiaries~~clients ~~exiting its program including without limitation by:~~

~~(1) Assisting the beneficiary~~client ~~in transferring to another CSSP or other service provider; and~~

~~(2) Providing copies of the beneficiary~~client~~'s service records to the beneficiary~~client~~, the beneficiary~~client~~'s legal guardian or custodian, and the CSSP or other service provider to which the beneficiary~~client ~~transfers after exiting the program.~~client

~~(d) A CSSP shall remain responsible for the health, safety, and welfare of the exiting beneficiary~~client ~~until all transitions to new service providers are complete.~~

MARK-UP

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

MARK-UP

~~(9) The schedule for completing re-evaluations of the beneficiary~~client~~'s condition and updating the ITP.~~

MARK-UP

Subchapter 4. Entries and Exi~~s~~ts.

401. Request to Change Provider.

(a) A client or, if applicable, the client's legal guardian, may initiate a request to change their selected CSSP at any time by contacting their assigned PASSE care coordinator.

(c) If requested by DHS, the client, or, if applicable, the client's legal guardian, a CSSP will remain responsible for the delivery of home and community-based services until such time as the client's transition to the new CSSP is complete.

(d) A CSSP will remain responsible for the health, safety, and welfare of the client until all transitions to new service providers are complete.

402. Entries.

(a) A CSSP ~~Agency~~ may enroll and provide those home and community-based services it is certified to delivery pursuant to its CSSP Agency certification to an eligible 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.

403~~2~~. Exits.

(a) A CSSP ~~Agency~~ may exit a client ~~from its program~~:

(1) ~~i~~If the client becomes ineligible for home and community-based services;~~,~~

(2) If the client chooses to use another CSSP ~~Agency for his or her home and community-based services~~;~~,~~ or

(3) ~~f~~For any other lawful reason.

(b) A CSSP ~~Agency~~ must document the exit of all clients regardless of reason~~from its program~~.

(c) A CSSP ~~Agency~~ must provide reasonable assistance to all exiting clients , which at a minimum includes~~exiting its program including without limitation by~~:

(1) Assisting the client in transferring to another CSSP ~~Agency~~ or other service provider, when applicable; ~~and~~

MARK-UP

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

(3)

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

(i) ~~t~~The client;~~,~~

(ii) ~~t~~The client's legal guardian, if applicable~~ or custodian~~;~~,~~ and

(iii) ~~the~~Any new CSSP ~~Agency~~ or other service provider to which the client transfers after exiting~~ the program~~.

(B) Service ~~R~~records ~~released at a minimum should~~ include:

(i) The client's treatment plan~~summary,~~; ~~current IPOC,~~

(ii) ~~m~~Medication logs;~~,~~ and

(iii) Any other records requested by the client in compliance with clinical discretion as allowed by law and accreditation.

~~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.~~

MARK-UP

Subchapter 5. Settings Requirements.

501. Emergency Plans and Drills.

(a) A CSSP must have a written emergency plan for all CSSP owned, leased, or controlled locations at which the CSSP performs home and community-based services.

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

(1) Fire;

(2) Flood;

(3) Tornado;

(4) Utility disruption;

(5) Bomb threat;

(6) Active shooter; and

(7) Infectious disease outbreak.

(c) A CSSP must evaluate and update written emergency plans at least annually.

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

(1) Designated relocation sites and evacuation routes;

(2) Procedures for notifying legal guardians of relocation;

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

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

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

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

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

(e)

(1) A CSSP must conduct emergency fire drills at least once a month.

MARK-UP

(2) A CSSP must conduct all other emergency drills set out in subsection (d) at least annually.

(3) A CSSP must document all emergency drills which must include:

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

(B) The type of emergency drill;

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

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

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

502. General CSSP Owned Service Setting Requirements.

(a) Each CSSP owned, leased, or controlled home and community-based service setting must meet the home and community-based service setting regulations as established by 42 CFR 441.301(c) (4)-(5).

(b) All CSSP owned, leased, or controlled home and community-based service locations must meet the following requirements:

(1) The interior of the location 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 each bathroom, and, if applicable, kitchen;

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

(F) Be free of:

(i) Offensive odors;

(ii) Pests;

(iii) Lead-based paint; and

MARK-UP

(iv) Hazardous materials.

(2) The exterior of each CSSP owned, leased, or controlled home and community-based service location'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;

(I) Driveways; and

(J) Parking lots.

(3) The surrounding grounds of each CSSP owned, leased, or controlled home and community-based service location must be maintained in a safe, clean, and manicured condition free of trash and other objects.

(4) Broken equipment, furniture, and appliances on or about the premises of each CSSP owned, leased, or controlled home and community-based service location must be either immediately repaired or appropriately discarded off premises and replaced.

(c) CSSP owned, leased, or controlled home and community-based service locations 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;

MARK-UP

(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 provider (PCP); 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 location;

(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) 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;

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

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

(d) Each bathroom in a CSSP owned, leased, or controlled home and community-based service location must have the following:

(1) Toilet;

(2) Sink with running hot and cold water;

(3) Toilet tissue;

(4) Liquid soap; and

(5) Towels or paper towels;

503. Specific CSSP Owned Residential Settings Requirements.

(a) Each CSSP owned, leased, or controlled home and community-based service residential setting must meet all the requirements of section 502 and this section 503.

(b)

(1) The following home and community-based service residential setting locations are limited to no more than sixteen (16) clients:

(A) Therapeutic Community; and

(B) Residential Community Reintegration.

(2) A home and community-based service residential setting that is a complex care home is limited to no more than eight (8) clients.

(3) Previously grandfathered group home locations continuously licensed by DDS since July 1, 1995, may continue to serve up to fourteen (14) unrelated adult clients with intellectual or developmental disabilities.

(4) CSSP owned, leased, or controlled home and community-based service residential settings that house at least one (1) client with an intellectual or development disability are limited to no more than four (4) clients.

(c) Each CSSP owned, leased, or controlled home and community-based service residential setting must provide each client with a bedroom that has:

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

(A) A firm mattress that is:

(i) At least four (4) inches thick; and

(ii) Covered with moisture repellant material;

(B) Pillows; and

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

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

(A) Shelf space;

(B) Storage space for personal items; and

(C) 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) Each CSSP owned, leased, or controlled home and community-based service residential setting must meet the following bathroom requirements:

(1) At least one (1) bathroom must have a shower or bathtub;

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

(3) All toilets, bathtubs, and showers must be designed and installed in an accessible manner for clients.

(e) Each CSSP owned, leased, or controlled home and community-based service residential setting 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

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

(f) Male and female clients cannot share a bedroom in a CSSP owned, leased, or controlled home and community-based service residential setting.

(g) Each CSSP owned, leased, or controlled home and community-based service residential setting must provide:

(1) A reasonably furnished living room;

(2) A reasonably furnished dining area; and

(3) A kitchen with equipment, utensils, and supplies necessary to properly store, prepare, and serve three (3) or more meals a day for up to one (1) week.

504. CSSP Owned Residential Setting Exceptions and Variations.

(a) Any client need or behavior that requires a variation or exception to the setting requirements set out in section 503 must be justified in the client's treatment plan.

(b) The justification for a variation or exception to any settings requirement 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, if applicable, the client's legal guardian; and

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

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Subchapter ~~5~~6. Incident and Accident Reporting.

~~5~~601. Incidents to be Reported.

A CSSP ~~Agency~~ must report all alleged, suspected, observed, or reported occurrences of any of the following events while a client is receiving a home and community-based service:~~.~~

(1) Death of a client;

(2) Serious injury to a client;

(3) ~~Adult or child m~~Maltreatment of a client;

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

(5) ~~Unauthorized u~~Use of a restrictive intervention on a client, including without limitation:

(A) ~~s~~Seclusion;~~,~~

(B) ~~a~~A restraint;~~,~~

(C) ~~a~~A chemical restraint;~~, or~~

(D) ~~a~~A mechanical restraint;

(6) Any situation ~~where~~ the whereabouts of a client are unknown for more than one (1) hour;

(7) Any unscheduled situation where a client's services ~~to the client~~ are interrupted for more than ~~one~~two (~~1~~2) hours;

(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;

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(12) A ~~positive case of a~~ client or ~~a staff member~~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.

~~Any CSSP Agency may report any other occurrences impacting the health, safety, or quality of life of a client.~~

~~5~~602. Reporting Requirements.

(a) A CSSP ~~Agency~~ must:

(1) Submit all reports of the following events within ~~two~~one (~~2~~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 all reports ~~of all incidents~~ to the client's assigned PASSE and 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~~from complying with other applicable reporting or disclosure requirements under state or federal laws, rules, or regulations.

~~5~~603. Notification to ~~Custodians and~~ Legal Guardians.

(a) A CSSP Agency must notify the ~~custodian or~~client's legal guardian ~~of a client~~ of any reportable incident involving ~~a~~the 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).

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Subchapter 7~~6~~. Enforcement.

~~6~~701. 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.

7~~6~~02. 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 ~~S~~section 301.

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~~6~~703. ~~Remedies~~Enforcement Actions.

(a)

(1) DPSQA shall not impose ~~any remedies imposed by~~ an enforcement action unless:

(A) The CSSP ~~Agency~~ is given written notice pursuant to section 702 and an opportunity to be heard pursuant to ~~Section 802 and S~~subchapter 9~~10~~; or

(B) DPSQA determines that public health, safety, or welfare imperatively requires emergency action;

(2) If DPSQA imposes an enforcement action ~~remedy~~ as an emergency action before the CSSP ~~Agency~~ ~~has~~ receives written 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~~Allow the CSSP ~~Agency with~~ an opportunity to be heard pursuant to Subchapter 9~~10~~.

(b) DPSQA may impose on a CSSP ~~Agency~~ any of the following enforcement actions for ~~the CSSP Agency's~~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 CSSP Agency certification;

(7) Revocation of CSSP Agency certification; and

(8) Any remedy authorized by law or rule including without limitation Ark. Code Ann. § ~~section~~ 25-15-217 ~~of the Arkansas Code~~.

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

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(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 actions~~remedies~~ are not mutually exclusive and DPSQA may apply multiple ~~remedies~~actions simultaneously to a failure to comply with these standards.

(f) The failure to comply with an enforcement actions~~remedy~~ imposed by DPSQA constitutes a separate violation of these standards.

~~6~~704. 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.

~~6~~705. 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.

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(b) If directed by DPSQA, ~~A~~a CSSP ~~Agency~~ must continue providing services until the client is transferred to ~~his or~~ their new service provider of choice.

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

~~6~~706. 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.

~~6~~707. 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 ~~S~~section ~~9~~801(a).

MARK-UP

Subchapter ~~7~~8. Closure.

~~7~~801. 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 client, or, if applicable, the client's legal guardian, ~~or custodian of each client~~ with written notice of the closure;

(B) Provide the client, or, if applicable, the client's legal guardian, ~~or custodian of each client~~ with written referrals to at least three (3) other appropriate service providers;

(C) Assist each client and, if applicable, the client's ~~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, if applicable, the client's ~~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 ~~S~~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 Agency 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)

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(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.

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Subchapter 9~~8~~. Appeals.

~~8~~901. 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.

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(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.

~~8~~902. 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~~ covered 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.

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Subchapter 10~~9~~. Intensive CSSP Agency~~Level Services~~ Certification.

~~6089~~1001. Intensive CSSP Agency~~Intensive~~ Certification ~~Service~~ Requirements.

(a) A CSSP with Intensive CSSP Agency ~~C~~certification must meet all standards applicable to Base CSSP ~~Basic~~Agency ~~C~~certification found in subchapters three (3) to nine (~~8~~9), in addition to the requirements set out in this subchapter ten (10).

~~Intensive CSSP Agency Certification~~

~~9~~1002. 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:~~

- ~~Is/are ultimately responsible for applicant/provider organization, staffing, policies and practices, and CSSP Agency service delivery;~~

- ~~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.~~(a)

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(1) Each CSSP with Intensive CSSP Agency certification must employ or contract with a Mmedical Ddirector: who is a licensed physician in good standing with the Arkansas Medical Board.

(2) The medical director is responsible for:

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) a. Be accountable forOversight of all medical services that may be deliveredperformed by athe CSSP-Agency;

b. (B) Be responsible for CSSP AgencyOversight of the CSSP's medical care and service quality and compliance; and

c. (C) AssureEnsuring that all medical services performed by the CSSP are provided:

(i) wWithin each practitioner's scope of practice under Arkansas law; and

(ii) uUnder such supervision as required by law for practitioners not licensed to practice independently.;

(3) The medical director must ensure appropriate medical services are accessible twenty-four (24) hours a day, seven (7) days a week for all clients receiving home and community-based services available under Intensive CSSP Agency certification.

b. (4) If the medical director is not a licensed psychiatrist, then the medical director shallmust contact a consultingthe licensed psychiatrist contracted or employed by the CSSP within twenty-four (24) hours in the following situations:

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

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

(C)iii. When there is significanta client clinical deterioration or crisis withcausing enhanced risk of danger to selfthe client or others.

(b)

(1) Each CSSP with Intensive CSSP Agency Certification must employ or contract with a licensed psychiatrist certified by one of the specialties of the American Board of Medical Specialties to serve as a consultant to the medical director and other employees, as needed.

(2) If the medical director is certified by one of the specialties of the American Board of Medical Specialties, then a CSSP is not required to retain a second licensed psychiatrist.

(c)

(1) Each CSSP with Intensive CSSP Agency certification serving clients under the age of twenty-one (21) must employ or contract with a board-certified child psychiatrist to serve as a consultant to the CSSP medical director and other employees, as needed.

(2) If the medical director is a board-certified child psychiatrist, then a CSSP is not required to retain a second board-certified child psychiatrist.

(d)

(1) Each CSSP with Intensive CSSP Agency certification must employ or contract with a full-time 2. Cclinical Ddirector (or functional equivalent) who holds one (1) of the following State of Arkansas licenses or certifications(full-time position or full-time equivalent positions): The person or persons identified to carry out clinical director functions must:

(A) Psychologist;

(B) Certified Social Worker;

(C) Psychological Examiner – Independent;

(D) Professional Counselor;

(E) Marriage and Family Therapist ;

(F) Advanced Practice Nurse with:

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(i) A specialty in psychiatry or mental health; and

(ii) A minimum of two (2) years' clinical experience post master's degree; or

(G) Clinical Nurse Specialist with:

(i) A specialty in psychiatry or mental health; and

(ii) A minimum of two (2) years' clinical experience post master's degree.

(2) The clinical director is responsible for:

(A) ~~Be accountable for~~Oversight of all home and community-based services (professional and paraprofessional) conducted by a CSSP pursuant to its Intensive CSSP Agency certification~~that may be delivered by a CSSP Agency~~;

(B) ~~Be responsible for~~ Oversight of the CSSP's ~~Agency~~ care and service quality and compliance;

(C) ~~Assure~~Ensuring ~~that~~ all home and community-based services (professional and paraprofessional) conducted by a CSSP pursuant to its Intensive CSSP Agency certification are provided:

(i) ~~w~~Within each employee's or practitioner's scope of practice under Arkansas law; and

(ii) ~~u~~Under such supervision as required by law for employees and practitioners not licensed to practice independently;

(D) ~~Assure that~~Ensuring all licensed professionals ~~directly~~appropriately supervise the delivery of all home and community-based services in accordance with the client's treatment plan~~Qualified Community Support Staff in accordance with service provided;~~

~~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.~~

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~~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.~~

(e)

(1) A CSSP must assign a multidisciplinary team to each client receiving one (1) or more home and community-based services pursuant to its Intensive CSSP Agency certification.

(2) The multidisciplinary team is responsible for:

(A) The development of the client's treatment plan for those home and community-based services to be performed by the CSSP; and

(B) The CSSP's delivery of all home and community-based services included in client's treatment plan.

(3)

(A) Each multidisciplinary team must have a designated multidisciplinary team leader.

(B) Each multidisciplinary team leader must be a mental health professional (MHP).

(C) The designated

~~4.~~ ~~M~~multidisciplinary ~~T~~team ~~L~~leader ~~(Individual who has~~must have licensure and training applicable to the treatment of the ~~individual~~ client as indicated in the ~~individualized plan of care)~~ client's PCSP.

(D) Each multidisciplinary team leader is responsible for:

(i) Overseeing the ~~D~~development of the treatment plan for those home and community-based services to be performed by the CSSP ~~an individualized plan of care which directs the provision of services;~~

(ii) Monitoring ~~and supervise~~ the CSSP's delivery of all home and community-based services ~~contained~~included in the client's treatment plan~~individualized plan of care~~;

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Monitor and supervise work assignments of Certified Peer Specialists;

(iii) Provide d Directly supervisiong the CSSP employees performing the home and community-based services included in the client's treatment planof Qualified Community Support Staff ;

(iv) Provideing case consultation and in-service training to members of the multidisciplinary team, as needed.;

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.

901003. Behavioral Health Crisis Response Services.

(a) A CSSP must establish, implement, and maintain a site-specific crisis response plan for all CSSP owned, leased, or controlled locations at which the CSSP performs home and community-based services pursuant to its Intensive CSSP Agency certification.

(b) Each site-specific crisis response plan must include a twenty-four (24) hour emergency telephone number that provides for a:

(1) Direct access call with a mental health professional (MHP) within fifteen (15) minutes of an emergency/crisis;

(2) Face-to-face crisis assessment of a client within two (2) hours of an emergency/crisis (which may be conducted through telemedicine) unless a different time frame is within clinical standards guidelines and mutually agreed upon by the requesting party and the responding MHP; and

(3) Clinical review by the clinical director within twenty-four (24) hours of the emergency/crisis.

(c) A CSSP must:

(1) Provide the twenty-four (24)-hour emergency telephone number to all clients;

(2) Post the twenty-four (24)-hour emergency telephone number on all public entrances to each location; and

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(3) Include the twenty-four (24)-hour emergency telephone phone number on all answering machine greetings.

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)

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(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

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~~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.~~

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Subchapter 110. Enhanced CSSP EnhancedAgency Certification.

10101. Enhanced CSSP Enhanced Agency Certification Service Requirements.

A CSSP with Enhanced CSSP Agency Ccertification providing Therapeutic Communities, Residential Community Reintegration, Substance Abuse Detox and Complex Care Homes for IDD must meet all standards applicable to Base CSSP BaseAgency certification and Intensive CSSP Agency Ccertification in subchapters three (3) through ten (10) in addition to the requirements set out in this subchapter.

1102. Enhanced Certification Medical Director Requirements.

(a)

(1) Each CSSP with Enhanced CSSP Agency certification must always have its medical director on-site or on-call during hours of operation.

(2) An on-call medical director must respond:

(A) Within twenty (20) minutes of initial contact; and

(B) In-person if required by the circumstances.

(b) A CSSP must document each after-hours contact with a its medical director, including without limitation:

(1) The date and time the medical director was contacted;

(2) The date and time the medical director responded; and

(3) The date and time an on-call medical director came on-site when called in due to circumstances.

CSSP Enhanced Certification providing Adult Rehabilitation Day Treatment and Partial Hospitalization must meet all standards applicable to CSSP Base and Intensive Certification in addition to the requirements set out in this subchapter, except Section 1002 General Requirement, Section 1003 Specific Requirements (c), (d) (2) and (3), (e), and (f), and Section 1004 Settings Exceptions and Variations.

Subchapter 4. Facility Requirements.

1002. General Requirements.

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~~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 Agency Therapeutic Community or Community Reintegration Program can house no more than sixteen (16) clients.~~

~~(2) A CSSP Complex Care Home for IDD 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:~~

~~The interior of the facility 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;~~

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Lead-based paint; and

Hazardous materials.

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:

Roof;

Foundation;

Doors;

Windows;

Siding;

Porches;

Patios;

Walkways; and

Driveway.

The surrounding grounds of the facility 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 facility must immediately be either repaired or appropriately discarded off premises and replaced.

(b) CSSP owned or leased facilities 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;

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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;

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

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~~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:~~

~~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 facility 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 facility must have a shower or bathtub;~~

~~All toilets, bathtubs, and showers must provide for individual privacy; and~~

MARK-UP

~~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:~~

~~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 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:~~

~~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.~~

MARK-UP

A CSSP location may have secure units and non-secure units.

A CSSP location secure unit is also known as Therapeutic Communities, Level 1.

A CSSP location secure unit must have:

Physical and procedural safeguards appropriate based on the needs of all clients to ensure the safety of all clients and employees; and

Enough employees present in the CSSP location secure unit to ensure the safety of all residents and staff.

A CSSP may place a client in a CSSP location secure unit only if:

The client is subject to a court order of commitment to a secure facility; or

Placement is otherwise required in the client's ITP.

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.

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 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.

All food brought in from outside sources must be:

From food service providers approved by ADH and transported per ADH requirements;

In individual, commercially pre-packaged containers; or

Individual meals or snacks brought from home by a client or a client's family.

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.

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~~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.~~

~~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.~~

~~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.~~

~~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.~~

~~A CSSP must not use a perishable food item after its expiration date;~~

~~A CSSP must keep all food service surfaces clean and in sanitary condition.~~

~~A CSSP must serve all food on individual plates, bowls, or other dishes that can be sanitized or discarded.~~

~~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.~~

~~A CSSP must store all food separately from medications, medical items, or hazardous items.~~

~~A CSSP must ensure that all refrigerators used for food storage are maintained at a temperature of 41 degrees Fahrenheit or below.~~

~~A CSSP must ensure that all freezers used for food storage are maintained at a temperature of 0 degrees Fahrenheit or below.~~

~~1006. Licensed Medical Professional Requirement~~

~~(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:~~

MARK-UP

a. In-person or remotely 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 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.

1007. Medications.

A client can self-administer medication as provided in the client's ITP.

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.

A CSSP can administer medication only by licensed nurses or other health care professionals authorized to administer medication.

A CSSP cannot administer prescription medication to a client without a prescription documented in the client's service record.

A CSSP must develop a medication management plan for all clients, if applicable.

A medication management plan must include without limitation:

The name of each medication;

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

A description of each medication prescribed and any symptom or symptoms to be addressed by each medication;

MARK-UP

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

How each medication will be charted;

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

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.

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.

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:

The name and dosage of medication administered;

The symptom for which the medication was used to address;

The method the medication was administered;

The date and time the medication was administered;

The name of the employee who administered the medication or assisted in the administration of the medication;

Any adverse reaction or other side effect from the medication;

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

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

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.

Medication errors must be:

Immediately reported to a supervisor;

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Documented in the medication log; and

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

All medications stored for a client by a CSSP must be:

Kept in the original medication container unless the client's legal guardian or custodian transfers the medication into individual dosage containers;

Labeled with the client's name;

Stored in an area, medication cart, or container that is always locked; and

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.

A CSSP must store all medications requiring cold storage in a separate refrigerator that is used only for the purpose of storing medications.

1008. Daily Service Logs.

A CSSP must document daily the delivery of each home and community-based service provided to a client.

Documentation required may be satisfied by a daily service log or other documentation of home and community-based service delivery.

The daily service log or other documentation of home and community-based service delivery must include at least:

The specific home and community-based service provided;

The date each home and community-based service was provided by the CSSP;

The beginning and ending time each home and community-based service was provided by the CSSP;

The name, title, and credential of each person providing home and community-based service for each date and time;

The relationship of the home and community-based service to the treatment objectives described in the client's ITP; and

MARK-UP

Progress notes that describe each client's status and progress toward the client's treatment objectives.

Each daily service log entry must be signed by the employee responsible for the home and community-based service or services provided.

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 beneficiaryclient.

(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.

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(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)

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(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

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~~(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 beneficiaries~~clients~~.~~

~~(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 beneficiaries~~clients ~~for each vehicle each day listing the driver, other persons, and name, age, date of birth, and emergency contact information for all beneficiaries~~clients ~~that will be transported in that vehicle.~~

~~(A) The daily roster shall be used to check beneficiaries~~clients ~~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 beneficiaries~~clients ~~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 beneficiaries~~clients ~~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)~~

MARK-UP

(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.

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(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:

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(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.

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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:

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(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

MARK-UP

(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.

MARK-UP

(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.

MARK-UP

(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;

MARK-UP

(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).

MARK-UP

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:

MARK-UP

(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 beneficiariesclients;

(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 beneficiaryclient's health, safety, or well-being;

(4) Responsiveness in correcting non-compliance;

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

MARK-UP

(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)

MARK-UP

~~(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).~~

MARK-UP

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 beneficiaryclient with written notice of the closure;

ii. Provide the legal guardian or custodian of each beneficiaryclient with written referrals to at least three (3) other appropriate service providers;

iii. Assist each beneficiaryclient and his or her legal guardian or custodian in transferring services and copies of beneficiaryclient records to any new service providers;

iv. Assist each beneficiaryclient and his or her legal guardian or custodian in transitioning to new service providers; and

v. Arrange for the storage of beneficiaryclient 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 beneficiaryclient 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.

MARK-UP

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.~~

MARK-UP

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.

MARK-UP

~~(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.~~

MARK-UP

Rules for the Division of Medical Services

Licensure Manual for Community Support System Providers

PROPOSED

LAST UPDATED: January 1, 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.

(c) Providers certified and enrolled as a Base CSSP Agency or an Outpatient Behavioral Health Agency that meet the certification requirements of Intensive CSSP Agency certification or Enhanced CSSP Agency certification, can receive provisional Intensive CSSP Agency certification or Enhanced CSSP Agency certification until July 1, 2023, by executing a provisional certification attestation from DPSQA.

102. Purpose.

The purpose of these standards is to:

(1) Serve as the minimum standards for home and community-based services and facilities;

(2) Ensure there are providers of home and community-based services that serve the needs of clients, including clients with behavioral health, intellectual disability, and developmental disability service needs; and

(3) Allow a client to receive from one provider all home and community-based services identified in the client's individualized plan of care.

103. Definitions.

(a) "Adverse agency action" means:

(1) A denial of CSSP Agency certification;

(2) Any enforcement action taken by DPSQA pursuant to sections 703 through 707; and

(3) Any other adverse regulatory action or claim covered by the Medicaid Fairness Act, Ark. Code Ann §§ 20-77-1701 to -1718.

(b) "Applicant" means an applicant for a CSSP Agency Certification.

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

(d) "Approved accrediting organization" means:

(1) The Commission on Accreditation of Rehabilitation Facilities;

(2) The Joint Commission;

(3) The Council on Accreditation; and

(4) The Council on Quality and Leadership.

(e) "Base CSSP Agency certification" means a CSSP that has been certified by DPSQA to perform the following services each as defined in the Home and Community-Based Services for Clients with Intellectual Disabilities and Behavioral Health Needs Medicaid manual:

(1) Adult life skills development;

(2) Supportive Housing;

(3) Supportive Employment;

(4) Supportive Life Skills Development (individual and group);

(5) Respite;

(6) Supported Employment;

(7) Supportive Living;

(8) Specialized Medical Supplies;

(9) Adaptive Equipment;

(10) Community Transition Services;

(11) Consultation;

(12) Environmental Modifications;

(13) Supplemental Support;

PROPOSED

(14) Pharmacological Counseling; and

(15) Therapeutic Host Homes.

(f) "Client" means any person receiving or who has received one (1) or more home and community-based services from a CSSP.

(g) "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.

(h) "Complex care home" means a CSSP owned, leased, or controlled residential setting where each client residing in the home has been diagnosed with an intellectual or developmental 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.

(i) "CSSP" means an entity that:

(1) Has received CSSP Agency certification; and

(2) Is enrolled with DMS as a Community Support System provider.

(j) "CSSP Agency certification" means one of the following certifications issued by DPSQA

(1) Base CSSP Agency certification;

(2) Intensive CSSP Agency certification; or

(3) Enhanced CSSP Agency certification.

(k) "DHS" means the Arkansas Department of Human Services.

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

(1) Provides training to a CSSP to correct noncompliance with these standards;

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

PROPOSED

(3) Specifies the length of the training;

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

(5) Is approved by DPSQA.

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

(n) "DPSQA" means the Arkansas Department of Human Services, Division of Provider Services and Quality Assurance.

(o) "Employee" means an employee, owner, independent contractor, or other agent of a CSSP 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..

(p) "Enhanced CSSP Agency certification" means a CSSP that has been certified by DPSQA to perform:

(1) All services available under Base CSSP Agency certification;

(2) All services available under Intensive CSSP Agency certification;

(3) All services available under the Counseling Services Medicaid manual; and

(4) The following services each as defined in the Home and Community-Based Services for Clients with Intellectual Disabilities and Behavioral Health Needs Medicaid manual:

(A) Therapeutic Communities;

(B) Residential Community Reintegration;

(C) Adult Rehabilitation Day Treatment;

(D) Substance Abuse Detox (Observational);

(E) Partial Hospitalization; and

(F) Complex care homes.

(q) "Home and community-based services" means services that are available under the Home and Community-Based Services for Clients with Intellectual Disabilities and Behavioral Health Needs Medicaid manual.

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(r) "Intensive CSSP Agency certification" means a CSSP that has been certified by DPSQA to perform:

(1) All services available under Base CSSP Agency certification;

(2) All services available under the Counseling Services Medicaid manual; and

(3) The following services each as defined in the Home and Community-Based Services for Clients with Intellectual Disabilities and Behavioral Health Needs 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.

(s) "Licensed professional" means a person who holds an Arkansas professional license in good standing in Arkansas operating within the scope of practice of their license.

(t)

(1) "Market" means the accurate and honest advertisement of a CSSP 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 CSSP;

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

PROPOSED

(D) Mentioning services offered by a CSSP in which the client or their family might have an interest;

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

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

(1) The client cannot easily remove; and

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

(v) "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 dose of medication;

(6) Incorrect medications administered;,

(7) Incorrect dose of medication administered;

(8) Incorrect time of administration;

(9) Incorrect route of administration; and

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

(w) "Mental health professional" or "MHP" means a person who holds an Arkansas professional license in good standing to provide one or more of the services set out in the Counseling Services Medicaid manual.

(x) "Multidisciplinary team" means a team of employees lead by a mental health professional who are responsible for the development of a client's treatment plan and the delivery of all home and community-based services in accordance with the treatment plan.

(y) "PASSE" means a client's assigned Provider-led Arkansas Shared Savings Entity.

PROPOSED

(z) "PCSP" means a client's person-centered service plan, which is a written, individualized service and support plan developed by the client's PASSE care coordinator, which sets out the home and community-based services to be received by the client.

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

(1) Provides the steps a CSSP must take to correct noncompliance with these standards;

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

(3) Is approved by DPSQA.

(bb) "Provider" means an entity that is certified by DHS and enrolled by DMS as a CSSP.

(cc)

(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 restrain.

(2) "Restraint" does not include:

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

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

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

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

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

(1) May cause death;

(2) May result in substantial permanent impairment;

(3) Requires hospitalization; and

(4) Requires the attention of:

(A) An emergency medical technician;

PROPOSED

(B) A paramedic; or

(C) An emergency room

(gg)

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

(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 service provider;

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

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

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

(hh) "Treatment plan" means a CSSP's written, individualized service plan for a client, outlining the specific method, schedule, and goals for home and community-based service(s) delivery by the CSSP.

PROPOSED

Subchapter 2. Certification.

201. Certification Requirements.

(a) A CSSP must have one of the following certifications issued by DPSQA pursuant to these standards:

(1) Base CSSP Agency certification;

(2) Intensive CSSP Agency certification; or

(3) Enhanced CSSP Agency certification.

(b) A CSSP cannot provide services outside of the authority provided through its CSSP Agency certification without obtaining a separate credential to provide such services independent of its CSSP Agency certification.

(c) A CSSP must comply with all requirements of these standards for all home and community-based services included within its CSSP Agency certification.

(d) A CSSP must demonstrate accreditation 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 Agency certification.

(e) A CSSP must comply with all requirements of its accreditations.

(f) A loss of a CSSP Agency's accreditation constitutes a violation of these standards.

(g) In the event of a conflict between these standards and the requirements of a CSSP's accreditations, the stricter requirement shall apply.

(h) In the event of an irreconcilable conflict between these standards and the requirements of a CSSP's accreditations, these standards shall govern.

202. Application for CSSP Agency Certification.

(a) To apply for a CSSP Agency certification, an applicant must submit a complete application to DPSQA.

(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;

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

(3) Documentation of the employees that the applicant intends to use as part of operating the CSSP;

(4) Documentation of all drug screens and criminal background, maltreatment, and other registry checks and searches required pursuant to section 302(c);;

(5) Documentation demonstrating compliance with these standards; and

(6) All other documentation or other information requested by DPSQA.

203. Certification Process.

(a) DPSQA may approve an application for CSSP Agency certification and issue a CSSP Agency certification if:

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

(2) DPSQA determines that all employees have successfully passed all required drug screens and criminal background, maltreatment, and other registry checks and searches required pursuant to section 302(c); and

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

(b) DPSQA may approve an application to change the ownership of an existing CSSP and change the ownership of an existing CSSP Agency certification if:

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

(2) DPSQA determines that all employees and operators have successfully passed all drug screens and criminal background, maltreatment, and other registry checks and searches required pursuant to section 302(c); and

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

(c) A CSSP Agency certification does not expire until terminated under these standards.

PROPOSED

Subchapter 3. Administration.

301. Organization and Ownership.

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

(b)

(1) A CSSP 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) This manager must have authority over the CSSP and all 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) A CSSP cannot transfer its CSSP Agency certification to any person or entity.

(2) A CSSP cannot change its ownership unless DPSQA approves the application of the new ownership pursuant to sections 202 and 203.

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

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

PROPOSED

(b) A CSSP must meet the minimum staffing-to-client ratio for each client as provided in each client's treatment plan.

(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) At least a five (5) panel drug screen both prior to hiring and as required thereafter by Ark. Code Ann. §20-77-128(b); 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, criminal background and registry checks and searches prescribed in subsection (c)(1) of this part are not required for any licensed professional.

(d)

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

(2) Employees must have a:

(A) High school diploma; or

(B) A GED.

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

(f) A CSSP must document all scheduled and actual employee staffing, including without limitation employee names, job title or credential, shift role, shift days, and shift times.

PROPOSED

303. Employee Training.

(a) Prior to having any direct contact with clients, all employees must meet each of the following:

(1) Have at least one (1) year of experience working with persons with:

(A) Developmental disabilities; or

(B) Behavioral support needs; and

(2) Receive training on the following topics:

(A) The Health Insurance Portability and Accountability Act (HIPAA), and other applicable state and federal laws and regulations governing the protection of medical, social, personal, financial, and electronically stored records;

(B) Mandated reporter requirements and procedures;

(C) Incident and accident reporting;

(D) Basic health and safety practices;

(E) Infection control practices;

(F) Verbal intervention; and

(G) De-escalation techniques.

(b)

(1) All employees must receive client-specific training in the amount necessary to safely meet the client's individualized needs prior to providing services to those clients.

(2) Every employee's client-specific training must at a minimum must include training on the client's:

(A) Treatment plan;

(B) Diagnosis and medical records;

(C) Medication management plan, if applicable;

(D) Positive behavioral support plan, if applicable;

PROPOSED

(E) Behavioral prevention and intervention plan; if applicable;

(F) Permitted interventions; if applicable; and

(G) Setting-specific emergency and evacuation procedures.

(3)

(A) Appropriate client-specific training on the additional topics listed in (3)(B) below are required for employees performing home and community-based services:

(i) Available under Intensive CSSP Agency certification;

(ii) Available under Enhanced CSSP Agency certification;

(iii) In a complex care home; and

(iv) Available under the Counseling Services Medicaid manual.

(B)

(i) Home and community-based service record keeping;

(ii) Appropriate relationships with a client;

(iii) Group interaction;

(iv) Listening techniques;

(v) Confidentiality;

(vi) Community resources available to individuals within community settings;

(vii) Cultural competency;

(viii) Direct care ethics; and

(ix) Childhood development, if serving a child or adolescent client.

(c) All employees must receive appropriate refresher training on the topics listed in subsections 303(a)(2) and 303 (b) at least once every calendar year

PROPOSED

(d)

(1) All employees must obtain and maintain in good standing the following credentials when performing home and community-based services on behalf of a CSSP:

(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.

(e) A licensed professional is not required to receive the training prescribed in this section 303.

304. <u>Employee Records</u>.

(a) A CSSP 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;

(6) All required sex offender registry searches;

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

PROPOSED

(8) Copy of current state or federal identification;

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

(10) Documentation demonstrating that the employee received all required trainings and certifications;

(11) Documentation demonstrating that the employee obtained and maintained in good standing all professional licenses, certifications, or credentials required for the employee or the home and community-based service the employee is performing; and

(12) 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 must retain all employee personnel records for five (5) years from the date an employee ceases providing services to the CSSP 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 (5)-year period.

305. Client Service Records.

(a)

(1) A CSSP must maintain a separate, updated, and complete service record for each client documenting the home and community-based services provided to the client and all other documentation required under these standards.

(2) A CSSP 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;

PROPOSED

(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 appliable; and

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

(2) The date client begam receiving home and community-based services from the CSSP;

(3) The date client exited from the CSSP, if applicable;

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

(5) The name, address, and phone number of the client's primary care provider (PCP).

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

(1) Client PSCP;

(2) The treatment plan developed by CSSP for the client;

(3) All home and community-based service authorizations;

(4) Positive behavioral support plan, as applicable;

(5) Behavioral prevention and intervention plan, as applicable;

(6) Service logs or other documentation for each home and community-based service;

(7) Medication management plan, if applicable;

(8) Medication logs, if applicable;

PROPOSED

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

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

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

(d)

(1) A CSSP 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) The client's assigned PASSE;

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

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

(E) Any other individual authorized in writing by the client or, if applicable, the client's legal guardian.

(2)

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

(B)

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

(ii) A CSSP 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 CSSP's electronic records system.

(e) A CSSP must retain all client service records for five (5) years from the date the client last exits from the CSSP 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 (5)-year period.

306. <u>Marketing and Solicitation</u>.

PROPOSED

(a) A CSSP can market its services.

(b) A CSSP cannot solicit a client or his or her family.

307. <u>Third-party Service Agreements</u>.

(a) A CSSP may contract in writing with third-party vendors to provide services or otherwise satisfy requirements under these standards.

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

308. <u>Financial Safeguards</u>.

(a)

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

(2) A CSSP may not limit a client's use or access to a client's own funds or other assets, unless:

(A) The client or, if applicable, the client's legal guardian, provides informed written consent; or

(B) The CSSP otherwise has the legal authority.

(3) A CSSP is deemed to be limiting a client's use or access to the client's own funds 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 the client's funds or other assets.

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

(1)

(A) The client, or, if applicable, the client's legal guardian, provides informed written consent; or

(B) The CSSP otherwise has the legal authority.

PROPOSED

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

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

(5) 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.

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

(c)

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

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

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

(d)

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

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

309. <u>Infection Control</u>.

(a)

PROPOSED

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

(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) If applicable, a CSSP must notify a client's legal guardian if the client becomes ill.

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

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

(b)

(1) In the event of a conflict between these standards and other applicable local, state, or federal laws, rules, 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 laws, rules, or regulation these standards shall govern to the extent not governed by local, state, or federal law.

311. Restraints and Other Restrictive Interventions.

(a)

(1) A CSSP cannot use a restraint 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 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.

PROPOSED

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

(1) Comply with the use of the restraint as prescribed by the client's:

(A) Treatment plan;

(B) Behavioral prevention and intervention plan, if applicable; and

(C) Positive behavior support plan, if applicable;

(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.

312. 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, Arkansas Department of Health (ADH) requirements, and other applicable laws and regulations.

(2) In the event of a conflict between these standards and U.S. Department of Agriculture guidelines, ADH requirements, or other applicable laws or regulations related to nutrition and food service, the stricter requirement shall apply.

PROPOSED

(b) All pre-prepared food obtained or purchased by a CSSP from outside sources for client consumption must be:

(1) From restaurants and other food service providers approved by ADH and transported per ADH requirements; or

(2) In individual, commercially pre-packaged containers.

(c)

(1) A CSSP must ensure that food provided to clients meet 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 by an employee 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 ensure all surfaces used by employees to prepare or serve food to clients are clean and in sanitary condition.

(5) A CSSP must serve food to clients 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 refrigerators used for food storage are maintained at a temperature of forty-one (41) degrees Fahrenheit or below.

(B) A CSSP must ensure that freezers used for food storage are maintained at a temperature of zero (0) degrees Fahrenheit or below.

313. Medications.

(a)

PROPOSED

(1) A client, or, if applicable, the client's 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 CSSP can administer medication only as:

(A) Provided in the client's treatment plan; or

(B) Otherwise ordered by:

(i) A physician; or

(ii) Other health care professional authorized to prescribe or otherwise order the administration of medication.

(2) A CSSP must administer medication in accordance with the Nurse Practice Act and the Consumer Directed Care Act.

(c)

(1) A CSSP must develop a medication management plan for any prescribed medication and routinely administered over-the-counter medication that is not self-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 the symptom or symptoms to be addressed by each medication;

(D) How each medication will be administered, including without limitation time(s) of administration, dose(s), route of administration, and persons who may lawfully administer each medication;

PROPOSED

(E) A list of the most common potential side effects caused by each medication; and

(F) The consent to the administration of each medication by the client or, if applicable, the client's legal guardian.

(d)

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

(2) A medication log must be available at each location a client 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 route of medication administration;

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

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

(E) If an over-the-counter medication administered for a specific symptom, the specific symptom addressed and the effectiveness of the medication;

(F) Any adverse reaction or other side effect from the medication;

(G) Any transfer of medication by an employee that is not self-administered from its original container into individual dosage containers by the client, or, if applicable, the client's legal guardian;

(H) Any error in administering the medication; 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

PROPOSED

(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 CSSP must be:

(1) Kept in the original medication container unless the client, or, if applicable, the client's 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 CSSP is no longer to be administered to the client, then the medication must be:

(1) Returned to a client's legal guardian, if applicable;

(2) Destroyed; or

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

314. <u>Service Logs</u>.

(a)

(1) A CSSP must document the delivery of each home and community-based service to a client.

(2) The documentation requirement may be satisfied by a daily service log or other electronic or paper documenting method.

(b) The service log or other documentation of home and community-based service delivery by a CSSP must include at least:

(1) The specific home and community-based service performed;

(2) The date the home and community-based service was performed;

(3) The beginning and ending time of the home and community-based service;

(4) The name, title, and credential of each person performing the home and community-based service for each date and time;

PROPOSED

(5) The relationship of the home and community-based service to the goals and objectives described in the client's treatment plan; and

(6) Progress notes that describe each client's status and progress toward the client's goals and objectives.

(c)

(1) Each service log entry must be signed by the employee responsible for the performance of the home and community-based service.

(2) Each service log entry must be included in the client's service record.

315. <u>Behavioral Management Plans for IDD Clients</u>.

(a) The requirements of this section 315 apply only to clients with a diagnosed intellectual or developmental disability as defined in Ark. Code. Ann. § 20-48-101.

(b)

(1)

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

(B) A behavioral prevention and intervention plan must address:

(i) Behavior shaping and management to reduce inappropriate behaviors; and

(ii) How the client will safely remain residing in the community and avoid an acute placement.

(2)

(A) A CSSP must develop a positive behavioral support plan if a client's risk mitigation plan identifies the 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:

PROPOSED

(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.

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

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

(e)

(1) A CSSP 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:

PROPOSED

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

(ii) The duration of each intervention;

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

(iv) 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.

PROPOSED

Subchapter 4. Entries and Exits.

401. Request to Change Provider.

(a) A client or, if applicable, the client's legal guardian, may initiate a request to change their selected CSSP at any time by contacting their assigned PASSE care coordinator.

(c) If requested by DHS, the client, or, if applicable, the client's legal guardian, a CSSP will remain responsible for the delivery of home and community-based services until such time as the client's transition to the new CSSP is complete.

(d) A CSSP will remain responsible for the health, safety, and welfare of the client until all transitions to new service providers are complete.

402. Entries.

(a) A CSSP may enroll and provide those home and community-based services it is certified to delivery pursuant to its CSSP Agency certification to an eligible client.

(b) A CSSP must document the enrollment of all clients in its program.

403. Exits.

(a) A CSSP may exit a client:

(1) If the client becomes ineligible for home and community-based services;

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

(3) For any other lawful reason.

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

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

(1) Assisting the client in transferring to another CSSP 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 the CSSP is serving as the client's representative payee; and

PROPOSED

(3)

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

(i) The client;,

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

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

(B) Service records include:

(i) The client's treatment plan;

(ii) Medication logs; and

(iii) Any other records requested by the client in compliance with clinical discretion as allowed by law and accreditation.

PROPOSED

Subchapter 5. Settings Requirements.

501. Emergency Plans and Drills.

(a) A CSSP must have a written emergency plan for all CSSP owned, leased, or controlled locations at which the CSSP performs home and community-based services.

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

(1) Fire;

(2) Flood;

(3) Tornado;

(4) Utility disruption;

(5) Bomb threat;

(6) Active shooter; and

(7) Infectious disease outbreak.

(c) A CSSP must evaluate and update written emergency plans at least annually.

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

(1) Designated relocation sites and evacuation routes;

(2) Procedures for notifying legal guardians of relocation;

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

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

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

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

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

(e)

(1) A CSSP must conduct emergency fire drills at least once a month.

PROPOSED

(2) A CSSP must conduct all other emergency drills set out in subsection (d) at least annually.

(3) A CSSP must document all emergency drills which must include:

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

(B) The type of emergency drill;

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

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

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

502. <u>General CSSP Owned Service Setting Requirements</u>.

(a) Each CSSP owned, leased, or controlled home and community-based service setting must meet the home and community-based service setting regulations as established by 42 CFR 441.301(c) (4)-(5).

(b) All CSSP owned, leased, or controlled home and community-based service locations must meet the following requirements:

(1) The interior of the location 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 each bathroom, and, if applicable, kitchen;

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

(F) Be free of:

(i) Offensive odors;

(ii) Pests;

(iii) Lead-based paint; and

PROPOSED

(iv) Hazardous materials.

(2) The exterior of each CSSP owned, leased, or controlled home and community-based service location'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;

(I) Driveways; and

(J) Parking lots.

(3) The surrounding grounds of each CSSP owned, leased, or controlled home and community-based service location must be maintained in a safe, clean, and manicured condition free of trash and other objects.

(4) Broken equipment, furniture, and appliances on or about the premises of each CSSP owned, leased, or controlled home and community-based service location must be either immediately repaired or appropriately discarded off premises and replaced.

(c) CSSP owned, leased, or controlled home and community-based service locations 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;

PROPOSED

(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 provider (PCP); 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 location;

(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) 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;

PROPOSED

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

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

(d) Each bathroom in a CSSP owned, leased, or controlled home and community-based service location must have the following:

(1) Toilet;

(2) Sink with running hot and cold water;

(3) Toilet tissue;

(4) Liquid soap; and

(5) Towels or paper towels;

503. <u>Specific CSSP Owned Residential Settings Requirements</u>.

(a) Each CSSP owned, leased, or controlled home and community-based service residential setting must meet all the requirements of section 502 and this section 503.

(b)

(1) The following home and community-based service residential setting locations are limited to no more than sixteen (16) clients:

(A) Therapeutic Community; and

(B) Residential Community Reintegration.

(2) A home and community-based service residential setting that is a complex care home is limited to no more than eight (8) clients.

(3) Previously grandfathered group home locations continuously licensed by DDS since July 1, 1995, may continue to serve up to fourteen (14) unrelated adult clients with intellectual or developmental disabilities.

(4) CSSP owned, leased, or controlled home and community-based service residential settings that house at least one (1) client with an intellectual or development disability are limited to no more than four (4) clients.

(c) Each CSSP owned, leased, or controlled home and community-based service residential setting must provide each client with a bedroom that has:

PROPOSED

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

(A) A firm mattress that is:

(i) At least four (4) inches thick; and

(ii) Covered with moisture repellant material;

(B) Pillows; and

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

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

(A) Shelf space;

(B) Storage space for personal items; and

(C) 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) Each CSSP owned, leased, or controlled home and community-based service residential setting must meet the following bathroom requirements:

(1) At least one (1) bathroom must have a shower or bathtub;

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

(3) All toilets, bathtubs, and showers must be designed and installed in an accessible manner for clients.

(e) Each CSSP owned, leased, or controlled home and community-based service residential setting 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

PROPOSED

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

(f) Male and female clients cannot share a bedroom in a CSSP owned, leased, or controlled home and community-based service residential setting.

(g) Each CSSP owned, leased, or controlled home and community-based service residential setting must provide:

(1) A reasonably furnished living room;

(2) A reasonably furnished dining area; and

(3) A kitchen with equipment, utensils, and supplies necessary to properly store, prepare, and serve three (3) or more meals a day for up to one (1) week.

504. <u>CSSP Owned Residential Setting Exceptions and Variations</u>.

(a) Any client need or behavior that requires a variation or exception to the setting requirements set out in section 503 must be justified in the client's treatment plan.

(b) The justification for a variation or exception to any settings requirement 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, if applicable, the client's legal guardian; and

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

PROPOSED

Subchapter 6. Incident and Accident Reporting.

601. Incidents to be Reported.

A CSSP must report all alleged, suspected, observed, or reported occurrences of any of the following events while a client is receiving a home and community-based 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:

(A) Seclusion;

(B) A restraint;

(C) A chemical restraint; or

(D) A mechanical restraint;

(6) Any situation the whereabouts of a client are unknown for more than one (1) hour;

(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 admission 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

PROPOSED

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

602. 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 client;

(B) Serious injury to a client; 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 all reports to the client's assigned PASSE and to DPSQA through DPSQA's website: https://humanservices.arkansas.gov/about-dhs/dpsqa.

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

603. Notification to Legal Guardians.

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

(b) A CSSP should maintain documentation evidencing notification required in (a).

PROPOSED

Subchapter 7. Enforcement.

701. 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.

702. Written Notice of Enforcement Action.

(a) DPSQA shall provide written notice to a 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.

PROPOSED

703. Enforcement Actions.

(a)

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

(A) The CSSP is given written notice pursuant to section 702 and an opportunity to be heard pursuant to subchapter 9; or

(B) DPSQA determines that public health, safety, or welfare imperatively requires emergency action;

(2) If DPSQA imposes an enforcement action as an emergency action before the CSSP receives written notice and an opportunity to be heard pursuant to (a)(1), DPSQA shall:

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

(B) Allow the CSSP an opportunity to be heard pursuant to Subchapter 9.

(b) DPSQA may impose on a CSSP 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 CSSP Agency certification;

(7) Revocation of CSSP Agency certification; and

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

(c) DPSQA 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;

PROPOSED

(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 to appropriate agencies for investigation and further action.

(2) DPSQA 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 DPSQA may apply multiple actions simultaneously to a failure to comply with these standards.

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

704. <u>Moratorium</u>.

(a) DPSQA may prohibit a CSSP from accepting new clients.

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

705. <u>Transfer of Clients</u>.

(a) DPSQA may require a CSSP to transfer a client to another CSSP if DPSQA finds that the CSSP cannot adequately provide services to the client.

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

PROPOSED

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

706. 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.

707. Suspension and Revocation of CSSP Certification.

(a)

(1) DPSQA may temporarily suspend a CSSP Agency certification if the CSSP fails to comply with these standards.

(2) If a CSSP Agency certification is suspended, the CSSP must immediately stop providing services until DPSQA reinstates its certification

(b)

(1) DPSQA may permanently revoke a CSSP Agency certification if the CSSP fails to comply with these standards.

(2) If a CSSP Agency certification is revoked, the CSSP must immediately stop providing services and comply with the permanent closure requirements in section 801(a).

PROPOSED

Subchapter 8. Closure.

801. Closure.

(a)

(1) A CSSP Agency certification ends if a CSSP permanently closes, whether voluntarily or involuntarily, and is effective the date of the permanent closure as determined by DPSQA.

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

(A) Provide the client, or, if applicable, the client's legal guardian, with written notice of the closure;

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

(C) Assist each client and, if applicable, the client's legal guardian, in transferring services and copies of client records to any new service providers;

(D) Assist each client and, if applicable, the client's legal guardian, 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 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 Agency certification for up to one (1) year from the date of the request.

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

(3)

(A) 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.

PROPOSED

(B) 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.

(4)

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

(B) 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.

PROPOSED

Subchapter 9. Appeals.

901. 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 issue its determination to the CSSP using the address and contact information provided in the request for reconsideration.

PROPOSED

(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.

902. Appeal of Regulatory Actions.

(a)

(1) A CSSP may administratively appeal any adverse regulatory action covered 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.

PROPOSED

Subchapter 10. Intensive CSSP Agency Certification.

1001. Intensive CSSP Agency Certification Requirements.

(a) A CSSP with Intensive CSSP Agency certification must meet all standards applicable to Base CSSP Agency certification found in subchapters three (3) to nine (9), in addition to the requirements set out in this subchapter ten (10).

1002. Employee and Staffing Requirements.

(a)

(1) Each CSSP with Intensive CSSP Agency certification must employ or contract with a medical director who is a licensed physician in good standing with the Arkansas Medical Board.

(2) The medical director is responsible for:

(A) Oversight of all medical services performed by the CSSP;

(B) Oversight of the CSSP's medical care quality and compliance; and

(C) Ensuring all medical services performed by the CSSP are provided:

(i) Within each practitioner's scope of practice under Arkansas law; and

(ii) Under such supervision as required by law for practitioners not licensed to practice independently.

(3) The medical director must ensure appropriate medical services are accessible twenty-four (24) hours a day, seven (7) days a week for all clients receiving home and community-based services available under Intensive CSSP Agency certification.

(4) If the medical director is not a licensed psychiatrist, then the medical director must contact the licensed psychiatrist contracted or employed by the CSSP within twenty-four (24) hours in the following situations:

(A) When antipsychotic or stimulant medications are used in dosages higher than recommended in guidelines published by DMS;

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

PROPOSED

(C) When there is a client clinical deterioration or crisis causing risk of danger to the client or others.

(b)

(1) Each CSSP with Intensive CSSP Agency Certification must employ or contract with a licensed psychiatrist certified by one of the specialties of the American Board of Medical Specialties to serve as a consultant to the medical director and other employees, as needed.

(2) If the medical director is certified by one of the specialties of the American Board of Medical Specialties, then a CSSP is not required to retain a second licensed psychiatrist.

(c)

(1) Each CSSP with Intensive CSSP Agency certification serving clients under the age of twenty-one (21) must employ or contract with a board-certified child psychiatrist to serve as a consultant to the CSSP medical director and other employees, as needed.

(2) If the medical director is a board-certified child psychiatrist, then a CSSP is not required to retain a second board-certified child psychiatrist.

(d)

(1) Each CSSP with Intensive CSSP Agency certification must employ or contract with a full-time clinical director (or functional equivalent) who holds one (1) of the following State of Arkansas licenses or certifications:

(A) Psychologist;

(B) Certified Social Worker;

(C) Psychological Examiner – Independent;

(D) Professional Counselor;

(E) Marriage and Family Therapist ;

(F) Advanced Practice Nurse with:

(i) A specialty in psychiatry or mental health; and

PROPOSED

(ii) A minimum of two (2) years' clinical experience post master's degree; or

(G) Clinical Nurse Specialist with:

(i) A specialty in psychiatry or mental health; and

(ii) A minimum of two (2) years' clinical experience post master's degree.

(2) The clinical director is responsible for:

(A) Oversight of all home and community-based services (professional and paraprofessional) conducted by a CSSP pursuant to its Intensive CSSP Agency certification;

(B) Oversight of the CSSP's care and service quality and compliance;

(C) Ensuring all home and community-based services (professional and paraprofessional) conducted by a CSSP pursuant to its Intensive CSSP Agency certification are provided:

(i) Within each employee's or practitioner's scope of practice under Arkansas law; and

(ii) Under such supervision as required by law for employees and practitioners not licensed to practice independently;

(D) Ensuring all licensed professionals appropriately supervise the delivery of all home and community-based services in accordance with the client's treatment plan;

(e)

(1) A CSSP must assign a multidisciplinary team to each client receiving one (1) or more home and community-based services pursuant to its Intensive CSSP Agency certification.

(2) The multidisciplinary team is responsible for:

(A) The development of the client's treatment plan for those home and community-based services to be performed by the CSSP; and

(B) The CSSP's delivery of all home and community-based services included in client's treatment plan.

PROPOSED

(3)

(A) Each multidisciplinary team must have a designated multidisciplinary team leader.

(B) Each multidisciplinary team leader must be a mental health professional (MHP).

(C) The designated multidisciplinary team leader must have licensure and training applicable to the treatment of the client as indicated in the client's PCSP.

(D) Each multidisciplinary team leader is responsible for:

(i) Overseeing the development of the treatment plan for those home and community-based services to be performed by the CSSP;

(ii) Monitoring the CSSP's delivery of all home and community-based services included in the client's treatment plan;

(iii) Directly supervising the CSSP employees performing the home and community-based services included in the client's treatment plan;

(iv) Providing case consultation and in-service training to members of the multidisciplinary team, as needed.

1003. <u>Behavioral Health Crisis Response Services</u>.

(a) A CSSP must establish, implement, and maintain a site-specific crisis response plan for all CSSP owned, leased, or controlled locations at which the CSSP performs home and community-based services pursuant to its Intensive CSSP Agency certification.

(b) Each site-specific crisis response plan must include a twenty-four (24) hour emergency telephone number that provides for a:

(1) Direct access call with a mental health professional (MHP) within fifteen (15) minutes of an emergency/crisis;

(2) Face-to-face crisis assessment of a client within two (2) hours of an emergency/crisis (which may be conducted through telemedicine) unless a different time frame is within clinical standards guidelines and mutually agreed upon by the requesting party and the responding MHP; and

(3) Clinical review by the clinical director within twenty-four (24) hours of the emergency/crisis.

PROPOSED

(c) A CSSP must:

(1) Provide the twenty-four (24)-hour emergency telephone number to all clients;

(2) Post the twenty-four (24)-hour emergency telephone number on all public entrances to each location; and

(3) Include the twenty-four (24)-hour emergency telephone phone number on all answering machine greetings.

PROPOSED

Subchapter 11. Enhanced CSSP Agency Certification.

1101. Enhanced CSSP Agency Certification Requirements.

A CSSP with Enhanced CSSP Agency certification must meet all standards applicable to Base CSSP Agency certification and Intensive CSSP Agency certification in subchapters three (3) through ten (10) in addition to the requirements set out in this subchapter.

1102. Enhanced Certification Medical Director Requirements.

(a)

(1) Each CSSP with Enhanced CSSP Agency certification must always have its medical director on-site or on-call during hours of operation.

(2) An on-call medical director must respond:

(A) Within twenty (20) minutes of initial contact; and

(B) In-person if required by the circumstances.

(b) A CSSP must document each after-hours contact with a its medical director, including without limitation:

(1) The date and time the medical director was contacted;

(2) The date and time the medical director responded; and

(3) The date and time an on-call medical director came on-site when called in due to circumstances.

PROPOSED

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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.

MARK-UP

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

MARKUP

~~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~~

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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.

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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

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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

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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;

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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.

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~~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~~

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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.

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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.

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~~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.~~

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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 for providers enrolled in the Primary Care Case Management (PCCM) program and 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.~~

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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 PsychotherapyCounseling Services 10-13-031-1-23

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 servicesthem. 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/herthe physician's office, or the outpatient hospital or the nursing home. Psychotherapy Counseling codes may not be billed in conjunction with an office visit, ainpatient hospital visit, or inpatient psychiatric facility visit and may not be billed when services are performed in a community mental health clinicas 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 with the exception of the place of service codes. Place of service will be limited to the following place of service codes: Place of Service Code 22 Outpatient Hospital, 11 Doctor's Office and 12 Patient's Home. Any additional services provided by a psychiatrist enrolled in the physician's program will count against the sixteen (126) visits per State Fiscal Year physician benefit limit. Record Review is not covered.

292.741 Behavioral Health ScreenIndividual Medical Psychotherapy 7-1-071-1-23

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 standardized 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

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~~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.~~

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203.270 Physician's Role in Behavioral Health Services 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 Supervision in the Provision of Behavioral Health Counseling Services 1-1-23

The counseling procedures covered under the Physician Program are allowed as a covered service for providers enrolled in the Primary Care Case Management (PCCM) program and when provided by the physician or by a qualified practitioner authorized by State licensure to provide 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 supervision of a physician in the clinic that is billing for the services. For counseling services only, the term 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 supervision. The physician must be immediately available to 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.

PROPOSED

292.740 Counseling Services 1-1-23

The **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 them.

Counseling Services must be provided by a physician or qualified performing provider in the physician's office or the outpatient hospital. Counseling codes may not be billed in conjunction with an inpatient hospital visit, or inpatient psychiatric facility visit and may not be billed when services are performed as Medicaid Behavioral Health Counseling Services at another enrolled Arkansas Medicaid provider type site. Only one (1) counseling visit per day is allowed in the physician's office, the outpatient hospital, or nursing home. 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 with the exception of the place of service codes. Place of service will be limited to the following place of service codes: Place of Service Code 22 Outpatient Hospital, 11 Doctor's Office and 12 Patient's Home. Any additional services provided by a psychiatrist enrolled in the physician's program will count against the sixteen (16) visits per State Fiscal Year physician benefit limit. Record Review is not covered.

292.741 Behavioral Health Screen 1-1-23

A physician, physician's assistant, or advanced nurse practitioner may administer a brief standardized 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.

PROPOSED

SECTION – ~~OUTPATIENT BEHAVIORAL HEALTH~~ COUNSELING SERVICES

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200.000 OUTPATIENT BEHAVIORAL HEALTHCOUNSELING SERVICES GENERAL INFORMATION

201.000 Introduction 3-1-191-1-23

Medicaid (Medical Assistance) is designed to assist eligible Medicaid beneficiarieclients 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 beneficiariesclients by enrolled providers.

Outpatient Behavioral HealthCounseling Services may be provided to eligible Medicaid beneficiariesclients 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 HealthCounseling Services 3-1-191-1-23

All behavioral health providers approved to receive Medicaid reimbursement for services to Medicaid beneficiariesclients 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.~~

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~~202.200 Providers with Multiple Sites~~ ~~7-1-17~~

~~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.~~

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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 or	Required

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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)	contracted by a certified Behavioral Health Agency, Community Support System Agency, or certified by the Dept. of Education as a school-based mental health provider	
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 PhysicianMust be employed or contracted by a certified Behavioral Health Agency, or Community Support System Agency	Collaborative Agreement with Physician Required
Physician	Doctor of Medicine (MD) Doctor of Osteopathic Medicine (DO)	No, must provide proof of licensureMust be employed or contracted by a certified Behavioral Health Agency, or Community Support	Not Required

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PROVIDER TYPE	LICENSES	STATE CERTIFICATION REQUIRED	SUPERVISION
		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

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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 Counseling Level Services, the provider must document medical necessity of Outpatient Behavioral Health Counseling Services. The documentation of medical necessity is a written intake assessment that evaluates the beneficiary's mental condition and, based on the beneficiary's diagnosis, determines whether treatment in the Outpatient Behavioral Health Services Program is appropriate. This documentation must be made part of the beneficiary's medical record.~~

The intake assessment, either the Mental Health Diagnosis, 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.

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

View or print the procedure codes for ~~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.~~

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214.100 Parent/Caregiver & Child (Dyadic treatment of Children age 0-47 months & Parent/Caregiver) 3-1-191-1-23

Outpatient Behavioral HealthCounseling Services Pproviders may provide dyadic treatment of beneficiaryclients age zero through forty-seven (0-47) months and the parent/caregiver of the eligible beneficiaryclient. 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 HealthCounseling 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: 0-3Rmost 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 VZ 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 9-1-201-1-23

Effective for dates of service on and after September 1, 2020, Medication Assisted Treatment for Opioid Use Disorders is available to all qualifying Medicaid beneficiariesclients 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 6-1-221-1-23

Each beneficiaryclient that receives only Ccounseling Level Sservices in the Outpatient Behavioral HealthCounseling Services program can receive a limited amount of Ccounseling Level Sservices. 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 beneficiaryclient's medical record.

A beneficiaryclient can receive ten (10) cCounseling 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 beneficiaryclient's medical record.

The Patient Centered Medical Home (PCMH) will be responsible for coordinating care with a beneficiaryclient's PCP or physician for Ccounseling Level Sservices. Medical responsibility for beneficiariesclients receiving Ccounseling Level Sservices shall be vested in a physician licensed in Arkansas.

The PCP referral or PCMH authorization for Ccounseling Level Sservices will serve as the prescription for those services.

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Verbal referrals from PCPs or PCMHs are acceptable to Medicaid as long as they are documented in the beneficiaryclient'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 BeneficiaryClient Services 7-1-171-1-23

For services that are not reimbursed on a per diem or per encounter rate, Medicaid has established daily benefit limits for all services. BeneficiariesClients will be limited to a maximum of eight (8) hours per twenty-four (24) hour day of Outpatient Behavioral HealthCounseling Services. BeneficiariesClients 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 3-1-191-1-23

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 3-1-191-1-23

Services not covered under the Outpatient Behavioral HealthCounseling 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 beneficiaryclient for services **(reimbursement for other Outpatient Behavioral HealthCounseling sServices is not allowed for the period of time the Medicaid beneficiaryclient 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 3-1-191-1-23

Certified Counseling Level Sservices providers aremust have relationships with a physician licensed in Arkansas responsible for communication with the client's primary care physician in order to ensure psychiatric and medical conditions are monitored and addressed by appropriate physician oversight and that medication evaluation and prescription services are available to individuals requiring pharmacological management.

Medical supervision responsibility shall include, but is not limited to, the following:

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

~~D~~C. Contain ~~O~~original signature, name, and credentials of the person, who provided the services~~, if different from authorizing professional~~

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

~~G~~F. Contain ~~U~~updates describing the patient's progress

~~H~~G. 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.~~ Th~~e~~is approval by the PCP or PCMH will serve as the prescription

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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 ~~o~~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~~

MARK-UP

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

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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

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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.

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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.

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229.200 Recoupment Process 7-1-171-1-23

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 beneficiaryclient 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 7-1-171-1-23

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

231.100 Prior Authorization 2-1-221-1-23

Prior Authorization is required for certain Outpatient Behavioral HealthCounseling Services provided to Medicaid-eligible beneficiariesclients 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 7-1-171-1-23

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 beneficiaryclient 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 beneficiariesclients. **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

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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 beneficiaryclient. There is no "carryover" of time from one day to another or from one beneficiaryclient to another.

Documentation in the beneficiaryclient'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 beneficiaryclient 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 3-1-191-1-23

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 7-1-171-1-23

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

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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

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	Psychotherapy, 60 min
SERVICE DESCRIPTION	**MINIMUM DOCUMENTATION REQUIREMENTS**
Individual Behavioral Health Counseling is a face-to-face treatment provided to an individual in an outpatient setting for the purpose of treatment and remediation of a condition as described in the current allowable DSM. The treatment service must reduce or alleviate identified symptoms related to either (a) Mental Health or (b) Substance Abuse condition, 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~~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

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	Health Counseling, unless prior to an extension of benefits is allowedapproved 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 beneficiariesclients 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 2-1-221-1-23

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 beneficiariesclients. Services leverage the emotional interactions of the group's members to assist in each beneficiaryclient's treatment process, support their rehabilitation effort, and to minimize relapse. Services pertain to a beneficiaryclient's (a) Mental Health or (b) Substance Abuse condition, or both.	• Date of Service • Start and stop times of actual group encounter that includes identified beneficiaryclient • Place of service • Number of participants • Diagnosis and pertinent interval history

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<table>
<tr><td>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.</td><td colspan="2">• Focus of group
• Brief mental status and observations
• Rationale for group counseling must coincide with the most recent intake~~Mental Health 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>
</table>

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Face-to-face Telemedicine (Adults, eighteen (18) years of age and above)	Counseling
ALLOWABLE PERFORMING PROVIDERS	**PLACE OF SERVICE**
• Independently Licensed Clinicians – Master's/Doctoral • Non-independently Licensed Clinicians – Master's/Doctoral • Licensed Alcoholism and Drug Abuse Counselor Master's • Advanced Practice Nurses • Physicians	02 (Telemedicine), 03 (School), 10 (Telehealth Provided in Client's Home), 11 (Office), 49 (Independent Clinic), 49 (Independent Clinic), 50 (Federally Qualified Health Center), 53 (Community Mental Health Center), 57 (Non-Residential Substances Abuse Treatment Facility), 71 (Public Health Clinic), 72 (Rural Health Clinic)

252.113 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**	• 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

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involves improving the parent-child relationship by transforming the interaction between the two parties. The primary goal of Dyadic Infant/Parent Psychotherapy is to strengthen the relationship between a child and his or her parent (or caregiver) as a vehicle for restoring the child's sense of safety, attachment, and appropriate affect and improving the child's cognitive, behavioral, and social functioning. This service uses child directed interaction to promote interaction between the parent and the child in a playful manner. Providers must utilize a nationally recognized evidence-based practice. Practices include, but are not limited to, Child-Parent 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.**	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 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

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	is allowed by the Quality Improvement Organization contracted with Arkansas Medicaid. **The following codeservices cannot be billed on the Same Date of Service:** Multi-Family Behavioral Health Counseling Marital/Family Behavioral Health Counseling without BeneficiaryClient 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 BeneficiaryClient Present 2-1-221-1-23

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**

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<table>
<tr>
<td>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, 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.</td>
<td colspan="2">• Date of Service
• Start and stop times of actual encounter with spouse/family
• Place of service
• 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</td>
</tr>
<tr>
<th>NOTES</th>
<th>UNIT</th>
<th>BENEFIT LIMITS</th>
</tr>
<tr>
<td>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.</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 Beneficiaries:~~ Twelve (12) encounters</td>
</tr>
<tr>
<th>APPLICABLE POPULATIONS</th>
<th colspan="2">SPECIAL BILLING INSTRUCTIONS</th>
</tr>
<tr>
<td>Children, Youth, and Adults</td>
<td colspan="2">A provider can only bill one (1) Marital/Family Behavioral Health Counseling with (or without)</td>
</tr>
</table>

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	~~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**

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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 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.**	• Date of Service • Start and stop times of actual encounter with ~~beneficiary~~client and spouse/family • 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~~services cannot be billed on the Same Date of Service:** Marital/Family Behavioral Health Counseling with

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	~~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)

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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.**

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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

2-1-221-1-23

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 beneficiaryclient, client-centered, and strength-based; with emphasis on needs as identified by the beneficiaryclient and provided with cultural competence.	• Date of Service • Start and stop times of the face-to-face encounter with the beneficiaryclient 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

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NOTES	UNIT	BENEFIT LIMITS
This service may be billed for face-to-face contact as well as for time spent obtaining necessary information for diagnostic purposes; however, this time may NOT be used for development or submission of required 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

MARK-UP

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)

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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 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:**	

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	Psychoeducation Psychiatric Assessment Multi-Family Behavioral Health Counseling Substance Abuse Assessment **View or print the procedure codes for OBHScounseling services.** This service can be provided via telemedicine to beneficiariesclients eighteen (18) years of age and above. This service can also be provided via telemedicine to beneficiariesclients 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 2-1-221-1-23

CPT®/HCPCS PROCEDURE CODE	PROCEDURE CODE DESCRIPTION

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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

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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)

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• 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)	

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252.121 Pharmacologic Management 2-1-221-1-23

CPT®/HCPCS PROCEDURE CODE	PROCEDURE CODE DESCRIPTION
View or print the procedure codes for OBHScounseling 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

<table>
<tr><td></td><td colspan="2">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.</td></tr>
<tr><td>**SERVICE DESCRIPTION**</td><td colspan="2">**MINIMUM DOCUMENTATION REQUIREMENTS**</td></tr>
<tr><td>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.</td><td colspan="2">• 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, 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</td></tr>
<tr><td>**NOTES**</td><td>**UNIT**</td><td>**BENEFIT LIMITS**</td></tr>
<tr><td>Applies only to medications prescribed to address targeted symptoms as identified in the Psychiatric Assessment.</td><td>Encounter</td><td>DAILY MAXIMUM OF ENCOUNTERS THAT MAY BE BILLED: One (1)

YEARLY MAXIMUM OF ENCOUNTERS</td></tr>
</table>

MARK-UP

		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)

MARK-UP

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></td><td colspan="2">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><th>NOTES</th><th>UNIT</th><th>BENEFIT LIMITS</th></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><th>APPLICABLE POPULATIONS</th><th colspan="2">SPECIAL BILLING INSTRUCTIONS</th></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><th>ALLOWED MODE(S) OF DELIVERY</th><th colspan="2">TIER</th></tr>
</table>

MARK-UP

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)

MARK-UP

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

<table>
<tr><td></td><td colspan="2">based on an individualized plan of care including assessment, counseling, crisis intervention, activity therapies or education.</td></tr>
<tr><th>SERVICE DESCRIPTION</th><th colspan="2">MINIMUM DOCUMENTATION REQUIREMENTS</th></tr>
<tr><td>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.</td><td colspan="2">• 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)</td></tr>
<tr><th>NOTES</th><th>UNIT</th><th>BENEFIT LIMITS</th></tr>
<tr><td></td><td>Per Diem</td><td>YEARLY MAXIMUM OF UNITS THAT MAY BE BILLED: (extension of benefits can be requested) Twenty-four (24)</td></tr>
<tr><th>APPLICABLE POPULATIONS</th><th colspan="2">SPECIAL BILLING INSTRUCTIONS</th></tr>
<tr><td>Adults and Youth</td><td colspan="2">A provider may not bill for any other service on the same date of service.</td></tr>
<tr><th>ALLOWED MODE(S) OF DELIVERY</th><th colspan="2">TIER</th></tr>
<tr><td>Face-to-face</td><td colspan="2">Counseling</td></tr>
<tr><th>ALLOWABLE PERFORMING PROVIDERS</th><th colspan="2">PLACE OF SERVICE</th></tr>
<tr><td>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.</td><td colspan="2">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),</td></tr>
</table>

MARK-UP

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**	

MARK-UP

Face-to-face Telemedicine (Adults, Youth, and Children)	Crisis
ALLOWABLE PERFORMING PROVIDERS	**PLACE OF SERVICE**
• Independently Licensed Clinicians – Master's/Doctoral • Non-independently Licensed Clinicians – Master's/Doctoral • Licensed Alcoholism and Drug Abuse Counselor Master's • Advanced Practice Nurses • Physicians	02 (Telemedicine) 03 (School), 04 (Homeless Shelter), 10 (Telehealth Provided in Client's Home), 11 (Office) 12 (Patient's Home), 15 (Mobile Unit), 23 (Emergency Room), 33 (Custodial Care facility), 49 (Independent Clinic), 50 (Federally Qualified Health Center), 53 (Community Mental Health Center), 57(Non-Residential Substance Abuse Treatment Facility), 71 (Public Health Clinic), 72 (Rural Health Clinic), 99 (Other Location)

255.001 Crisis Intervention

~~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**

MARK-UP

<table>
<tr><td>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. No PCP referral is required for crisis intervention

The provider of this service MUST complete a Mental Health Diagnosis within seven (7) days of provision of this service, if provided to a ~~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.</td><td>Fifteen (15) minutes</td><td>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)</td></tr>
<tr><th>APPLICABLE POPULATIONS</th><th colspan="2">SPECIAL BILLING INSTRUCTIONS</th></tr>
<tr><td>Children, Youth, and Adults</td><td colspan="2"></td></tr>
<tr><th>ALLOWED MODE(S) OF DELIVERY</th><th colspan="2">TIER</th></tr>
<tr><td>Face-to-face

Telemedicine (Adults, Youth, and Children)</td><td colspan="2">Crisis</td></tr>
<tr><th>ALLOWABLE PERFORMING PROVIDERS</th><th colspan="2">PLACE OF SERVICE</th></tr>
<tr><td>• Independently Licensed Clinicians – Master's/Doctoral
• Non-independently Licensed Clinicians – Master's/Doctoral ~~(must be employed by Behavioral Health Agency)~~
• Advanced Practice Nurses
• Physicians ~~(must be employed by Behavioral Health Agency)~~</td><td colspan="2">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)</td></tr>
</table>

MARK-UP

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~~r~~fits required for additional days •

MARK-UP

	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)

MARKUP

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 8-1-181-1-23

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
Federally Qualified Health Center	50
Community Mental Health Center	53

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~~Place of Service~~	~~POS Codes~~
~~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).
CITY	Name of the city in which the ~~beneficiary~~client or participant resides.

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Field Name and Number	Instructions for Completion
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.
11. INSURED'S POLICY GROUP OR FECA NUMBER	Not required when Medicaid is the only payer.

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Field Name and Number	Instructions for Completion
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.

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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.

MARK-UP

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.

MARK-UP

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

SECTION –COUNSELING SERVICES

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200.000 COUNSELING SERVICES GENERAL INFORMATION

201.000 Introduction 1-1-23

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

Counseling Services may be provided to eligible Medicaid 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 Counseling Services 1-1-23

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

Providers must meet the Provider Participation and enrollment requirements contained within Section 140.000 of this manual as well as the following criteria to be eligible to participate in the Arkansas Medicaid Program:

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

B. Must be certified by the Divisions of Provider Services and Quality Assurance (DPSQA) 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)

PROPOSED

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.

210.000 PROGRAM COVERAGE

211.000 Coverage of Services 1-1-23

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

An Counseling Services providers must establish an emergency response plan. Each provider must have 24-hour emergency response capability to meet the emergency treatment needs of the Counseling Services clients served by the provider. The provider must implement and maintain a written policy reflecting the specific coverage plan to meet this requirement. A machine recorded voice mail message to call 911 or report to the nearest emergency room in and of itself is not sufficient to meet the requirement.

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

211.200 Staff Requirements 1-1-23

Each Counseling Services provider must ensure that they employ staff which are able and available to provide appropriate and adequate services offered by the provider. Counseling Services staff members must provide services only within the scope of their individual licensure.

PROPOSED

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 Certified Social Worker (LCSW) Licensed Marital and Family Therapist (LMFT) Licensed Psychologist (LP) Licensed Psychological Examiner – Independent (LPEI) Licensed Professional Counselor (LPC)	Yes, must be licensed through the relevant licensing board to provide services	Not Required
Non-independently Licensed Clinicians – Master's/Doctoral	Licensed Master Social Worker (LMSW) Licensed Associate Marital and Family Therapist (LAMFT) Licensed Associate Counselor (LAC) Licensed Psychological Examiner (LPE) Provisionally Licensed Psychologist (PLP) Provisionally Licensed Master Social Worker (PLMSW)	Yes, must be licensed through the relevant licensing board to provide services and be employed or contracted by a certified Behavioral Health Agency, Community Support System Agency, or certified by the Dept. of Education as a school-based mental health provider	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	Must be employed or contracted by a certified Behavioral Health Agency, or Community Support System Agency	Collaborative Agreement with Physician Required

PROPOSED

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

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

When a Counseling Services provider files a claim with Arkansas Medicaid, the staff member who actually performed the service must be identified on the claim as the rendering provider. This action is taken in compliance with the federal Improper Payments Information Act of 2002 (IPIA), Public Law 107-300, and the resulting Payment Error Rate Measurement (PERM) program initiated by the Centers for Medicare and Medicaid Services (CMS).

211.300 Certification of Performing Providers 1-1-23

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

211.400 Facility Requirements 1-1-23

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

211.500 Non-Refusal Requirement 1-1-23

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

PROPOSED

212.000 Scope 1-1-23

The Counseling Services Program provides treatment and services which are provided by a certified Behavioral Health Services provider to Medicaid-eligible 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 client. Counseling services and Crisis Services can be provided to any client as long as the services are medically necessary

COUNSELING SERVICES

Time-limited behavioral health services provided by qualified licensed practitioners in an allowable setting for the purpose of assessing and treating mental health and/or substance abuse conditions. Counseling Services settings shall mean a behavioral health clinic/office, healthcare center, physician office, child advocacy center, home, shelter, group home, and/or school.

213.000 Counseling Services Program Entry 1-1-23

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

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

View or print the procedure codes for counseling services.

213.100 Independent Assessment Referral 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 Services 1-1-23

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

214.100 Parent/Caregiver & Child (Dyadic treatment of Children age 0-47 months & Parent/Caregiver) 1-1-23

Counseling Services providers may provide dyadic treatment of clients age zero through forty-seven (0-47) months and the parent/caregiver of the eligible client. A prior authorization will be required for all dyadic treatment services (the Mental Health Diagnosis and Interpretation of Diagnosis DO NOT require a prior authorization). All performing providers of parent/caregiver and child Counseling Services MUST be certified by DAABHS to provide those services.

Providers will diagnose children through the age of forty-seven (47) months based on the most current version of the Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood. Providers will then crosswalk the diagnosis to a DMS diagnosis.

PROPOSED

Specified Z and T codes and conditions that may be the focus of clinical attention according to DSM 5 or subsequent editions will be allowable for this population.

214.200 Medication Assisted Treatment and Opioid Use Disorder Treatment Drugs 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 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 1-1-23

Each client that receives counseling services in the Counseling Services program can receive a limited amount of counseling services. Once those limits are reached, a Primary Care Physician (PCP) referral or PCMH approval will be necessary to continue treatment. This referral or approval must be retained in the client's medical record.

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

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

The PCP referral or PCMH authorization for counseling services will serve as the prescription for those services.

Verbal referrals from PCPs or PCMHs are acceptable to Medicaid as long as they are documented in the client's chart as described in Section 171.410.

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

219.110 Daily Limit of Client Services 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. Clients will be limited to a maximum of eight (8) hours per twenty-four (24) hour day of Counseling Services. 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 1-1-23

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

223.000 Exclusions 1-1-23

PROPOSED

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

A. Room and board residential costs

B. Educational services

C. Telephone contacts with patient

D. Transportation services, including time spent transporting a client for services **(reimbursement for other Counseling Services is not allowed for the period of time the Medicaid client is in transport)**

E. Services to individuals with developmental disabilities that are non-behavioral health in nature

F. Services which are found not to be medically necessary

G. Services provided to nursing home and ICF/IDD residents other than those specified in the applicable populations sections of the service definitions in this manual

224.000 Physician's Role 1-1-23

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

225.000 Diagnosis and Clinical Impression 1-1-23

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

226.000 Documentation/Record Keeping Requirements

226.100 Documentation 1-1-23

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

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

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

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

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

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

F. Contain updates describing the patient's progress

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

PROPOSED

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 Counseling Services 1-1-23

The approval by the PCP or PCMH will serve as the prescription for counseling services in the Counseling Services program. Please see Section 217.100 for limits. Medicaid will not cover any service outside of the established limits without a current prescription signed by the PCP or PCMH.

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

228.000 Provider Reviews 1-1-23

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

228.130 Retrospective Reviews 1-1-23

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 counseling services provided by Counseling Services providers. **View or print current contractor contact information.**

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

228.131 Purpose of the Review 1-1-23

The purpose of the review is to:

A. Ensure that services are delivered in accordance with the counselor's 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 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 1-1-23

On a calendar quarterly basis, the contractor will select a statistically valid random sample from an electronic data set of all Counseling Services clients whose dates of service occurred during the three (3) -month selection period. If a 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

PROPOSED

alternate client will be substituted. The utilization review process will be conducted in accordance with 42 CFR § 456.23.

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

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

228.133 Review Process 1-1-23

The record will be reviewed using a review tool based upon the promulgated Medicaid Counseling Services manual. The review tool is designed to facilitate review of regulatory compliance, incomplete documentation and medical necessity. All reviewers must have a professional license in therapy (LP, LCSW, LMSW, LPE, LPE-I, LPC, LAC, LMFT, LAMFT, etc.). The reviewer will screen the record to determine whether complete information was submitted for review. If it is determined that all requested information was submitted, then the reviewer will review the documentation in more detail to determine whether it meets medical necessity criteria based upon the reviewer's professional judgment.

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

The reviewer will also 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 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 Client Appeal Process 1-1-23

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

The appeal request must be in writing and received by the Appeals and Hearings Section 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 1-1-23

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

PROPOSED

229.200 Recoupment Process 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 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 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 1-1-23

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

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

View or print procedure codes that require prior authorization for Counseling Services

231.200 Extension of Benefits 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 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 clients. **View or print current contractor contact information.** Information related to clinical management guidelines and authorization request processes is available at **current contractor's website**.

240.000 REIMBURSEMENT

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

A. Counseling Services

Fifteen (15) -Minute Units, unless otherwise stated

PROPOSED

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

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

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

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

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

241.000 Fee Schedule 1-1-23

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.

PROPOSED

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

242.000 Rate Appeal Process 1-1-23

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 1-1-23

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

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

252.000 CMS-1500 Billing Procedures

252.100 Procedure Codes for Types of Covered Services 1-1-23

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

The allowable services differ by the age of the 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 1-1-23

PROPOSED

<table>
<tr><th>CPT®/HCPCS PROCEDURE CODE</th><th colspan="2">PROCEDURE CODE DESCRIPTION</th></tr>
<tr><td>View or print the procedure codes for counseling services.</td><td colspan="2">Psychotherapy, 30 min
Psychotherapy, 45 min
Psychotherapy, 60 min</td></tr>
<tr><th>SERVICE DESCRIPTION</th><th colspan="2">MINIMUM DOCUMENTATION REQUIREMENTS</th></tr>
<tr><td>Individual Behavioral Health Counseling is a face-to-face treatment provided to an individual in an outpatient setting for the purpose of treatment and remediation of a condition as described in the current allowable DSM. The treatment service must reduce or alleviate identified symptoms related to either (a) Mental Health or (b) Substance Abuse condition, and maintain or improve level of functioning, and/or prevent deterioration. Additionally, tobacco cessation counseling is a component of this service.</td><td colspan="2">• Date of Service
• Start and stop times of face-to-face encounter with 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
• 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</td></tr>
<tr><th>NOTES</th><th>UNIT</th><th>BENEFIT LIMITS</th></tr>
<tr><td>Services provided must be congruent with the objectives and interventions articulated on the most recent intake assessment. Services must be consistent with established behavioral healthcare standards. Individual Psychotherapy is not permitted with clients who do not have the cognitive ability to benefit from the service.

This service is not for clients under four (4) years of age except in documented exceptional cases. This service will require a Prior Authorization for clients four (4) years of age.</td><td>30 minutes
45 minutes
60 minutes
View or print the procedure codes for counseling services.</td><td>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):
Twelve (12) encounters between all three (3) codes</td></tr>
<tr><th>APPLICABLE POPULATIONS</th><th colspan="2">SPECIAL BILLING INSTRUCTIONS</th></tr>
<tr><td>Children, Youth, and Adults
Residents of Long-Term Care Facilities</td><td colspan="2">A provider may only bill one (1) Individual Behavioral Health Counseling Code per day per client. A provider cannot bill any other Individual Behavioral Health Counseling Code on the same date of service for the same client. There are twelve (12) total individual counseling encounters allowed per year regardless of code billed for</td></tr>
</table>

PROPOSED

	Individual Behavioral Health Counseling, unless prior to an extension of benefits 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 clients under four (4) years of age must be trained and certified in specific evidence-based practices to be reimbursed for those services
  o 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
  o 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)

PROPOSED

252.112 Group Behavioral Health Counseling 1-1-23

CPT®/HCPCS PROCEDURE CODE	PROCEDURE CODE DESCRIPTION
View or print the procedure codes for counseling services.	Group psychotherapy (other than of a multiple-family group)
SERVICE DESCRIPTION	**MINIMUM DOCUMENTATION REQUIREMENTS**
Group Behavioral Health Counseling is a face-to-face treatment provided to a group of clients. Services leverage the emotional interactions of the group's members to assist in each client's treatment process, support their rehabilitation effort, and to minimize relapse. Services pertain to a client's (a) Mental Health or (b) Substance Abuse condition, or both. Additionally, tobacco cessation counseling is a component of this	• Date of Service • Start and stop times of actual group encounter that includes identified client • Place of service • Number of participants • Diagnosis and pertinent interval history • Focus of group

service. Services must be congruent with the age and abilities of the client, client-centered, and strength-based; with emphasis on needs as identified by the client and provided with cultural competence.	• Brief mental status and observations • Rationale for group counseling must coincide with the most recent intake assessment • Client's response to the group counseling that includes current progress or regression and prognosis • Any revisions indicated for diagnosis, or medication concerns • Plan for next group session, including any homework assignments or crisis plans, or both • Staff signature/credentials/date of signature	
NOTES	**UNIT**	**BENEFIT LIMITS**
This does NOT include psychosocial groups. Clients eligible for Group Behavioral Health Counseling must demonstrate the ability to benefit from experiences shared by others, the ability to participate in a group dynamic process while respecting the others' rights to confidentiality, and must be able to integrate feedback received from other group members. For groups of clients eighteen (18) years of age and over, the minimum number that must be served in a specified group is two (2). The maximum that may be served in a specified group is twelve (12). For groups of clients under eighteen (18) years of age, the minimum number that must be served in a specified group is two (2). The maximum that may be served in a specified group is ten (10). A client must be at least four (4) years of age to receive group therapy. Group treatment must be age and developmentally appropriate, (i.e., sixteen (16) year-olds and four (4) year-olds must not be treated in the same group). Providers may bill for services only at times during which clients participate in group activities.	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) encounters
APPLICABLE POPULATIONS	**SPECIAL BILLING INSTRUCTIONS**	
Children, Youth, and Adults	A provider can only bill one (1) Group Behavioral Health Counseling encounter per day. There are twelve (12) total group behavioral health counseling encounters allowed per year, unless an extension of benefits is allowed by the Quality Improvement Organization contracted with Arkansas Medicaid.	
ALLOWED MODE(S) OF DELIVERY	**TIER**	
Face-to-face Telemedicine (Adults, eighteen (18) years of age and above)	Counseling	
ALLOWABLE PERFORMING PROVIDERS	**PLACE OF SERVICE**	

PROPOSED

• 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 Client Present 1-1-23

CPT®/HCPCS PROCEDURE CODE	PROCEDURE CODE DESCRIPTION
View or print the procedure codes for counseling services.	Family psychotherapy (conjoint psychotherapy) (with patient present)
SERVICE DESCRIPTION	**MINIMUM DOCUMENTATION REQUIREMENTS**
Marital/Family Behavioral Health Counseling with Client Present is a face-to-face treatment provided to one (1) or more family members in the presence of a 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 client's (a) Mental Health or (b) Substance Abuse condition, or both. Additionally, tobacco cessation counseling is a component of this service. Services must be congruent with the age and abilities of the client, client-centered, and strength-based; with emphasis on needs as identified by the client and provided with cultural competence. ***Dyadic treatment is available for parent/caregiver and child for dyadic treatment of children who are from zero through forty-seven (0-47) months of age and parent/caregiver. Dyadic treatment must be prior authorized. Dyadic Infant/Caregiver Psychotherapy is a behaviorally based therapy that involves improving the parent-child relationship by transforming the interaction between the two parties. The primary goal of Dyadic Infant/Parent Psychotherapy is to strengthen the relationship between a child and his or her parent (or caregiver) as a vehicle for restoring the child's sense of safety, attachment, and appropriate affect and improving the**	• Date of Service • Start and stop times of actual encounter with client and spouse/family • Place of service • Participants present and relationship to client • Diagnosis and pertinent interval history • Brief mental status of client and observations of client with spouse/family • Rationale, and description of treatment used must coincide with the most recent intake assessment and improve the impact the client's condition has on the spouse/family or improve marital/family interactions between the client and the spouse/family, or both • Client and spouse/family's response to treatment that includes current progress or regression and prognosis • Any revisions indicated for the diagnosis, or medication concerns • Plan for next session, including any homework assignments or crisis plans, or both • Staff signature/credentials/date of signature • HIPAA compliant Release of Information, completed, signed, and dated

PROPOSED

<table>
<tr><td>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.</td><td colspan="2"></td></tr>
<tr><th>NOTES</th><th>UNIT</th><th>BENEFIT LIMITS</th></tr>
<tr><td>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) client per family, per therapy session, may be billed.</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):

Twelve (12) encounters</td></tr>
<tr><th>APPLICABLE POPULATIONS</th><th colspan="2">SPECIAL BILLING INSTRUCTIONS</th></tr>
<tr><td>Children, Youth, and Adults</td><td colspan="2">A provider can only bill one (1) Marital/Family Behavioral Health Counseling with (or without) Patient encounter per day. There are twelve (12) total Marital/Family Behavioral Health Counseling with Client Present encounters allowed, per year, unless an extension of benefits is allowed by the Quality Improvement Organization contracted with Arkansas Medicaid.

The following services cannot be billed on the Same Date of Service:

Multi-Family Behavioral Health Counseling

Marital/Family Behavioral Health Counseling without Client Present</td></tr>
</table>

PROPOSED

	Psychoeducation View or print the procedure codes for counseling services.
ALLOWED MODE(S) OF DELIVERY	**TIER**
Face-to-face Telemedicine (Adults, Youth, and Children)	Counseling
ALLOWABLE PERFORMING 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)

PROPOSED

252.114 Marital/Family Behavioral Health Counseling without Client Present 1-1-23

CPT®/HCPCS PROCEDURE CODE	PROCEDURE CODE DESCRIPTION
View or print the procedure codes for counseling services.	Family psychotherapy (without the patient present)
SERVICE DESCRIPTION	**MINIMUM DOCUMENTATION REQUIREMENTS**
Marital/Family Behavioral Health Counseling without Client Present is a face-to-face treatment provided to one (1) or more family members outside the presence of a client. Services are designed to enhance insight into family interactions, facilitate inter-family emotional or practical support, and develop alternative strategies to address familial issues, problems, and needs. Services pertain to a client's (a) Mental Health or (b) Substance Abuse condition, or both. Additionally, tobacco	• Date of Service • Start and stop times of actual encounter with spouse/family • Place of service • Participants present and relationship to client • Diagnosis and pertinent interval history • Brief observations with spouse/family

<table>
<tr><td>cessation counseling is a component of this service.

Services must be congruent with the age and abilities of the client or family member(s), client-centered, and strength-based; with emphasis on needs as identified by the client and family and provided with cultural competence.</td><td colspan="2">• Rationale, and description of treatment used must coincide with the most recent intake assessment and improve the impact the client's condition has on the spouse/family, or improve marital/family interactions between the client and the spouse/family, or both
• Client and spouse/family's response to treatment that includes current progress or regression and prognosis
• Rationale for excluding the identified client
• Any revisions indicated for the diagnosis, or medication concerns
• Plan for next session, including any homework assignments or crisis plans, or both
• Staff signature/credentials/date of signature
• HIPAA compliant Release of Information, completed, signed, and dated</td></tr>
<tr><th>NOTES</th><th>UNIT</th><th>BENEFIT LIMITS</th></tr>
<tr><td>Natural supports may be included in these sessions, if justified in service documentation, and if supported in Mental Health Diagnosis. Only one (1) client per family per therapy session may be billed.</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):

Twelve (12) encounters</td></tr>
<tr><th>APPLICABLE POPULATIONS</th><th colspan="2">SPECIAL BILLING INSTRUCTIONS</th></tr>
<tr><td>Children, Youth, and Adults</td><td colspan="2">A provider can only bill one (1) Marital/Family Behavioral Health Counseling with (or without) 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 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 counseling services.</td></tr>
</table>

PROPOSED

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)

PROPOSED

252.115 Psychoeducation 1-1-23

CPT®/HCPCS PROCEDURE CODE	PROCEDURE CODE DESCRIPTION
View or print the procedure codes for counseling services.	Psychoeducational service; per fifteen (15) minutes
SERVICE DESCRIPTION	**MINIMUM DOCUMENTATION REQUIREMENTS**
Psychoeducation provides clients and their families with pertinent information regarding mental illness, substance abuse, and tobacco cessation, and teaches problem-solving, communication, and coping skills to support recovery. Psychoeducation can be implemented in two (2) formats: multifamily group and/or single-family group. Due to the group format, 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 client, client-centered, and strength-based; with emphasis on needs as identified by the client and provided with cultural competence. ***Dyadic treatment is available for parent/caregiver and child for dyadic treatment of children from zero through**	• Date of Service • Start and stop times of actual encounter with client and spouse/family • Place of service • Participants present • Nature of relationship with client • Rationale for excluding the identified client, if applicable • Diagnosis and pertinent interval history • Rationale and objective used must coincide with the most recent intake assessment and improve the impact the client's condition has on the spouse/family or improve marital/family interactions between the client and the

<table>
<tr><td>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.</td><td colspan="2">spouse/family, or both
• Client and Spouse/family response to treatment that includes current progress or regression and prognosis
• Any revisions indicated for the diagnosis, or medication concerns
• Plan for next session, including any homework assignments or crisis plans, or both
• HIPAA compliant Release of Information forms, completed, signed, and dated
• Staff signature/credentials/date of signature</td></tr>
<tr><th>NOTES</th><th>UNIT</th><th>BENEFIT LIMITS</th></tr>
<tr><td>Information to support the appropriateness of excluding the identified 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 client and that support's expected role in attaining treatment goals is documented. Only one (1) client per family per therapy session may be billed.</td><td>Fifteen (15) minutes</td><td>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)</td></tr>
<tr><th>APPLICABLE POPULATIONS</th><th colspan="2">SPECIAL BILLING INSTRUCTIONS</th></tr>
<tr><td>Children, Youth, and Adults</td><td colspan="2">A provider can only bill a total of forty-eight (48) units of Psychoeducation
The following cservices cannot be billed on the Same Date of Service:
Marital/Family Behavioral Health Counseling with Client Present
Marital/Family Behavioral Health Counseling without Client Present
View or print the procedure codes for counseling services.</td></tr>
<tr><th>ALLOWED MODE(S) OF DELIVERY</th><th colspan="2">TIER</th></tr>
<tr><td>Face-to-face
Telemedicine (Adults, Youth, and Children)</td><td colspan="2">Counseling</td></tr>
<tr><th>ALLOWABLE PERFORMING PROVIDERS</th><th colspan="2">PLACE OF SERVICE</th></tr>
<tr><td>• Independently Licensed Clinicians - Master's/Doctoral
• Non-independently Licensed Clinicians – Master's/Doctoral
• Licensed Alcoholism and Drug Abuse Counselor Master's
• Advanced Practice Nurse</td><td colspan="2">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)</td></tr>
</table>

PROPOSED

• 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	

252.116 Multi-Family Behavioral Health Counseling 1-1-23

CPT®/HCPCS PROCEDURE CODE	PROCEDURE CODE DESCRIPTION	
View or print the procedure codes for 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) clients and their family members or significant others. Services are a more cost-effective alternative to Marital/Family Behavioral Health Counseling, designed to enhance members' insight into family interactions, facilitate inter-family emotional or practical support and to develop alternative strategies to address familial issues, problems and needs. Services may pertain to a 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 client, client-centered and strength-based; with emphasis on needs as identified by the client and family and provided with cultural competence.	• Date of Service • Start and stop times of actual encounter with client and/or spouse/family • Place of service • Participants present • Nature of relationship with client • Diagnosis and pertinent interval history • Rationale for and objective used to improve the impact the client's condition has on the spouse/family and/or improve marital/family interactions between the client and the spouse/family. • Client and Spouse/Family response to treatment that includes current progress or regression and prognosis • Any revisions indicated for the diagnosis or medication(s) • Plan for next session, including any homework assignments and/or crisis plans • HIPAA compliant Release of Information forms, completed, signed, and dated • Staff signature/credentials/date of signature	
NOTES	**UNIT**	**BENEFIT LIMITS**

PROPOSED

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 services cannot be billed on the Same Date of Service:** Marital/Family Behavioral Health Counseling without Client Present Marital/Family Behavioral Health Counseling with Client Present Interpretation of Diagnosis Interpretation of Diagnosis, Telemedicine **View or print the procedure codes for 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)

PROPOSED

252.117 Mental Health Diagnosis 1-1-23

CPT®/HCPCS PROCEDURE CODE	PROCEDURE CODE DESCRIPTION
View or print the procedure codes for counseling services.	Psychiatric diagnostic evaluation (with no medical services)
SERVICE DESCRIPTION	**MINIMUM DOCUMENTATION REQUIREMENTS**
Mental Health Diagnosis is a clinical service for the purpose of determining the existence, type,	• Date of Service • Start and stop times of the face-to-face

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 client, client-centered, and strength-based; with emphasis on needs as identified by the client and provided with cultural competence.	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 • Culturally and age-appropriate psychosocial history and assessment • Mental status (Clinical observations and impressions) • Current functioning plus strengths and needs • DSM diagnostic impressions • Treatment recommendations • Staff signature/credentials/date of signature

NOTES	UNIT	BENEFIT LIMITS
This service may be billed for face-to-face contact as well as for time spent obtaining necessary information for diagnostic purposes; however, this time may NOT be used for development or submission of required paperwork processes This service can be provided via telemedicine ***Dyadic treatment is available for parent/caregiver and child for dyadic treatment of children from zero through forty-seven (0-47) months of age and parent/caregiver. A Mental Health Diagnosis will be required for all children through forty-seven (47) months of age to receive services. This service includes up to four (4) encounters for children through the age of forty-seven (47) months of age and can be provided without a prior authorization. This service must include an assessment of:** o **Presenting symptoms and behaviors** o **Developmental and medical history** o **Family psychosocial and medical history** o **Family functioning, cultural and communication patterns, and current environmental conditions and stressors**	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)

PROPOSED

<table>
<tr><td>
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
</td><td></td><td></td></tr>
<tr><th>APPLICABLE POPULATIONS</th><th colspan="2">SPECIAL BILLING INSTRUCTIONS</th></tr>
<tr><td>Children, Youth, and Adults
Residents of Long-Term Care</td><td colspan="2">The following codes cannot be billed on the Same Date of Service:
Psychiatric Assessment
View or print the procedure codes for counseling services.</td></tr>
<tr><th>ALLOWED MODE(S) OF DELIVERY</th><th colspan="2">TIER</th></tr>
<tr><td>Face-to-face
Telemedicine (Adults, Youth, and Children)</td><td colspan="2">Counseling</td></tr>
<tr><th>ALLOWABLE PERFORMING PROVIDER</th><th colspan="2">PLACE OF SERVICE</th></tr>
<tr><td>
Independently Licensed Clinicians – Master's/Doctoral
Non-independently Licensed Clinicians – Master's/Doctoral
Advanced Practice 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
</td><td colspan="2">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)</td></tr>
</table>

PROPOSED

252.118 Interpretation of Diagnosis 1-1-23

CPT®/HCPCS PROCEDURE CODE	PROCEDURE CODE DESCRIPTION
View or print the procedure codes for 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 client and their family. Services pertain to a 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 client, client-centered, and strength-based; with emphasis on needs as identified by the client and provided with cultural competence.	• Date of service • Start and stop times of face-to-face encounter with client and/or parent(s) or guardian(s) • Place of service • Participants present and relationship to client • Diagnosis and pertinent interval history • Rationale for and description of the treatment used that must coincide with the most recent intake assessment • Participant(s) response and feedback • Recommendation for additional supports including referrals, resources, and information • Staff signature/credentials/date of signature(s)

NOTES	UNIT	BENEFIT LIMITS
For clients under eighteen (18) years of age, the time may be spent face-to-face with the client; the client and the parent(s) or guardian(s); or alone with the parent(s) or guardian(s). For clients over eighteen (18) years of age, the time may be spent face-to-face with the client and the spouse, legal guardian, or significant other. This service can be provided via telemedicine to clients eighteen (18) years of age and above. This service can also be provided via telemedicine to 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**	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)

PROPOSED

identifies and prioritizes the infant's needs, establishes a diagnosis, and helps to determine the care and services to be provided.		
APPLICABLE POPULATIONS	**SPECIAL BILLING INSTRUCTIONS**	
Children, Youth, and Adults	**The following 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 counseling services.** This service can be provided via telemedicine to clients eighteen (18) years of age and above. This service can also be provided via telemedicine to 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
	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)	

PROPOSED

Parent/Caregiver) Provider	

252.119 Substance Abuse Assessment 1-1-23

<table>
<tr><th>CPT®/HCPCS PROCEDURE CODE</th><th colspan="2">PROCEDURE CODE DESCRIPTION</th></tr>
<tr><td>View or print the procedure codes for counseling services.</td><td colspan="2">Alcohol and/or drug assessment</td></tr>
<tr><th>SERVICE DESCRIPTION</th><th colspan="2">MINIMUM DOCUMENTATION REQUIREMENTS</th></tr>
<tr><td>Substance Abuse Assessment is a service that identifies and evaluates the nature and extent of a client's substance abuse condition using the Addiction Severity Index (ASI) or an assessment instrument approved by DAABHS and DMS. The assessment must screen for and identify any existing co-morbid conditions. The assessment should assign a diagnostic impression to the client, resulting in a treatment recommendation and referral appropriate to effectively treat the condition(s) identified.

Services must be congruent with the age and abilities of the client, client-centered, and strength-based; with emphasis on needs, as identified by the client, and provided with cultural competence.</td><td colspan="2">• Date of Service
• Start and stop times of the face-to-face encounter with the client and the interpretation time for diagnostic formulation
• Place of service
• Identifying information
• Referral reason
• Presenting problem(s), history of presenting problem(s) including duration, intensity, and response(s) to prior treatment
• Cultural and age-appropriate psychosocial history and assessment
• Mental status (Clinical observations and impressions)
• Current functioning and strengths in specified life domains
• DSM diagnostic impressions
• Treatment recommendations and prognosis for treatment
• Staff signature/credentials/date of signature</td></tr>
<tr><th>NOTES</th><th>UNIT</th><th>BENEFIT LIMITS</th></tr>
<tr><td>The assessment process results in the assignment of a diagnostic impression, client recommendation for treatment regimen appropriate to the condition and situation presented by the client, initial plan (provisional) of care, and referral to a service appropriate to effectively treat the condition(s) identified. If indicated, the assessment process must refer the client for a psychiatric consultation.</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><th>APPLICABLE POPULATIONS</th><th colspan="2">SPECIAL BILLING INSTRUCTIONS</th></tr>
<tr><td>Children, Youth, and Adults</td><td colspan="2">The following codes cannot be billed on the Same Date of Service:
Interpretation of Diagnosis</td></tr>
</table>

PROPOSED

	[View or print the procedure codes for counseling services.](#)
ALLOWED MODE(S) OF DELIVERY	**TIER**
Face-to-face Telemedicine (Adults, Youth, Children)	Counseling
ALLOWABLE PERFORMING PROVIDERS	**PLACE OF SERVICE**
• Independently Licensed Clinicians – Master's/Doctoral • 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)

252.121 Pharmacologic Management 1-1-23

CPT®/HCPCS PROCEDURE CODE	PROCEDURE CODE DESCRIPTION
[View or print the procedure codes for 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 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	• Date of Service • Start and stop times of actual encounter with client • Place of service • Diagnosis and pertinent interval history

PROPOSED

supervision, as well as informing 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 client, client-centered, and strength-based; with emphasis on needs as identified by the client and provided with cultural competence.	• Brief mental status and observations • Rationale for and treatment used that must coincide with the Psychiatric Assessment • 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)	

PROPOSED

252.122 Psychiatric Assessment 1-1-23

CPT®/HCPCS PROCEDURE CODE	PROCEDURE CODE DESCRIPTION

View or print the procedure codes for 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 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 clients to receive counseling services.	• 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 • The interview should obtain or verify the following: 1. The 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 4. History of problems 5. Treatment history 6. Response to prior treatment interventions 7. Medical history (and examination as indicated) • For 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

PROPOSED

	• 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 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 Telemedicine (Adults, Youth, and Children)	**The following services cannot be billed on the Same Date of Service:** Mental Health Diagnosis **View or print the procedure codes for counseling services.**	
ALLOWED MODE(S) OF DELIVERY	**TIER**	
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 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 client entering care. The collaborative agreement must comply	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)	

PROPOSED

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	

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

PROPOSED

		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

PROPOSED

	• Staff signature/credentials/date of signature(s)	
NOTES	**UNIT**	**BENEFIT LIMITS**
A psychiatric or behavioral crisis is defined as an acute situation in which an individual is experiencing a serious mental illness or emotional disturbance to the point that the client or others are at risk for imminent harm or in which to prevent significant deterioration of the client's functioning. This service is a planned intervention that MUST be on the client's treatment plan to serve as an alternative to twenty-four (24) -hour inpatient care.	Fifteen (15) minutes	DAILY MAXIMUM OF UNITS THAT MAY BE BILLED: Twelve (12) units YEARLY MAXIMUM OF UNITS THAT MAY BE BILLED (extension of benefits can be requested): Seventy-two (72) units
APPLICABLE POPULATIONS	**SPECIAL BILLING INSTRUCTIONS**	
Children, Youth, and Adults		
ALLOWED MODE(S) OF DELIVERY	**TIER**	
Face-to-face Telemedicine (Adults, Youth, and Children)	Crisis	
ALLOWABLE PERFORMING PROVIDERS	**PLACE OF SERVICE**	
• Independently Licensed Clinicians – Master's/Doctoral • Non-independently Licensed Clinicians – Master's/Doctoral • Licensed Alcoholism and Drug Abuse Counselor Master's • Advanced Practice Nurses • Physicians	02 (Telemedicine) 03 (School), 04 (Homeless Shelter), 10 (Telehealth Provided in Client's Home), 11 (Office) 12 (Patient's Home), 15 (Mobile Unit), 23 (Emergency Room), 33 (Custodial Care facility), 49 (Independent Clinic), 50 (Federally Qualified Health Center), 53 (Community Mental Health Center), 57(Non-Residential Substance Abuse Treatment Facility), 71 (Public Health Clinic), 72 (Rural Health Clinic), 99 (Other Location)	

255.001 Crisis Intervention 1-1-23

CPT®/HCPCS PROCEDURE CODE	**PROCEDURE CODE DESCRIPTION**
View or print the procedure codes for counseling services.	Crisis intervention service, per fifteen (15) minutes
SERVICE DESCRIPTION	**MINIMUM DOCUMENTATION REQUIREMENTS**
Crisis Intervention is unscheduled, immediate, short-term treatment activities provided to a Medicaid-eligible client who is experiencing a psychiatric or behavioral crisis. Services are to be congruent with the age, strengths, needed accommodation for any disability, and cultural framework of the client and his/her family. These services are designed to stabilize the person in crisis, prevent further deterioration and provide immediate indicated treatment in the least restrictive setting. (These activities include evaluating a Medicaid-eligible client to	• 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

PROPOSED

<table>
<tr><td>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 client and their family.</td><td colspan="2">• 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)</td></tr>
<tr><th>NOTES</th><th>UNIT</th><th>BENEFIT LIMITS</th></tr>
<tr><td>A psychiatric or behavioral crisis is defined as an acute situation, in which an individual is experiencing a serious mental illness or emotional disturbance to the point that the client or others are at risk for imminent harm, or in which to prevent significant deterioration of the client’s functioning.

This service can be provided to clients that have not been previously assessed or have not previously received behavioral health services. No PCP referral is required for crisis intervention

The provider of this service MUST complete a Mental Health Diagnosis within seven (7) days of provision of this service, if provided to a client who is not currently a client.

View or print the procedure codes for counseling services.

If the client cannot be contacted or does not return for a Mental Health Diagnosis appointment, attempts to contact the client must be placed in the client’s medical record. If the client needs more time to be stabilized, this must be noted in the client’s medical record and the Division of Medical Services Quality Improvement Organization (QIO) must be notified.</td><td>Fifteen (15) minutes</td><td>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)</td></tr>
<tr><th>APPLICABLE POPULATIONS</th><th colspan="2">SPECIAL BILLING INSTRUCTIONS</th></tr>
<tr><td>Children, Youth, and Adults</td><td colspan="2"></td></tr>
<tr><th>ALLOWED MODE(S) OF DELIVERY</th><th colspan="2">TIER</th></tr>
<tr><td>Face-to-face

Telemedicine (Adults, Youth, and Children)</td><td colspan="2">Crisis</td></tr>
</table>

PROPOSED

ALLOWABLE PERFORMING PROVIDERS	PLACE OF SERVICE
• Independently Licensed Clinicians – Master's/Doctoral • Non-independently Licensed Clinicians – Master's/Doctoral • Advanced Practice Nurses • Physicians	02 (Telemedicine), 03 (School), 04 (Homeless Shelter), 10 (Telehealth Provided in Client's Home), 11 (Office) 12 (Patient's Home), 15 (Mobile Unit), 23 (Emergency Room), 33 (Custodial Care facility), 49 (Independent Clinic), 50 (Federally Qualified Health Center), 53 (Community Mental Health Center), 57 (Non-Residential Substance Abuse Treatment Facility), 71 (Public Health Clinic), 72 (Rural Health Clinic), 99 (Other Location)

255.003 Acute Crisis Units 1-1-23

CPT®/HCPCS PROCEDURE CODE	PROCEDURE CODE DESCRIPTION
View or print the procedure codes for counseling services.	Behavioral Health; short-term residential
SERVICE DESCRIPTION	**MINIMUM DOCUMENTATION REQUIREMENTS**
Acute Crisis Units provide brief (96 hours or less) crisis treatment services to persons eighteen (18) years of age and over, who are experiencing a psychiatric or substance abuse-related crisis, or both, and may pose an escalated risk of harm to self or others. Acute Crisis Units provide hospital diversion and step-down services in a safe environment with psychiatry and substance abuse services on-site at all times, as well as on-call psychiatry available twenty-four (24) hours a day. Services provide ongoing assessment and observation; crisis intervention; psychiatric, substance, and co-occurring treatment; and initiate referral mechanisms for independent assessment and care planning as needed.	• 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**

PROPOSED

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

255.004 Substance Abuse Detoxification 1-1-23

CPT®/HCPCS PROCEDURE CODE	PROCEDURE CODE DESCRIPTION
View or print the procedure codes for counseling services.	Alcohol and/or drug services; detoxification
SERVICE DESCRIPTION	**MINIMUM DOCUMENTATION REQUIREMENTS**
Substance Abuse Detoxification is a set of interventions aimed at managing acute intoxication and withdrawal from alcohol or other drugs. Services help stabilize clients by clearing toxins from the client’s body. Services are short-term and may be provided in a crisis unit, inpatient, or outpatient setting, and may include evaluation, observation, medical monitoring, and addiction treatment. Detoxification seeks to minimize the physical harm caused by the abuse of substances and prepares the client for ongoing treatment.	• Date of service • Assessment information including mental health and substance abuse psychosocial evaluation, initial discharge plan, strengths and abilities to be considered for community re-entry • Place of service • Specific persons providing pertinent information and relationship to client • Diagnosis and synopsis of events leading up to acute crisis admission • Interpretive summary • Brief mental status and observations • Utilization of previously established psychiatric advance directive or crisis plan as pertinent to current situation OR rationale for crisis intervention activities utilized • Client’s response to the intervention that includes current progress or regression and prognosis Clear resolution of the current crisis and/or plans for further services

PROPOSED

	• Development of a clearly defined crisis plan or revision to existing plan • Thorough discharge plan including treatment and community resources • Staff signature/credentials/date of signature(s)
NOTES	**EXAMPLE ACTIVITIES**

APPLICABLE POPULATIONS	**UNIT**	**BENEFIT LIMITS**
Youth and Adults	N/A	• Six (6) encounters per SFY; Extension of Benefits required for additional encounters
	PROGRAM SERVICE CATEGORY	
	Crisis Services	
ALLOWED MODE(S) OF DELIVERY	**TIER**	
Face-to-face	N/A	
ALLOWABLE PERFORMING PROVIDERS	**PLACE OF SERVICE**	
Substance Abuse Detoxification must be provided in a facility that is licensed by the Division of Provider Services and Quality Assurance as a Substance Abuse Detoxification provider.	21 (Inpatient Hospital), 55 (Residential Substance Abuse Treatment Facility)	

PROPOSED

256.200 Reserved 1-1-23

256.500 Billing Instructions – Paper Only 1-1-23

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

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

Completed claim forms should be forwarded to the Arkansas Medicaid fiscal agent. View or print Claims contact information.

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

256.510 Completion of the CMS-1500 Claim Form 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)	Client's or participant's 10-digit Medicaid or ARKids First-A or ARKids First-B identification number.

Field Name and Number	Instructions for Completion
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)	Client's or participant's last name and first name.
3. PATIENT'S BIRTH DATE	Client's or participant's date of birth as given on the individual's Medicaid or ARKids First-A or ARKids First-B identification card. Format: MM/DD/YY.
SEX	Check M for male or F for female.
4. INSURED'S NAME (Last Name, First Name, Middle Initial)	Required if insurance affects this claim. Insured's last name, first name, and middle initial.
5. PATIENT'S ADDRESS (No., Street)	Optional. Client's or participant's complete mailing address (street address or post office box).
CITY	Name of the city in which the client or participant resides.
STATE	Two-letter postal code for the state in which the client or participant resides.
ZIP CODE	Five-digit zip code; nine digits for post office box.
TELEPHONE (Include Area Code)	The client's or participant's telephone number or the number of a reliable message/contact/ emergency telephone
6. PATIENT RELATIONSHIP TO INSURED	If insurance affects this claim, check the box indicating the patient's relationship to the insured.
7. INSURED'S ADDRESS (No., Street)	Required if insured's address is different from the patient's address.
CITY	
STATE	
ZIP CODE	
TELEPHONE (Include Area Code)	
8. PATIENT STATUS	Not required.
9. OTHER INSURED'S NAME (Last name, First Name, Middle Initial)	If patient has other insurance coverage as indicated in Field 11d, the other insured's last name, first name, and middle initial.
a. OTHER INSURED'S POLICY OR GROUP NUMBER	Policy and/or group number of the insured individual.
b. OTHER INSURED'S DATE OF BIRTH	Not required.
SEX	Not required.
c. EMPLOYER'S NAME OR SCHOOL NAME	Required when items 9 a-d are required. Name of the insured individual's employer and/or school.
d. INSURANCE PLAN NAME OR PROGRAM NAME	Name of the insurance company.

PROPOSED

Field Name and Number	Instructions for Completion
10. IS PATIENT'S CONDITION RELATED TO:	
a. EMPLOYMENT? (Current or Previous)	Check YES or NO.
b. AUTO ACCIDENT?	Required when an auto accident is related to the services. Check YES or NO.
PLACE (State)	If 10b is YES, the two-letter postal abbreviation for the state in which the automobile accident took place.
c. OTHER ACCIDENT?	Required when an accident other than automobile is related to the services. Check YES or NO.
10d. RESERVED FOR LOCAL USE	Not used.
11. INSURED'S POLICY GROUP OR FECA NUMBER	Not required when Medicaid is the only payer.
a. INSURED'S DATE OF BIRTH	Not required.
SEX	Not required.
b. EMPLOYER'S NAME OR SCHOOL NAME	Not required.
c. INSURANCE PLAN NAME OR PROGRAM NAME	Not required.
d. IS THERE ANOTHER HEALTH BENEFIT PLAN?	When private or other insurance may or will cover any of the services, check YES and complete items 9a through 9d.
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE	Not required.
13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE	Not required.
14. DATE OF CURRENT: ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)	Required when services furnished are related to an accident, whether the accident is recent or in the past. Date of the accident.
15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE	Not required.
16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION	Not required.
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	Primary Care Physician (PCP) referral or PCMH sign-off is required for Counseling Services for all clients after ten (10) counseling services. If services are the result of a Child Health Services (EPSDT) screening/ referral, enter the referral source, including name and title.

PROPOSED

Field Name and Number	Instructions for Completion
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 client's or participant's inpatient hospitalization, enter the individual's admission and discharge dates. Format: MM/DD/YY.
19. RESERVED FOR LOCAL USE	Not applicable to Counseling Services.
20. OUTSIDE LAB?	Not required.
$ CHARGES	Not required.
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	

PROPOSED

Field Name and Number		Instructions for Completion
	CPT/HCPCS	Enter the correct CPT or HCPCS procedure codes from Sections 252.100 through 252.150.
	MODIFIER	Use applicable modifier.
E.	DIAGNOSIS POINTER	Enter the diagnosis code reference letter (pointer) as shown in Item Number 21 to relate to the date of service and the procedures performed to the primary diagnosis. When multiple services are performed, the primary reference letter for each service should be listed first; other applicable services should follow. The reference letter(s) should be A-L or multiple letters as applicable. The “Diagnosis Pointer” is the line letter from Item Number 21 that relates to the reason the service(s) was performed.
F.	$ CHARGES	The full charge for the service(s) totaled in the detail. This charge must be the usual charge to any client, patient, or other 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.

PROPOSED

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 1-1-23

PROPOSED