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213.210 Medicaid Utilization Management Program (MUMP) 94-1-0726

The Medicaid Utilization Management Program (MUMP) determines covered lengths of stay in inpatient acute care and /general hospitals, in-state and out-of-state.

Length-of-stay determinations are made by the Quality Improvement Organization (QIO), Arkansas Foundation for Medical Care, Inc. (AFMC), under contract towith the Arkansas Medicaid Program.

Individuals in all Medicaid eligibility categories and all age groups, except individuals under age one (1), are subject to this policy. Medicaid beneficiaries under age one (1) at the time of admission are exempt from the MUMP policy for dates of service before their first birthday. Refer to item "D" below for the procedure to follow when a child's first birthday occurs during an inpatient stay.

The procedures for the MUMP are as follows:

A. Medicaid will reimburse hospitals for up to four seven (47) days of inpatient service at an acute care or general hospital, or both, with no precertification requirement, except for admissions by transfer from another hospital. For stays at a freestanding rehabilitative hospital, Medicaid will reimburse for up to ten (10) days with no precertification requirement.

B. If the attending certified nurse-midwife clinician determines that the patient should not be discharged by the fifth eighth day of acute care or general hospitalization, or both, or eleventh day of freestanding rehabilitative hospital stay, a hospital medical staff member may contact AFMC the QIO and request an extension of inpatient days. The following information is required:

1. PatientBeneficiary name and address (including zip code)
2. PatientBeneficiary birth date
3. PatientBeneficiary Medicaid number
4. Admission date
5. Hospital name
6. Hospital provider identification number
7. Attending certified nurse-midwifeclinician provider identification number
8. Principal diagnosis and other diagnoses influencing this stay
9. Surgical procedures performed or planned
10. The number of days being requested for continued inpatient care
11. All available medical information justifying or supporting the necessity of continued stay in the hospital.

C. Contact AFMC the QIO for procedure precertification or length of stay review procedures. **View or print AFMC contact information for the QIO.** AFMC The QIO reviewers will base the number of days allowed for an extension on their medical judgment utilizing Medicaid guidelines and current standards of clinical practice.

D. When a Medicaid beneficiary reaches age one (1) during an inpatient stay, the days from the admission date through the day before the patientbeneficiary's birthday are exempt from the MUMP policy. MUMP policy becomes effective on the one-year birthday. The patientbeneficiary's birthday is the first day of the four seven (7) days not requiring MUMP

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certification in acute care or general hospitals, or both, or the first day of the ten (10) days in freestanding rehabilitative hospitals. If the stay continues beyond the ~~fourth~~ seventh day (inclusive) or tenth freestanding rehabilitative hospital day (inclusive) of the ~~patient~~beneficiary's first birthday, hospital staff must apply for MUMP certification of the additional days.

E. ~~Additional~~ More extensions may be requested as needed.

F. ~~AFMC~~ The QIO assigns an authorization number to an approved extension request and sends written notification to the hospital.

G. Reconsideration reviews of denied extensions may be requested by sending the medical record to ~~AFMC~~ the QIO~~through regular mail, or expedited by overnight express~~. The hospital will be notified by the next working day of the decision. **View or print ~~AFMC~~ contact information for the QIO.**

H. ~~Calls~~Requests for extension of days may be made at any point from the ~~fourth~~seventh day of the acute care and general hospital stay through discharge, or eleventh day of the freestanding rehabilitative hospital stay through discharge. However, the provider must accept ~~the~~ financial liability should the stay not meet the necessary medical criteria for inpatient services. If the provider chooses to delay ~~calling for~~requesting extension verification and the services are denied based on medical necessity, the beneficiary m~~ay~~ust not be held liable. ~~All~~If requesting by phone, all calls will be limited to ten (10) minutes to allow equal access to all providers.

I. If the ~~fifth~~ last day of ~~an~~ the MUMP period of admission falls on a Saturday, Sunday or holiday, it is recommended that the hospital provider call for an extension prior to the ~~fifth~~ last day of the MUMP review period if the certified nurse-midwife has recommended a continued stay.

J. Inpatient stays for bone marrow, liver, heart, lung, skin and pancreas/kidney transplant procedures are excluded from this review program.

K. The retrospective or post payment random sample review will be continued for all admissions, including acute care and general hospital inpatient stays of ~~four~~seven (7) days or less or freestanding rehabilitative hospital inpatient stays of ten (10) days or less, to ensure that medical necessity for the services is substantiated.

L. Admissions of retroactively eligible beneficiaries: If eligibility is identified while the ~~patient~~beneficiary is still an inpatient, the hospital may call for retrospective review of those days already used past the acute care and general hospital's original ~~four~~seven (7) or the freestanding rehabilitative hospital's original ten (10) for a determination of post authorization and concurrent evaluation of future extended days.

If the retroactive eligibility is not identified until after discharge and the hospital bills and receives a denial for any days past the original acute care and general hospital's ~~four~~seven (7) or freestanding rehabilitative hospital's ten (10) allowed, then the hospital may call for post-extension evaluation approval of the denied days, which, if granted, may be rebilled. If the length of stay is more than thirty (30) days, the provider may submit the entire medical record ~~to AFMC to~~for review.

M. Out-of-state claims are subject to the determination of medical necessity for out-of-state treatment. In addition, the claim and records will be reviewed retrospectively for lengths of stay beyond the ~~four~~ days allowed before precertification is required. "Out-of-state" refers to states not bordering Arkansas.

N. Medicaid will automatically deny claims submitted for any days billed beyond the ~~fourth~~seventh acute care or general hospital, or both, or tenth freestanding rehabilitative hospital day if the provider has not ~~called for~~requested an extension ~~request~~. There will be no exceptions granted except for claims reflecting third party liability.

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O. If a ~~patient~~beneficiary is transferred from one facility to another, the receiving facility must contact ~~AFMC~~the QIO within twenty-four (24) hours of admitting the ~~patient~~beneficiary to qualify the inpatient stay. If an admission falls on a weekend or holiday, the provider must contact ~~AFMC~~the QIO on the first working day following the admission.

P. The certification process for extensions of inpatient days described in this section is a separate requirement from the prior authorization process. If a procedure requires prior authorization, the provider must request and receive prior authorization for the procedure in order to be reimbursed.

Q. If a provider fails to contact ~~AFMC~~the QIO for an extension of inpatient days due to the ~~patient's~~beneficiary having private insurance or Medicare Part A and later receives a denial due to non-covered service, lost eligibility, benefits exhausted, etc., post certification of days past the acute care and general hospital's original ~~four~~seven (7) or the freestanding rehabilitative hospital's original ten (10) days may be obtained by the following procedures:

~~Send~~ Submit a request for certification of the inpatient days via the portal and include a copy of the denial notice received from the third-party payer to ~~AFMC~~the QIO. **View or print ~~AFMC~~ contact information for the QIO.** ~~Include a note requesting post certification and the full name of the requester and a phone number where the requester may be reached. Upon receipt of the denial copy and the provider request, an AFMC coordinator will call the provider and obtain certification information.~~

R. If a third-party insurer pays for an approved number of days~~,~~; Medicaid will not grant an extension for days beyond the number of days approved by the private insurer.

213.220 Benefit Limit – Inpatient Hospital Services ~~79~~-1-~~0~~26

Individual beneficiary lengths of stay beyond seven (7) acute care or general hospital, or both, or ten (10) freestanding rehabilitative hospital days are determined by the Medicaid Utilization Management Program (MUMP) process. While the number of days is determined by MUMP, once the number of days has reached twenty-four (24), any authorized days beyond are paid at a reduced per diem.

~~A. There is an annual benefit limit of 24 medically necessary days per state fiscal year (July 1 through June 30) for Medicaid beneficiaries ages 21 and older.~~

~~B. There is no inpatient hospital benefit limit for individuals under age 21 in the Child Health Services (EPSDT) Program.~~

~~C. Inpatient hospital services for ARKids First-B beneficiaries aged 1 year and older are limited to 4 days. Additional days of services must be prior authorized.~~

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213.210 Medicaid Utilization Management Program (MUMP) 9-1-26

The Medicaid Utilization Management Program (MUMP) determines covered lengths of stay in inpatient acute care and general hospitals, in-state and out-of-state.

Length-of-stay determinations are made by the Quality Improvement Organization (QIO) under contract with the Arkansas Medicaid Program.

Individuals in all Medicaid eligibility categories and all age groups, except individuals under age one (1), are subject to this policy. Medicaid beneficiaries under age one (1) at the time of admission are exempt from the MUMP policy for dates of service before their first birthday. Refer to item "D" below for the procedure to follow when a child's first birthday occurs during an inpatient stay.

The procedures for the MUMP are as follows:

A. Medicaid will reimburse hospitals for up to seven (7) days of inpatient service at an acute care or general hospital, or both, with no precertification requirement, except for admissions by transfer from another hospital. For stays at a freestanding rehabilitative hospital, Medicaid will reimburse for up to ten (10) days with no precertification requirement.

B. If the attending clinician determines that the patient should not be discharged by the eighth day of acute care or general hospitalization, or both, or eleventh day of freestanding rehabilitative hospital stay, a hospital medical staff member may contact the QIO and request an extension of inpatient days. The following information is required:

1. Beneficiary name and address (including zip code)
2. Beneficiary birth date
3. Beneficiary Medicaid number
4. Admission date
5. Hospital name
6. Hospital provider identification number
7. Attending clinician provider identification number
8. Principal diagnosis and other diagnoses influencing this stay
9. Surgical procedures performed or planned
10. The number of days being requested for continued inpatient care
11. All available medical information justifying or supporting the necessity of continued stay in the hospital.

C. Contact the QIO for precertification or length of stay review procedures. **View or print contact information for the QIO.** The QIO reviewers will base the number of days allowed for an extension on medical judgment utilizing Medicaid guidelines and current standards of clinical practice.

D. When a Medicaid beneficiary reaches age one (1) during an inpatient stay, the days from the admission date through the day before the beneficiary's birthday are exempt from the MUMP policy. MUMP policy becomes effective on the one-year birthday. The beneficiary's birthday is the first day of the seven (7) days not requiring MUMP certification in acute care or general hospitals, or both, or the first day of the ten (10) days in freestanding rehabilitative hospitals. If the stay continues beyond the seventh day

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(inclusive) or tenth freestanding rehabilitative hospital day (inclusive) of the beneficiary's first birthday, hospital staff must apply for MUMP certification of the additional days.

E. More extensions may be requested as needed.

F. The QIO assigns an authorization number to an approved extension request and sends written notification to the hospital.

G. Reconsideration reviews of denied extensions may be requested by sending the medical record to the QIO. The hospital will be notified by the next working day of the decision. **View or print contact information for the QIO.**

H. Requests for extension of days may be made at any point from the seventh day of the acute care and general hospital stay through discharge, or eleventh day of the freestanding rehabilitative hospital stay through discharge. However, the provider must accept financial liability should the stay not meet the necessary medical criteria for inpatient services. If the provider chooses to delay requesting extension verification and the services are denied based on medical necessity, the beneficiary must not be held liable. If requesting by phone, all calls will be limited to ten (10) minutes to allow equal access to all providers.

I. If the last day of the MUMP period of admission falls on a Saturday, Sunday or holiday, it is recommended that the hospital provider call for an extension prior to the last day of the MUMP review period if the certified nurse-midwife has recommended a continued stay.

J. Inpatient stays for bone marrow, liver, heart, lung, skin and pancreas/kidney transplant procedures are excluded from this review program.

K. The retrospective or post payment random sample review will be continued for all admissions, including acute care and general hospital inpatient stays of seven (7) days or less or freestanding rehabilitative hospital inpatient stays of ten (10) days or less, to ensure that medical necessity for the services is substantiated.

L. Admissions of retroactively eligible beneficiaries: If eligibility is identified while the beneficiary is still an inpatient, the hospital may call for retrospective review of those days already used past the acute care and general hospital's original seven (7) or the freestanding rehabilitative hospital's original ten (10) for a determination of post authorization and concurrent evaluation of future extended days.

If the retroactive eligibility is not identified until after discharge and the hospital bills and receives a denial for any days past the original acute care and general hospital's seven (7) or freestanding rehabilitative hospital's ten (10) allowed, then the hospital may call for post-extension evaluation approval of the denied days, which, if granted, may be rebilled. If the length of stay is more than thirty (30) days, the provider may submit the entire medical record for review.

M. Out-of-state claims are subject to the determination of medical necessity for out-of-state treatment. In addition, the claim and records will be reviewed retrospectively for lengths of stay beyond the days allowed before precertification is required. "Out-of-state" refers to states not bordering Arkansas.

N. Medicaid will automatically deny claims submitted for any days billed beyond the seventh acute care or general hospital, or both, or tenth freestanding rehabilitative hospital day if the provider has not requested an extension. There will be no exceptions granted except for claims reflecting third party liability.

O. If a beneficiary is transferred from one facility to another, the receiving facility must contact the QIO within twenty-four (24) hours of admitting the beneficiary to qualify the inpatient stay. If an admission falls on a weekend or holiday, the provider must contact the QIO on the first working day following the admission.

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P. The certification process for extensions of inpatient days described in this section is a separate requirement from the prior authorization process. If a procedure requires prior authorization, the provider must request and receive prior authorization for the procedure in order to be reimbursed.

Q. If a provider fails to contact the QIO for an extension of inpatient days due to the beneficiary having private insurance or Medicare Part A and later receives a denial due to non-covered service, lost eligibility, benefits exhausted, etc., post certification of days past the acute care and general hospital's original seven (7) or the freestanding rehabilitative hospital's original ten (10) days may be obtained by the following procedures:

Submit a request for certification of the inpatient days via the portal and include a copy of the denial notice received from the third-party payer to the QIO. **View or print contact information for the QIO.**

R. If a third-party insurer pays for an approved number of days; Medicaid will not grant an extension for days beyond the number of days approved by the private insurer.

213.220 Benefit Limit – Inpatient Hospital Services 9-1-26

Individual beneficiary lengths of stay beyond seven (7) acute care or general hospital, or both, or ten (10) freestanding rehabilitative hospital days are determined by the Medicaid Utilization Management Program (MUMP) process. While the number of days is determined by MUMP, once the number of days has reached twenty-four (24), any authorized days beyond are paid at a reduced per diem.

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211.000 Rehabilitation Services Provided Within Acute Care Hospitals 9-1-26

211.100 Criteria 9-1-26

The criteria for acute inpatient rehabilitation include that the beneficiary:

A. Require active and ongoing intervention of at least two (2) of the multiple therapy disciplines (Physical Therapy, Occupational Therapy, Speech-language Pathology, or prosthetics/orthotics), with at least one of which being physical therapy or occupational therapy; AND

B. Require an intensive rehabilitation therapy program.

C. Be able to actively participate in rehabilitation services and significantly benefit from the program.

D. Show measurable improvement of practical value, as documented in the medical record and submitted for review.

E. Be able to actively participate in rehabilitation services for three (3) hours per day or fifteen (15) hours per week.

211.110 Regulation of Plan of Care (POC) 9-1-26

A. At a minimum the documentation must indicate that the Plan of Care (POC) was synthesized by the rehabilitation physician and within four (4) days of receipt of rehabilitation only services.

B. The POC must include:

1. Beneficiary's medical prognosis
2. Functional outcomes
3. Planned discharge date and destination
4. Estimated length of stay
5. Details of each anticipated therapy intervention by discipline including intensity (number of hours per day), frequency (number of days per week), and duration (number of days during the IRF stay)

C. Group and concurrent treatment minutes can be counted toward meeting the intensity requirement but must not be more than fifty percent (50%) of the treatment provided.

D. If caregiving needs are anticipated following discharge, family members and caregivers identified prior to or during admission are expected to participate in the plan of care. The discharge planning begins with identification of the beneficiary's need for rehabilitative services.

211.120 Rehabilitation Physician Visits 9-1-26

The beneficiary's services must be supervised by a rehabilitation physician or other licensed treating physician with specialized training and experience in rehabilitation. There must be face-

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to-face visits at least three (3) days per week, beginning with the first week and throughout the time the patient is receiving rehabilitation only services.

NOTE: Beginning the second week of the rehabilitation only stay, a non-physician practitioner may conduct one (1) of the three (3) required weekly visits.

211.125 List of Medical Conditions Requiring Intensive Rehabilitative Services 9-1-26

The following list includes the medical conditions that may require intensive rehabilitative services:

A. Stroke

B. Spinal cord injury

C. Congenital deformity

D. Amputation

E. Major multiple trauma

F. Fracture of femur (hip fracture)

G. Brain Injury

H. Neurological disorders, including multiple sclerosis, motor neuron diseases, polyneuropathy, muscular dystrophy, and Parkinson's disease

I. Burns

J. Active, polyarticular rheumatoid arthritis; psoriatic arthritis,; and seronegative arthropathies resulting in significant functional impairment of ambulation; and other activities of daily living that have not improved after an appropriate, aggressive, and sustained course of outpatient therapy services or services in other less intensive rehabilitation settings immediately preceding the inpatient rehabilitation admission, or that result from a systemic disease activation immediately before admission, but have the potential to improve with more intensive rehabilitation

K. Systemic vasculidities with joint inflammation, resulting in significant functional impairment of ambulation and other activities of daily living that have not improved after an appropriate, aggressive, and sustained course of outpatient therapy services

L. Severe or advanced osteoarthritis (osteoarthrosis or degenerative joint disease) involving two or more major weight bearing joints (elbow, shoulders, hips, or knees, but not counting a joint with a prosthesis) with joint deformity and substantial loss of range of motion, atrophy of muscles surrounding the joint, significant functional impairment of ambulation and other activities of daily living that have not improved after the patient has participated in an appropriate, aggressive, and sustained course of outpatient therapy services or services in other less intensive rehabilitation settings immediately preceding the inpatient rehabilitation admission but have the potential to improve with more intensive rehabilitation. (A joint replaced by a prosthesis no longer is considered to have osteoarthritis, or other arthritis, even though this condition was the reason for the joint replacement.)

M. Knee or hip joint replacement, or both, during an acute hospitalization immediately preceding the inpatient rehabilitation stay and also meet one (1) or more of the following specific criteria:

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1. The patient underwent bilateral knee or bilateral hip joint replacement surgery during the acute hospital admission immediately preceding the intensive rehabilitation only days;

2. The patient is extremely obese with a Body Mass Index of at least fifty (50) at the time of rehabilitation only days; or

3. The patient is eighty-five (85) years of age or older at the time of rehabilitation only days.

212.400 Inpatient Hospital Benefit Limitation 9-1-26

212.401 Inpatient Hospital Services Benefit Limit ~~8-1-21~~9-1-26

A. There is no benefit limit for acute care or~~/~~ general and rehabilitative hospital inpatient services for Medicaid beneficiaries ~~under age twenty-one (21) in the Child Health Services (EPSDT) Program~~. ~~Inpatient services must be approved by the QIO as medically necessary.~~ Once beneficiaries have used twenty-four (24) paid inpatient days per state fiscal year (July 1 through June 30), any additional medically necessary days within the SFY may be reimbursed at a reduced per diem. The length of stay after day seven (7) for beneficiaries aged one (1) and older is subject to MUMP review.

B. ~~The benefit limit for acute care/general and rehabilitative hospital inpatient services is 24 paid inpatient days per state fiscal year (July 1 through June 30) for Medicaid beneficiaries aged twenty-one (21) and older.~~

~~C.~~ Included in the total of paid inpatient days are any days covered by primary third-party resources (except Medicare and Railroad Retirement) for which Medicaid receives a secondary-payer claim that it adjudicates as paid. A Medicaid-secondary claim that adjudicates as a paid claim is counted toward the inpatient benefit limit.

1. Medicaid, when it is secondary to a third-party resource other than Medicare or Railroad Retirement, covers only the difference between the primary resource's remittance and Medicaid's per diem or maximum allowable fee for Medicaid-covered services reimbursed by the primary resource.

2. Even when the Medicaid paid amount is $0.00 because the third-party payment equals or exceeds Medicaid's per diem, the days thus paid are counted toward the benefit limit.

~~D~~C. ~~Extension of the 24-day inpatient benefit is available under the Medicaid Utilization Management Program (MUMP).~~

~~E. Inpatient stays that are prior authorized for heart, liver and lung transplants are not counted toward the 24-day inpatient benefit limit.~~

~~F.~~ See Section 272.406 regarding special billing instructions for beneficiaries who turn twenty-one (21) years of age~~age 21~~ during an inpatient hospital stay.

212.503 Paper Review After Administrative Reconsiderations: Special Cases ~~6-1-25~~9-1-26

A. Infrequently, the following sequence of events may occur: An extension of days is denied or only partially approved and the determination is upheld on reconsideration; however, before the ~~patient~~beneficiary can be discharged, he or she becomes acutely ill and remains hospitalized for treatment of that illness.

B. In strict accordance with the regulation above in Section 212.502, the provider would be precluded from requesting certification of any of the inpatient days required for treatment of the late-appearing acute illness, because the case has already been reconsidered once.

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C. However, if the beneficiary had not been hospitalized when he or she became acutely ill, Medicaid would have covered up to ~~four (4)~~seven (7) inpatient days without certification and the beneficiary's case would have been eligible for consideration for certification if the stay for treatment had been longer than ~~four (4)~~seven (7) days.

D. ~~In order t~~To give due consideration to cases of true medical necessity while avoiding repeated reviews of the same admission, the following procedure for reviewing cases of this nature has been established.

E. After the beneficiary's discharge, the provider may submit the medical record for the entire admission and indicate in writing the dates to be considered for certification.

1. Only the dates requested by the provider will be considered for possible authorization,
2. The review and determination procedure is the same as described in Section 212.501.

F. ~~AFMC~~The QIO will not reconsider denials and partial denials of these requests; however, the beneficiary may appeal the decision, or the provider may appeal on behalf of the beneficiary.

212.507 Post Payment Review

~~6-1-06~~9-1-26

A post payment review of a random sample is conducted on all admissions, including inpatient stays of ~~four~~ seven (7) days or less, to ensure that medical necessity for the services is substantiated.

212.510 MUMP Applicability

~~8-1-21~~9-1-26

A. Medicaid covers up to ~~four (4)~~seven (7) days of acute care or general hospital, or both, inpatient service without a ~~no~~ certification requirement, except in the case of a transfer (see part C, below). The days are subject to retrospective review for medical necessity.

B. If a ~~patient~~ beneficiary is not discharged before or during the ~~fifth~~ eighth day of hospitalization, additional days are covered only if certified.

C. When a ~~patient~~ beneficiary is transferred from one hospital to another, the stay must be certified from the first day.

212.511 MUMP Exemptions

~~6-1-06~~9-1-26

A. Individuals in all Medicaid eligibility categories and all age groups, except beneficiaries under age one (1)~~,~~ are subject to this policy. Medicaid beneficiaries under age one (1) at the time of admission are exempt from MUMP requirements for dates of service before their first birthday.

1. When a Medicaid beneficiary reaches age one (1) during an inpatient stay, the days from the admission date through the day before the ~~patient~~beneficiary's birthday are exempt from the MUMP.
2. The MUMP becomes effective on the one-year birthday.
   a. The ~~patient~~beneficiary's birthday is the first day of the ~~four~~ seven (7) days not requiring MUMP certification.
   b. ~~If the patient is not discharged before or during the fourth day following the patient's first birthday, h~~Hospital staff must apply for MUMP certification of ~~the~~ additional days (starting with the eighth day after the beneficiary's first birthday)

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if the beneficiary is not discharged prior to then.

B. The MUMP does not apply to inpatient stays for bone marrow, liver, liver/bowel, heart, lung, skin and pancreas/kidney transplant procedures. Information about prior approval for transplants is given in Sections 217.060 through 217.069 and Sections 245.000 through 245.020.

C. When there is primary coverage by a third-party resource and the provider seeks secondary coverage by Medicaid, Medicaid covers the same number of inpatient days as the primary resource whether the number of covered days is less than, equal to or greater than fourseven (7).

1. Therefore, MUMP certification is not required in this circumstance.
2. Medicaid processes the provider's claim in accordance with CMS's regulations governing third party liability.

212.520 MUMP Certification Request Procedure

8-1-219-1-26

When a patientbeneficiary is transferred from another hospital (see Section 212.530 below) or when a patientbeneficiary's attending physician clinician determines the patientbeneficiary should not be discharged by the fifeighth day of hospitalization, hospital utilization review or case management personnel may request an extension of inpatient days. **View or print contact information to obtain the DHS or designated vendor step-by-step process for requesting MUMP certification.**

A. Additional extensions may be requested as needed.The number of days allowed for an extension will be based on medical judgment utilizing Medicaid guidelines and clinical standards of practice.

B. The Arkansas Medicaid Utilization Management Program (MUMP) certification process is separate from prior authorization requirements.The certification process for extensions of inpatient days described in this section is a separate requirement from the prior authorization process. If a procedure requires prior authorization, the provider must request and receive prior authorization for the procedure in order to be reimbursed.

1. Prior authorization for medical procedures must be obtained by the appropriate providers.
2. Hospital stays for restricted procedures are disallowed when required prior authorizations are not obtained.

C. Except for the exemptions listed in Section 212.511, Medicaid does not cover fifeighth and subsequent days of inpatient hospital admissions unless they have been certified, in accordance with applicable procedures for concurrent or retroactive MUMP certification.

212.540 Post Certification Due to Retroactive Eligibility

8-1-219-1-26

When eligibility is determined while the patientbeneficiary is still an inpatient, the hospital may request post-certification of inpatient days beyond the first four (4)seven (7) (or all days if the admission was by transfer) and a concurrent certification of additional days, if needed. **View or print contact information to obtain instructions for submitting the request.**

215.420 CAH Coverage Restrictions

8-1-219-1-26

A. Arkansas Department of Health regulations stipulate that Critical Access Hospitals (CAH) may provide medically necessary acute inpatient care for a period not to exceed ninety-six (96) hours, unless:

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1. A longer period is required because transfer to a hospital is precluded due to inclement weather or other emergency conditions or

2. A peer review organization or equivalent entity, upon request, waives the ninety-six (96) hour restriction on a case-by-case basis.

B. DHS or its designated vendor shall determine and certify lengths of stay in the Medicaid Utilization Management Program (MUMP). **View or print contact information to obtain the DHS or designated vendor regarding coverage restrictions.**

1. CAHs shall follow MUMP procedures to certify stays longer than four (4) days.

2. CAHs receiving inpatients by transfer from a hospital or another CAH must obtain certification of inpatient stays of any length.

3. In addition to MUMP criteria of medical necessity, DHS or its designated vendor will, when applicable, review a CAH's justification for retaining a ~~patient~~beneficiary instead of transferring the ~~patient~~beneficiary to a hospital.

a. Inpatient stays of any length may be retrospectively reviewed for medical necessity.

b. Inpatient stays of any length may be retrospectively reviewed to ascertain justification for retaining a ~~patient~~ beneficiary instead of transferring the ~~patient~~beneficiary to a hospital.

C. Medicaid beneficiaries under age one (1) at the time of admission are exempt from the 96-hour inpatient stay limitation and the MUMP policy for dates of service before their first birthday.

D. A CAH may provide medically necessary acute inpatient care for a period that does not exceed, as determined on an annual average basis, ninety-six (96) hours per ~~patient~~beneficiary.

1. Discharges and average stays are identified and calculated by the Medicare fiscal intermediary and are the same as those used for Medicare purposes.

2. The CAH's average lengths of stay will be reported to the CMS regional office by the Medicare fiscal intermediary.

a. If a CAH exceeds the average length of stay limit, it will be required to develop and implement a corrective action plan acceptable to the CMS regional office.

b. If the CAH fails to implement the corrective action plan, the CAH will be subject to termination of its Medicaid provider agreement and other sanctions established under Title XVIII of the Social Security Act.

250.100 Introduction to Reimbursement

~~10-13-03~~9-1-26

A. All Medicaid-enrolled acute care hospitals in Arkansas and some acute care hospitals in adjacent states are reimbursed for inpatient services by interim per diem and year-end cost settlement. Most hospitals outside Arkansas are reimbursed for inpatient services by means of a prospective payment system.

B. Reimbursement for outpatient hospital services and end-stage renal disease (ESRD) services is by a fee-for-service methodology in accordance with an established fee schedule and without cost settlement, with the following exceptions:

1. ~~Arkansas~~ Medicaid cost-settles for outpatient services with in-state pediatric hospitals.

2. ~~Arkansas~~ Medicaid cost-settles for outpatient services with Arkansas State Operated Teaching Hospitals, effective for cost reporting periods ending on and after June 30, 2000.

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3. Effective May 18, 2000, Arkansas State Operated Teaching Hospitals receive an annual outpatient reimbursement adjustment based on the previous state fiscal year's (SFY) outpatient Medicare-related upper payment limit (UPL) for "as identified Medicaid-reimbursed" outpatient services. See Section 252.130.

C. Reimbursement for Acute Rehabilitation Unit Services within an acute care hospital is reimbursed at the per diem rate for rehabilitative inpatient services as specified in section 231.000 of the Rehabilitative Hospital Manual.

272.406 Billing for Inpatient Hospital Services When a Beneficiary Turns Age 21

~~10-22-10~~9-1-26

~~A. The benefit limit for acute care/general and rehabilitative hospital inpatient services is 24 paid inpatient days per state fiscal year (July 1 through June 30) for Medicaid beneficiaries aged 21 and older.~~There is no benefit limit for acute care, general, and rehabilitative hospital inpatient services for Medicaid beneficiaries aged twenty-one (21) and older. Once beneficiaries have used twenty-four (24) paid inpatient days per state fiscal year (July 1 through June 30), any additional medically necessary days within the SFY may be reimbursed at a reduced per diem. The length of stay beyond the seventh day is subject to MUMP review regardless of number of days required.

~~B~~A. When a beneficiary turns twenty-one (21) during an inpatient hospital stay, the dates of service ~~on or after his/her~~ starting with the twenty-first~~21st~~ birthday must be billed separately.

~~C~~B. ~~Arkansas~~ Medicaid covers up to 4seven (7) days of acute care or general hospital, or both, inpatient services with no certification requirement. If a beneficiary is not discharged before or during the ~~fif~~eighth day, additional days are covered only if certified. The Medicaid Utilization Management Program (MUMP) determines covered acute care or general hospital, or both, inpatient lengths of stay in general ~~and rehabilitative~~ hospitals, in and out of state. MUMP also determines covered freestanding rehabilitative hospital lengths of stay up to ten (10) days prior to requiring certification of additional days, in and out of state. See Sections 212.510 for MUMP applicability and 212.520 for MUMP certification request procedures.

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211.000 Rehabilitation Services Provided Within Acute Care Hospitals 9-1-26

211.100 Criteria 9-1-26

The criteria for acute inpatient rehabilitation include that the beneficiary:

A. Require active and ongoing intervention of at least two (2) of the multiple therapy disciplines (Physical Therapy, Occupational Therapy, Speech-language Pathology, or prosthetics/orthotics), with at least one of which being physical therapy or occupational therapy; AND

B. Require an intensive rehabilitation therapy program.

C. Be able to actively participate in rehabilitation services and significantly benefit from the program.

D. Show measurable improvement of practical value, as documented in the medical record and submitted for review.

E. Be able to actively participate in rehabilitation services for three (3) hours per day or fifteen (15) hours per week.

211.110 Regulation of Plan of Care (POC) 9-1-26

A. At a minimum the documentation must indicate that the Plan of Care (POC) was synthesized by the rehabilitation physician and within four (4) days of receipt of rehabilitation only services.

B. The POC must include:

1. Beneficiary's medical prognosis
2. Functional outcomes
3. Planned discharge date and destination
4. Estimated length of stay
5. Details of each anticipated therapy intervention by discipline including intensity (number of hours per day), frequency (number of days per week), and duration (number of days during the IRF stay)

C. Group and concurrent treatment minutes can be counted toward meeting the intensity requirement but must not be more than fifty percent (50%) of the treatment provided.

D. If caregiving needs are anticipated following discharge, family members and caregivers identified prior to or during admission are expected to participate in the plan of care. The discharge planning begins with identification of the beneficiary's need for rehabilitative services.

211.120 Rehabilitation Physician Visits 9-1-26

The beneficiary's services must be supervised by a rehabilitation physician or other licensed treating physician with specialized training and experience in rehabilitation. There must be face-

PROPOSED

to-face visits at least three (3) days per week, beginning with the first week and throughout the time the patient is receiving rehabilitation only services.

NOTE: Beginning the second week of the rehabilitation only stay, a non-physician practitioner may conduct one (1) of the three (3) required weekly visits.

211.125 List of Medical Conditions Requiring Intensive Rehabilitative Services 9-1-26

The following list includes the medical conditions that may require intensive rehabilitative services:

A. Stroke

B. Spinal cord injury

C. Congenital deformity

D. Amputation

E. Major multiple trauma

F. Fracture of femur (hip fracture)

G. Brain Injury

H. Neurological disorders, including multiple sclerosis, motor neuron diseases, polyneuropathy, muscular dystrophy, and Parkinson's disease

I. Burns

J. Active, polyarticular rheumatoid arthritis; psoriatic arthritis,; and seronegative arthropathies resulting in significant functional impairment of ambulation; and other activities of daily living that have not improved after an appropriate, aggressive, and sustained course of outpatient therapy services or services in other less intensive rehabilitation settings immediately preceding the inpatient rehabilitation admission, or that result from a systemic disease activation immediately before admission, but have the potential to improve with more intensive rehabilitation

K. Systemic vasculidities with joint inflammation, resulting in significant functional impairment of ambulation and other activities of daily living that have not improved after an appropriate, aggressive, and sustained course of outpatient therapy services

L. Severe or advanced osteoarthritis (osteoarthrosis or degenerative joint disease) involving two or more major weight bearing joints (elbow, shoulders, hips, or knees, but not counting a joint with a prosthesis) with joint deformity and substantial loss of range of motion, atrophy of muscles surrounding the joint, significant functional impairment of ambulation and other activities of daily living that have not improved after the patient has participated in an appropriate, aggressive, and sustained course of outpatient therapy services or services in other less intensive rehabilitation settings immediately preceding the inpatient rehabilitation admission but have the potential to improve with more intensive rehabilitation. (A joint replaced by a prosthesis no longer is considered to have osteoarthritis, or other arthritis, even though this condition was the reason for the joint replacement.)

M. Knee or hip joint replacement, or both, during an acute hospitalization immediately preceding the inpatient rehabilitation stay and also meet one (1) or more of the following specific criteria:

PROPOSED

1. The patient underwent bilateral knee or bilateral hip joint replacement surgery during the acute hospital admission immediately preceding the intensive rehabilitation only days;
2. The patient is extremely obese with a Body Mass Index of at least fifty (50) at the time of rehabilitation only days; or
3. The patient is eighty-five (85) years of age or older at the time of rehabilitation only days.

212.400 Inpatient Hospital Benefit Limitation 9-1-26

212.401 Inpatient Hospital Services Benefit Limit 9-1-26

A. There is no benefit limit for acute care or general and rehabilitative hospital inpatient services for Medicaid beneficiaries. Once beneficiaries have used twenty-four (24) paid inpatient days per state fiscal year (July 1 through June 30), any additional medically necessary days within the SFY may be reimbursed at a reduced per diem. The length of stay after day seven (7) for beneficiaries aged one (1) and older is subject to MUMP review.

B. Included in the total of paid inpatient days are any days covered by primary third-party resources (except Medicare and Railroad Retirement) for which Medicaid receives a secondary-payer claim that it adjudicates as paid. A Medicaid-secondary claim that adjudicates as a paid claim is counted toward the inpatient benefit limit.

1. Medicaid, when it is secondary to a third-party resource other than Medicare or Railroad Retirement, covers only the difference between the primary resource's remittance and Medicaid's per diem or maximum allowable fee for Medicaid-covered services reimbursed by the primary resource.
2. Even when the Medicaid paid amount is $0.00 because the third-party payment equals or exceeds Medicaid's per diem, the days thus paid are counted toward the benefit limit.

C. See Section 272.406 regarding special billing instructions for beneficiaries who turn twenty-one (21) years of age during an inpatient hospital stay.

212.503 Paper Review After Administrative Reconsiderations: Special Cases 9-1-26

A. Infrequently, the following sequence of events may occur: An extension of days is denied or only partially approved and the determination is upheld on reconsideration; however, before the beneficiary can be discharged, he or she becomes acutely ill and remains hospitalized for treatment of that illness.

B. In strict accordance with the regulation above in Section 212.502, the provider would be precluded from requesting certification of any of the inpatient days required for treatment of the late-appearing acute illness, because the case has already been reconsidered once.

C. However, if the beneficiary had not been hospitalized when he or she became acutely ill, Medicaid would have covered up to seven (7) inpatient days without certification and the beneficiary's case would have been eligible for consideration for certification if the stay for treatment had been longer than seven (7) days.

D. To give due consideration to cases of true medical necessity while avoiding repeated reviews of the same admission, the following procedure for reviewing cases of this nature has been established.

PROPOSED

E. After the beneficiary's discharge, the provider may submit the medical record for the entire admission and indicate in writing the dates to be considered for certification.

1. Only the dates requested by the provider will be considered for possible authorization,

2. The review and determination procedure is the same as described in Section 212.501.

F. The QIO will not reconsider denials and partial denials of these requests; however, the beneficiary may appeal the decision, or the provider may appeal on behalf of the beneficiary.

212.507 Post Payment Review 9-1-26

A post payment review of a random sample is conducted on all admissions, including inpatient stays of seven (7) days or less, to ensure that medical necessity for the services is substantiated.

212.510 MUMP Applicability 9-1-26

A. Medicaid covers up to seven (7) days of acute care or general hospital, or both, inpatient service without a certification requirement, except in the case of a transfer (see part C, below). The days are subject to retrospective review for medical necessity.

B. If a beneficiary is not discharged before or during the eighth day of hospitalization, additional days are covered only if certified.

C. When a beneficiary is transferred from one hospital to another, the stay must be certified from the first day.

212.511 MUMP Exemptions 9-1-26

A. Individuals in all Medicaid eligibility categories and all age groups, except beneficiaries under age one (1) are subject to this policy. Medicaid beneficiaries under age one (1) at the time of admission are exempt from MUMP requirements for dates of service before their first birthday.

1. When a Medicaid beneficiary reaches age one (1) during an inpatient stay, the days from the admission date through the day before the beneficiary's birthday are exempt from the MUMP.

2. The MUMP becomes effective on the one-year birthday.

a. The beneficiary's birthday is the first day of the seven (7) days not requiring MUMP certification.

b. Hospital staff must apply for MUMP certification of additional days (starting with the eighth day after the beneficiary's first birthday) if the beneficiary is not discharged prior to then.

B. The MUMP does not apply to inpatient stays for bone marrow, liver, liver/bowel, heart, lung, skin and pancreas/kidney transplant procedures. Information about prior approval for transplants is given in Sections 217.060 through 217.069 and Sections 245.000 through 245.020.

C. When there is primary coverage by a third-party resource and the provider seeks secondary coverage by Medicaid, Medicaid covers the same number of inpatient days as the primary resource whether the number of covered days is less than, equal to or greater than seven (7).

1. Therefore, MUMP certification is not required in this circumstance.

PROPOSED

2. Medicaid processes the provider's claim in accordance with CMS's regulations governing third party liability.

212.520 MUMP Certification Request Procedure 9-1-26

When a beneficiary is transferred from another hospital (see Section 212.530 below) or when a beneficiary's attending clinician determines the beneficiary should not be discharged by the eighth day of hospitalization, hospital utilization review or case management personnel may request an extension of inpatient days. **View or print contact information to obtain the DHS or designated vendor step-by-step process for requesting MUMP certification.**

A. The number of days allowed for an extension will be based on medical judgment utilizing Medicaid guidelines and clinical standards of practice.

B. The certification process for extensions of inpatient days described in this section is a separate requirement from the prior authorization process. If a procedure requires prior authorization, the provider must request and receive prior authorization for the procedure in order to be reimbursed.

1. Prior authorization for medical procedures must be obtained by the appropriate providers.

2. Hospital stays for restricted procedures are disallowed when required prior authorizations are not obtained.

C. Except for the exemptions listed in Section 212.511, Medicaid does not cover eighth and subsequent days of inpatient hospital admissions unless they have been certified, in accordance with applicable procedures for concurrent or retroactive MUMP certification.

212.540 Post Certification Due to Retroactive Eligibility 9-1-26

When eligibility is determined while the beneficiary is still an inpatient, the hospital may request post-certification of inpatient days beyond the first seven (7) (or all days if the admission was by transfer) and a concurrent certification of additional days, if needed. **View or print contact information to obtain instructions for submitting the request.**

215.420 CAH Coverage Restrictions 9-1-26

A. Department of Health regulations stipulate that Critical Access Hospitals (CAH) may provide medically necessary acute inpatient care for a period not to exceed ninety-six (96) hours, unless:

1. A longer period is required because transfer to a hospital is precluded due to inclement weather or other emergency conditions or

2. A peer review organization or equivalent entity, upon request, waives the ninety-six (96) hour restriction on a case-by-case basis.

B. DHS or its designated vendor shall determine and certify lengths of stay in the Medicaid Utilization Management Program (MUMP). **View or print contact information to obtain the DHS or designated vendor regarding coverage restrictions.**

1. CAHs shall follow MUMP procedures to certify stays longer than four (4) days.

2. CAHs receiving inpatients by transfer from a hospital or another CAH must obtain certification of inpatient stays of any length.

3. In addition to MUMP criteria of medical necessity, DHS or its designated vendor will, when applicable, review a CAH's justification for retaining a beneficiary instead of transferring the beneficiary to a hospital.

a. Inpatient stays of any length may be retrospectively reviewed for medical

PROPOSED

necessity.

b. Inpatient stays of any length may be retrospectively reviewed to ascertain justification for retaining a beneficiary instead of transferring the beneficiary to a hospital.

C. Medicaid beneficiaries under age one (1) at the time of admission are exempt from the 96-hour inpatient stay limitation and the MUMP policy for dates of service before their first birthday.

D. A CAH may provide medically necessary acute inpatient care for a period that does not exceed, as determined on an annual average basis, ninety-six (96) hours per beneficiary.

1. Discharges and average stays are identified and calculated by the Medicare fiscal intermediary and are the same as those used for Medicare purposes.

2. The CAH's average lengths of stay will be reported to the CMS regional office by the Medicare fiscal intermediary.

a. If a CAH exceeds the average length of stay limit, it will be required to develop and implement a corrective action plan acceptable to the CMS regional office.

b. If the CAH fails to implement the corrective action plan, the CAH will be subject to termination of its Medicaid provider agreement and other sanctions established under Title XVIII of the Social Security Act.

250.100 Introduction to Reimbursement 9-1-26

A. All Medicaid-enrolled acute care hospitals in Arkansas and some acute care hospitals in adjacent states are reimbursed for inpatient services by interim per diem and year-end cost settlement. Most hospitals outside Arkansas are reimbursed for inpatient services by means of a prospective payment system.

B. Reimbursement for outpatient hospital services and end-stage renal disease (ESRD) services is by a fee-for-service methodology in accordance with an established fee schedule and without cost settlement, with the following exceptions:

1. Medicaid cost-settles for outpatient services with in-state pediatric hospitals.

2. Medicaid cost-settles for outpatient services with Arkansas State Operated Teaching Hospitals, effective for cost reporting periods ending on and after June 30, 2000.

3. Effective May 18, 2000, Arkansas State Operated Teaching Hospitals receive an annual outpatient reimbursement adjustment based on the previous state fiscal year's (SFY) outpatient Medicare-related upper payment limit (UPL) for "as identified Medicaid-reimbursed" outpatient services. See Section 252.130.

C. Reimbursement for Acute Rehabilitation Unit Services within an acute care hospital is reimbursed at the per diem rate for rehabilitative inpatient services as specified in section 231.000 of the Rehabilitative Hospital Manual.

272.406 Billing for Inpatient Hospital Services When a Beneficiary Turns Age 21 9-1-26

There is no benefit limit for acute care, general, and rehabilitative hospital inpatient services for Medicaid beneficiaries aged twenty-one (21) and older. Once beneficiaries have used twenty-four (24) paid inpatient days per state fiscal year (July 1 through June 30), any additional medically necessary days within the SFY may be reimbursed at a reduced per diem. The length of stay beyond the seventh day is subject to MUMP review regardless of number of days required.

A. When a beneficiary turns twenty-one (21) during an inpatient hospital stay, the dates of service starting with the twenty-first birthday must be billed separately.

PROPOSED

B. Medicaid covers up to seven (7) days of acute care or general hospital, or both, inpatient services with no certification requirement. If a beneficiary is not discharged before or during the eighth day, additional days are covered only if certified. The Medicaid Utilization Management Program (MUMP) determines covered acute care or general hospital, or both, inpatient lengths of stay in general hospitals, in and out of state. MUMP also determines covered freestanding rehabilitative hospital lengths of stay up to ten (10) days prior to requiring certification of additional days, in and out of state. See Sections 212.510 for MUMP applicability and 212.520 for MUMP certification request procedures.

PROPOSED

TOC not required

203.600 The Nurse Practitioner's Role in Hospital Services

~~8-1-21~~9-1-26

A. Medicaid covers medically necessary hospital services, within the constraints of the Medicaid Utilization Management Program (MUMP) and applicable benefit limitations. (Refer to Section 214.711.)

B. The care and treatment of a ~~patient~~beneficiary must be under the direction of a licensed ~~physician, a licensed nurse practitioner, a certified nurse-midwife or dentist~~clinician with hospital staff affiliation.

C. DHS or its designated vendor reviews all inpatient hospital transfers, and all acute care and general inpatient stays longer than ~~four~~ seven (~~4~~7) days for the Medicaid Utilization Management Program (MUMP). Freestanding rehabilitative inpatient hospital stays longer than ten (10) days are reviewed for the MUMP.

DHS or its designated vendor also completes post-payment reviews of hospital stays for medical necessity determinations. **View or print contact information to obtain the DHS or designated vendor step-by-step process for requesting extension of inpatient stays.**

D. ~~Hospital claims are also subject to review by the Medicaid Peer Review Committee or the Medical Director for the Medicaid Program.~~When Arkansas Medicaid's Division of Medical Services' Medical Director for Clinical Affairs, QIO or other designee determines – whether prospectively, concurrently, or retrospectively – that a hospital service is not medically necessary, Medicaid covers neither the hospital service nor any related nurse practitioner services.

1. If Medicaid denies a hospital's claim for lack of medical necessity, payments to ~~nurse~~ practitioners for evaluation and management services incidental to the hospitalization are subject to recoupment by the Medicaid agency.
2. ~~Nurse p~~Practitioners and hospitals may not bill a Medicaid beneficiary for a service Medicaid has declared not medically necessary.
3. ~~Nurse p~~Practitioners and hospitals may not rebill inpatient services previously denied for lack of medical necessity as outpatient services.

214.711 Medicaid Utilization Management Program (MUMP)

~~8-1-21~~9-1-26

The Medicaid Utilization Management Program (MUMP) determines covered lengths of stay in inpatient acute care ~~and/~~or general hospitals, or both, and freestanding rehabilitative hospitals, in state and out of state.

Length-of-stay determinations are made by ~~the~~ a Quality Improvement Organization (QIO)~~,~~ under contract to the ~~Arkansas~~ Medicaid Program.

Individuals in all Medicaid eligibility categories and all age groups, except beneficiaries under age one (1), are subject to this policy. Medicaid beneficiaries under age one (1) at the time of admission are exempt from the MUMP policy for dates of service before their first birthday. Refer to item "D~~E~~" below for the procedure to follow when a child's first birthday occurs during an inpatient stay.

The procedures for the MUMP are as follows:

MARK-UP

A. Medicaid will reimburse acute care or general hospitals, or both, for up to ~~four~~ seven (~~4~~7) days of inpatient service with no pre-certification requirement, except for admissions by transfer from another hospital. Freestanding rehabilitative hospitals are reimbursed for up to ten (10) days of rehabilitative stay before pre-certification is required.

B. If the attending ~~nurse practitioner~~clinician determines the ~~patient~~beneficiary should not be discharged by the ~~fif~~eighth day of acute care or general hospitalization, or both, or the tenth day of freestanding rehabilitative hospitalization, a hospital medical staff member may contact DHS or its designated vendor and request an extension of inpatient days.

View or print contact information to obtain the DHS or designated vendor step-by-step process for requesting extension of inpatient stays.

C. The number of days allowed for an extension will be based on medical judgment utilizing Medicaid guidelines and clinical standards of practice.

D. When a Medicaid beneficiary reaches age one (1) during an inpatient stay, the days from the admission date through the day before the ~~patient~~beneficiary's birthday are exempt from the MUMP policy. MUMP policy becomes effective on the one-year birthday. The ~~patient~~beneficiary's birthday is the first day of the ~~four~~seven (~~4~~7) acute care and general hospital days or the ten (10) freestanding rehabilitative hospital days not requiring MUMP certification. If the stay continues beyond the ~~fourth~~seven (7) days or ten (10) days (inclusive~~)~~ of the ~~patient~~beneficiary's first birthday), hospital staff must apply for MUMP certification of the additional days.

E. ~~Additional extensions may be requested as needed.~~

~~F.~~ Requests for r~~R~~econsideration ~~reviews~~ of denied extensions may be ~~requested by sending the medical record to AFMC through regular mail, or expedited by overnight express~~made through the **prior authorization portal**. The hospital will be notified by the next working day of the decision.

F~~G~~. ~~Call~~Requests for extension of days may be made at any point from the ~~fourth~~ seventh day of stay through for acute care and general hospital discharge or any point from the tenth day stay through freestanding rehabilitative hospital discharge. However, the provider must accept ~~the~~ financial liability should the stay not meet the necessary medical criteria for inpatient services. If the provider chooses to delay ~~calling for~~requesting extension verification and the services are denied based on medical necessity, the beneficiary mu~~stay~~ not be held liable. ~~All~~When requests ~~calls~~ for extension are made by phone, the calls ~~will be~~are limited to ten (10) minutes to allow equal access to all providers.

G~~H~~. Inpatient stays for bone marrow, liver, heart, lung, skin and pancreas and/or kidney transplant procedures are excluded from this review program. Information about transplant prior approval is given in Sections 217.060 through 217.069 and Sections 245.000 through 245.020 in the Hospital provider manual.

H~~I~~. A retrospective or post-payment random sample review will be conducted for all admissions, including acute care and general inpatient stays of ~~four~~ seven (~~4~~7) days or less and freestanding rehabilitative hospital inpatient stays of ten (10) days or less, to ensure that medical necessity for the services is substantiated.

I~~J~~. Admissions of retroactive eligible beneficiary: If eligibility is identified while the ~~patient~~ beneficiary is still an inpatient, the hospital may request retrospective review of those days already used past the original ~~four~~seven (7) acute care and general days or ten (10) freestanding rehabilitative hospital days for a determination of post-authorization and concurrent evaluation of future extended days.

If the retroactive eligible beneficiary is not identified until after discharge, and the hospital files a claim and receives a denial for any days past the original ~~four~~ days allowed, the hospital may request post-extension evaluation approval of the denied days. If granted,

MARK-UP

the claim may be refiled. If the length of stay is more than thirty (30) days, the provider shall submit the entire medical record to DHS or its designated vendor for review.

~~K.~~J. Claims submitted without an extension will result in automatic denials of any days billed beyond the ~~fourth~~ last day of the MUMP period of admission. The only exceptions are for claims reflecting third party liability and ~~patients~~beneficiaries with retroactive Medicaid eligibility described in items ~~G~~ F and ~~J~~ I above.

K~~L~~. If a ~~patient~~beneficiary is transferred from one facility to another, the receiving facility must contact DHS or its designated vendor within twenty-four (24) hours of admitting the ~~patient~~beneficiary to qualify the inpatient stay. If an admission falls on a weekend or holiday, the provider may contact DHS or its designated vendor on the first working day following the weekend or holiday.

L~~M~~. The certification process for extensions of inpatient days described in this section is a separate requirement from the prior authorization process for services provided for treatment of the beneficiary's condition. If a procedure requires prior authorization, the provider must request and receive prior authorization for the procedure code ~~in order~~ to be reimbursed.

M~~N~~. If a provider fails to contact DHS or its designated vendor for an extension of inpatient days due to the ~~patient's~~beneficiary having private insurance or Medicare Part A and later receives a denial due to non-covered service, lost eligibility, benefits exhausted, etc., post-certification of days past the original ~~four~~ days of the MUMP period may be obtained by the following procedures:

1. Send a copy of the denial notice received from the third-party payer to DHS or its designated vendor.
2. Include a note requesting post-certification and the full name of the requester and a phone number where the requester may be reached.

   Upon receipt of the denial copy and the provider request, a coordinator will call the provider and obtain certification information.

~~O~~N. If a third-party insurer pays for an approved number of days, Medicaid will not grant an extension for days beyond the number of days approved by the private insurer.

MARK-UP

TOC not required

203.600 The Nurse Practitioner's Role in Hospital Services 9-1-26

A. Medicaid covers medically necessary hospital services, within the constraints of the Medicaid Utilization Management Program (MUMP) and applicable benefit limitations. (Refer to Section 214.711.)

B. The care and treatment of a beneficiary must be under the direction of a licensed clinician with hospital staff affiliation.

C. DHS or its designated vendor reviews all inpatient hospital transfers, and all acute care and general inpatient stays longer than seven (7) days for the Medicaid Utilization Management Program (MUMP). Freestanding rehabilitative inpatient hospital stays longer than ten (10) days are reviewed for the MUMP.

DHS or its designated vendor also completes post-payment reviews of hospital stays for medical necessity determinations. **View or print contact information to obtain the DHS or designated vendor step-by-step process for requesting extension of inpatient stays.**

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

1. If Medicaid denies a hospital's claim for lack of medical necessity, payments to practitioners for evaluation and management services incidental to the hospitalization are subject to recoupment by the Medicaid agency.
2. Practitioners and hospitals may not bill a Medicaid beneficiary for a service Medicaid has declared not medically necessary.
3. Practitioners and hospitals may not rebill inpatient services previously denied for lack of medical necessity as outpatient services.

214.711 Medicaid Utilization Management Program (MUMP) 9-1-26

The Medicaid Utilization Management Program (MUMP) determines covered lengths of stay in inpatient acute care or general hospitals, or both, and freestanding rehabilitative hospitals, in state and out of state.

Length-of-stay determinations are made by a Quality Improvement Organization (QIO) under contract to the Medicaid Program.

Individuals in all Medicaid eligibility categories and all age groups, except beneficiaries under age one (1), are subject to this policy. Medicaid beneficiaries under age one (1) at the time of admission are exempt from the MUMP policy for dates of service before their first birthday. Refer to item "D" below for the procedure to follow when a child's first birthday occurs during an inpatient stay.

The procedures for the MUMP are as follows:

A. Medicaid will reimburse acute care or general hospitals, or both, for up to seven (7) days of inpatient service with no pre-certification requirement, except for admissions by transfer from another hospital. Freestanding rehabilitative hospitals are reimbursed for up to ten (10) days of rehabilitative stay before pre-certification is required.

PROPOSED

B. If the attending clinician determines the beneficiary should not be discharged by the eighth day of acute care or general hospitalization, or both, or the tenth day of freestanding rehabilitative hospitalization, a hospital medical staff member may contact DHS or its designated vendor and request an extension of inpatient days.

View or print contact information to obtain the DHS or designated vendor step-by-step process for requesting extension of inpatient stays.

C. The number of days allowed for an extension will be based on medical judgment utilizing Medicaid guidelines and clinical standards of practice.

D. When a Medicaid beneficiary reaches age one (1) during an inpatient stay, the days from the admission date through the day before the beneficiary's birthday are exempt from the MUMP policy. MUMP policy becomes effective on the one-year birthday. The beneficiary's birthday is the first day of the seven (7) acute care and general hospital days or the ten (10) freestanding rehabilitative hospital days not requiring MUMP certification. If the stay continues beyond the seven (7) days or ten (10) days (inclusive of the beneficiary's first birthday), hospital staff must apply for MUMP certification of the additional days.

E. Requests for reconsideration of denied extensions may be made through the **prior authorization portal**. The hospital will be notified by the next working day of the decision.

F. Requests for extension of days may be made at any point from the seventh day of stay through for acute care and general hospital discharge or any point from the tenth day stay through freestanding rehabilitative hospital discharge. However, the provider must accept financial liability should the stay not meet the necessary medical criteria for inpatient services. If the provider chooses to delay requesting extension verification and the services are denied based on medical necessity, the beneficiary must not be held liable. When requests for extension are made by phone, the calls are limited to ten (10) minutes to allow equal access to all providers.

G. Inpatient stays for bone marrow, liver, heart, lung, skin and pancreas and/or kidney transplant procedures are excluded from this review program. Information about transplant prior approval is given in Sections 217.060 through 217.069 and Sections 245.000 through 245.020 in the Hospital provider manual.

H. A retrospective or post-payment random sample review will be conducted for all admissions, including acute care and general inpatient stays of seven (7) days or less and freestanding rehabilitative hospital inpatient stays of ten (10) days or less, to ensure that medical necessity for the services is substantiated.

I. Admissions of retroactive eligible beneficiary: If eligibility is identified while the beneficiary is still an inpatient, the hospital may request retrospective review of those days already used past the original seven (7) acute care and general days or ten (10) freestanding rehabilitative hospital days for a determination of post-authorization and concurrent evaluation of future extended days.

If the retroactive eligible beneficiary is not identified until after discharge, and the hospital files a claim and receives a denial for any days past the original days allowed, the hospital may request post-extension evaluation approval of the denied days. If granted, the claim may be refiled. If the length of stay is more than thirty (30) days, the provider shall submit the entire medical record to DHS or its designated vendor for review.

J. Claims submitted without an extension will result in automatic denials of any days billed beyond the last day of the MUMP period of admission. The only exceptions are for claims reflecting third party liability and beneficiaries with retroactive Medicaid eligibility described in items F and I above.

PROPOSED

K. If a beneficiary is transferred from one facility to another, the receiving facility must contact DHS or its designated vendor within twenty-four (24) hours of admitting the beneficiary to qualify the inpatient stay. If an admission falls on a weekend or holiday, the provider may contact DHS or its designated vendor on the first working day following the weekend or holiday.

L. The certification process for extensions of inpatient days described in this section is a separate requirement from the prior authorization process for services provided for treatment of the beneficiary's condition. If a procedure requires prior authorization, the provider must request and receive prior authorization for the procedure code to be reimbursed.

M. If a provider fails to contact DHS or its designated vendor for an extension of inpatient days due to the beneficiary having private insurance or Medicare Part A and later receives a denial due to non-covered service, lost eligibility, benefits exhausted, etc., post-certification of days past the original days of the MUMP period may be obtained by the following procedures:

1. Send a copy of the denial notice received from the third-party payer to DHS or its designated vendor.
2. Include a note requesting post-certification and the full name of the requester and a phone number where the requester may be reached.

   Upon receipt of the denial copy and the provider request, a coordinator will call the provider and obtain certification information.

N. If a third-party insurer pays for an approved number of days, Medicaid will not grant an extension for days beyond the number of days approved by the private insurer.

PROPOSED

TOC not required

203.170 Physician's Role in Hospital Services

~~8-1-21~~9-1-26

A. Medicaid covers medically necessary hospital services, within the constraints of the Medicaid Utilization Management Program (MUMP) and applicable benefit limitations.

B. The care and treatment of a ~~patient~~beneficiary must be under the direction of a licensed ~~physician or dentist~~clinician with hospital staff affiliation. Most inpatient admissions require a PCP referral. (Refer to Section I of this manual.)

C. DHS or its designated vendor reviews all inpatient hospital transfers, and all acute care and general inpatient stays longer than ~~four~~ seven (74) days for the Medicaid Utilization Management Program. Freestanding rehabilitative hospital inpatient stays are reviewed for stays longer than ten (10) days.

DHS or its designated vendor also completes post-payment reviews of hospital stays of any length for medical necessity determinations. **View or print DHS or designated vendor contact information to obtain MUMP information.**

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

1. If Medicaid denies a hospital's claim for lack of medical necessity, payments to practitioners for evaluation and management services incidental to the hospitalization are subject to recoupment by the Medicaid agency.
2. Practitioners and hospitals ~~may~~ must not bill a Medicaid beneficiary for a service Medicaid has declared not medically necessary.
3. Practitioners and hospitals ~~may~~ must not rebill ~~as outpatient services,~~ inpatient services previously denied for lack of medical necessity as outpatient services.
4. Refer to Sections I and III of th~~is~~e provider manuals for Medicare deductible and coinsurance information.

224.210 MUMP Applicability

~~8-1-21~~9-1-26

A. Medicaid covers up to ~~four~~ seven (74) days of acute care or general inpatient service, or both, and up to ten (10) days of freestanding rehabilitative hospital inpatient service with no certification requirement, except in the case of a transfer (see part ~~B~~C, below).

B. ~~–~~If a ~~patient~~beneficiary is not discharged before or during the ~~fifth~~ last day of the MUMP period of hospitalization, additional days are covered only if certified by DHS or its designated vendor.

~~B~~C. When a ~~patient~~beneficiary is transferred from one hospital to another, the stay must be certified from the first day.

224.310 Direct Admissions

~~8-1-21~~9-1-26

A. **View or print contact information to obtain the DHS or designated vendor step-by-step process for requesting extension of inpatient days.**

MARKUP

~~Calls~~Requests for extension of days may be made at any time during the inpatient stay (except in the case of a transfer from another hospital - refer to Section 224.320).

Providers initiating their request after the ~~four~~seventh day of acute care and general inpatient admission or the tenth day of freestanding rehabilitative hospital inpatient admission must accept ~~the~~ financial liability should the stay not meet the necessary medical criteria for inpatient services. If the provider delays ~~calling~~ requesting ~~for~~ extension verification and the services are denied based on medical necessity, the beneficiary ~~may~~ must not be held liable.

B. When a Medicaid client reaches age one (1) during an inpatient stay, the days from the admission date through the day before the ~~patient~~ beneficiary's birthday are exempt from the Medicaid Utilization Management Program (MUMP) policy. MUMP policy becomes effective on the one-year birthday. The ~~patient~~beneficiary's birthday is the first day of the ~~four~~ seven (~~4~~7) days acute care and general admission or the ten (10) days freestanding rehabilitative hospital admission not requiring MUMP certification. If the stay continues beyond the ~~four~~seventh day or tenth day following the ~~patient~~ beneficiary's first birthday, hospital staff must apply for MUMP certification of the additional days.

C. ~~DHS or its designated vendor utilizes Medicaid guidelines and the medical judgment of its professional staff to determine the number of days to allow.~~The number of days allowed for an extension will be based on medical judgment utilizing Medicaid guidelines and clinical standards of practice.

D. ~~Additional extensions may be requested as needed.~~

~~E.~~ The certification process under the MUMP is separate from prior authorization requirements for services provided during the hospital admission. Prior authorization for medical procedures thus restricted must be obtained by the appropriate providers. Hospital stays for restricted procedures may be disallowed if required prior authorizations are not obtained.

~~F~~E. Out-of-state claims (claims from providers in non-bordering states) are subject to the determination for medical necessity for out-of-state treatment. In addition, the claim and records will be reviewed retrospectively for lengths of stay beyond the ~~four~~seven (~~4~~7) days allowed for acute care or general hospital inpatient stays, or both, or ten (10) days allowed for freestanding rehabilitative hospital inpatient stays.

~~G~~F. Claims submitted without an approved extension request will result in automatic denials of any days billed beyond the ~~fourth~~ last allowed MUMP ~~day~~period of inpatient stay. No exceptions will be granted except for claims reflecting third party liability.

224.330 Retroactive Eligibility

~~8-1-21~~9-1-26

A. If eligibility is determined while the ~~patient~~beneficiary is still an inpatient, the hospital may request post-certification of inpatient days beyond the first ~~four~~seven (~~4~~7) (or all days if the admission was by transfer) and a concurrent certification of additional days, if needed. If eligibility is determined while the beneficiary is still an inpatient of a freestanding rehabilitative hospital, a request for post-certification of inpatient days beyond the first ten (10) and a concurrent certification of additional days may be made, if needed.

B. If eligibility is determined after discharge the hospital may contact DHS or its designated vendor for post-certification of inpatient days beyond the first ~~four~~seven (~~4~~7) for acute care or general hospitalization, or both, or ten (10) for freestanding rehabilitative hospitalization (or all days if the admission was by transfer). If certification sought is for a stay longer than thirty (30) days, the provider must submit the entire medical record for review.

MARK-UP

224.400 Post Payment Review

~~10-13-039~~-1-26

A post payment review of a ~~30%~~ random sample is conducted on all admissions, including inpatient stays *of* ~~*four*~~ *seven (7) days or less*, or inpatient stays *of ten (10) days or less for freestanding rehabilitative hospitals* to ensure that medical necessity for the services is substantiated.

MARK-UP

TOC not required

203.170 Physician's Role in Hospital Services 9-1-26

A. Medicaid covers medically necessary hospital services, within the constraints of the Medicaid Utilization Management Program (MUMP) and applicable benefit limitations.

B. The care and treatment of a beneficiary must be under the direction of a licensed clinician with hospital staff affiliation. Most inpatient admissions require a PCP referral. (Refer to Section I of this manual.)

C. DHS or its designated vendor reviews all inpatient hospital transfers, and all acute care and general inpatient stays longer than seven (7) days for the Medicaid Utilization Management Program. Freestanding rehabilitative hospital inpatient stays are reviewed for stays longer than ten (10) days.

DHS or its designated vendor also completes post-payment reviews of hospital stays of any length for medical necessity determinations. **View or print DHS or designated vendor contact information to obtain MUMP information.**

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

1. If Medicaid denies a hospital's claim for lack of medical necessity, payments to practitioners for evaluation and management services incidental to the hospitalization are subject to recoupment by the Medicaid agency.
2. Practitioners and hospitals must not bill a Medicaid beneficiary for a service Medicaid has declared not medically necessary.
3. Practitioners and hospitals must not rebill inpatient services previously denied for lack of medical necessity as outpatient services.
4. Refer to Sections I and III of the provider manuals for Medicare deductible and coinsurance information.

224.210 MUMP Applicability 9-1-26

A. Medicaid covers up to seven (7) days of acute care or general inpatient service, or both, and up to ten (10) days of freestanding rehabilitative hospital inpatient service with no certification requirement, except in the case of a transfer (see part C, below).

B. If a beneficiary is not discharged before or during the last day of the MUMP period of hospitalization, additional days are covered only if certified by DHS or its designated vendor.

C. When a beneficiary is transferred from one hospital to another, the stay must be certified from the first day.

224.310 Direct Admissions 9-1-26

A. **View or print contact information to obtain the DHS or designated vendor step-by-step process for requesting extension of inpatient days.**

Requests for extension of days may be made at any time during the inpatient stay (except in the case of a transfer from another hospital - refer to Section 224.320).

PROPOSED

Providers initiating their request after the seventh day of acute care and general inpatient admission or the tenth day of freestanding rehabilitative hospital inpatient admission must accept financial liability should the stay not meet the necessary medical criteria for inpatient services. If the provider delays requesting extension verification and the services are denied based on medical necessity, the beneficiary must not be held liable.

B. When a Medicaid client reaches age one (1) during an inpatient stay, the days from the admission date through the day before the beneficiary's birthday are exempt from the Medicaid Utilization Management Program (MUMP) policy. MUMP policy becomes effective on the one-year birthday. The beneficiary's birthday is the first day of the seven (7) days acute care and general admission or the ten (10) days freestanding rehabilitative hospital admission not requiring MUMP certification. If the stay continues beyond the seventh day or tenth day following the beneficiary's first birthday, hospital staff must apply for MUMP certification of the additional days.

C. The number of days allowed for an extension will be based on medical judgment utilizing Medicaid guidelines and clinical standards of practice.

D. The certification process under the MUMP is separate from prior authorization requirements for services provided during the hospital admission. Prior authorization for medical procedures thus restricted must be obtained by the appropriate providers. Hospital stays for restricted procedures may be disallowed if required prior authorizations are not obtained.

E. Out-of-state claims (claims from providers in non-bordering states) are subject to the determination for medical necessity for out-of-state treatment. In addition, the claim and records will be reviewed retrospectively for lengths of stay beyond the seven (7) days allowed for acute care or general hospital inpatient stays, or both, or ten (10) days allowed for freestanding rehabilitative hospital inpatient stays.

F. Claims submitted without an approved extension request will result in automatic denials of any days billed beyond the last allowed MUMP period of inpatient stay. No exceptions will be granted except for claims reflecting third party liability.

224.330 Retroactive Eligibility 9-1-26

A. If eligibility is determined while the beneficiary is still an inpatient, the hospital may request post-certification of inpatient days beyond the first seven (7) (or all days if the admission was by transfer) and a concurrent certification of additional days, if needed. If eligibility is determined while the beneficiary is still an inpatient of a freestanding rehabilitative hospital, a request for post-certification of inpatient days beyond the first ten (10) and a concurrent certification of additional days may be made, if needed.

B. If eligibility is determined after discharge the hospital may contact DHS or its designated vendor for post-certification of inpatient days beyond the first seven (7) for acute care or general hospitalization, or both, or ten (10) for freestanding rehabilitative hospitalization (or all days if the admission was by transfer). If certification sought is for a stay longer than thirty (30) days, the provider must submit the entire medical record for review.

224.400 Post Payment Review 9-1-26

A post payment review of a random sample is conducted on all admissions, including inpatient stays *of seven (7) days or less*, or inpatient stays *of ten (10) days or less for freestanding rehabilitative hospitals* to ensure that medical necessity for the services is substantiated.

PROPOSED

TOC not required

213.010 Inpatient Hospital Services Benefit Limit

~~8-1-21~~9-1-26

A. ~~There is no benefit limit for acute care/general and rehabilitative hospital inpatient services for beneficiaries under age twenty-one (21) in the Child Health Services (EPSDT) Program. Inpatient services must be approved by the QIO as medically necessary.~~

~~B.~~ There is no benefit limit for acute care, ~~/~~general, and freestanding rehabilitative hospital inpatient services ~~is twenty-four (24) paid inpatient days per state fiscal year (July 1 through June 30)~~ for Medicaid beneficiaries ~~aged twenty-one (21) and older~~. Once beneficiaries have used twenty-four (24) paid inpatient days per state fiscal year (July 1 through June 30), any additional medically necessary days within the SFY may be reimbursed at a reduced per diem. The length of stay in a freestanding rehabilitative hospital beyond the tenth day for beneficiaries aged one (1) and older is subject to MUMP review regardless of number of days required.

~~C~~B. When a beneficiary turns twenty-one (21) during an inpatient stay, the dates of service ~~on or after his/her~~beginning on the twenty-first ~~21st~~ birthday must be billed separately.

~~D~~C. ~~Arkansas~~ Medicaid covers up to ~~four~~ten (~~4~~10) days of freestanding rehabilitative hospital inpatient services with no certification requirement. If a beneficiary is not discharged before or during the ~~fifth~~ eleventh day, additional days are covered only if certified. The Medicaid Utilization Management Program (MUMP) determines covered inpatient lengths of stay in acute care, ~~/~~general, and freestanding rehabilitative hospitals, in and out of state. See Sections 213.100 and 213.110 for MUMP certification request procedures.

~~E~~D. Included in the total of paid inpatient days are any days covered by primary third-party resources (except Medicare and Railroad Retirement) for which Medicaid receives a secondary ~~-~~payer claim that it adjudicates as paid. A Medicaid-secondary claim that adjudicates as a paid claim is counted toward the inpatient benefit limit.

1. Medicaid, when it is secondary to a third-party resource other than Medicare or Railroad Retirement, covers only the difference between the primary resource's remittance and Medicaid's per diem or maximum allowable fee for Medicaid-covered services reimbursed by the primary resource.
2. Even when the Medicaid paid amount is $0.00 because the third-party payment equals or exceeds Medicaid's per diem, the days thus paid are counted toward the benefit limit.

~~F. Extension of the 24-day inpatient benefit is available under the Medicaid Utilization Management Program (MUMP).~~

213.110 MUMP Applicability

~~8-1-21~~9-1-26

A. Medicaid covers up to ~~four~~ten (~~4~~10) days of freestanding rehabilitative hospital inpatient service with no certification requirement, except in the case of a transfer (see part B, below). If a ~~patient~~ beneficiary is not discharged before or during the ~~fifth~~ eleventh day of hospitalization, additional days are covered only if certified by DHS or its designated vendor. **View or print contact information for how to submit the request.**

B. When a ~~patient~~beneficiary is transferred from one hospital to another, the ~~stay must be certified from the first day~~receiving facility must certify the stay from the first day.

MARK-UP

213.150 Retroactive Eligibility

~~8-1-21~~9-1-26

A. If eligibility is determined while the ~~patient~~beneficiary is still an inpatient of the freestanding rehabilitative hospital, the hospital may contact DHS or its designated vendor to request post-certification of freestanding rehabilitative inpatient days beyond the first ~~four~~ten (4~~1~~0) days (or all days if the admission was by transfer) and a concurrent certification of additional days, if needed. **View or print contact information for how to submit the request.**

B. If eligibility is determined after discharge the freestanding rehabilitative hospital may contact DHS or its designated vendor for post-certification of freestanding rehabilitative inpatient days beyond the first ~~four~~ten (4~~1~~0) days (or all days if the admission was by transfer). If certification sought is for a stay longer than thirty (30) days, the provider must submit the entire medical record for review. **View or print contact information for how to submit the request.**

213.180 Post Payment Review

~~10-13-03~~9-1-26

A post payment review of a random sample is conducted on all admissions, including freestanding rehabilitative inpatient stays *of ~~four~~ ten (10) days or less*, to ensure that medical necessity for the services is substantiated.

MARK-UP

TOC not required

213.010 Inpatient Hospital Services Benefit Limit 9-1-26

A. There is no benefit limit for acute care, general, and freestanding rehabilitative hospital inpatient services for Medicaid beneficiaries. Once beneficiaries have used twenty-four (24) paid inpatient days per state fiscal year (July 1 through June 30), any additional medically necessary days within the SFY may be reimbursed at a reduced per diem. The length of stay in a freestanding rehabilitative hospital beyond the tenth day for beneficiaries aged one (1) and older is subject to MUMP review regardless of number of days required.

B. When a beneficiary turns twenty-one (21) during an inpatient stay, the dates of service beginning on the twenty-first birthday must be billed separately.

C. Medicaid covers up to ten (10) days of freestanding rehabilitative hospital inpatient services with no certification requirement. If a beneficiary is not discharged before or during the eleventh day, additional days are covered only if certified. The Medicaid Utilization Management Program (MUMP) determines covered inpatient lengths of stay in acute care, general, and freestanding rehabilitative hospitals, in and out of state. See Sections 213.100 and 213.110 for MUMP certification request procedures.

D. Included in the total of paid inpatient days are any days covered by primary third-party resources (except Medicare and Railroad Retirement) for which Medicaid receives a secondary payer claim that it adjudicates as paid. A Medicaid-secondary claim that adjudicates as a paid claim is counted toward the inpatient benefit limit.

1. Medicaid, when it is secondary to a third-party resource other than Medicare or Railroad Retirement, covers only the difference between the primary resource's remittance and Medicaid's per diem or maximum allowable fee for Medicaid-covered services reimbursed by the primary resource.
2. Even when the Medicaid paid amount is $0.00 because the third-party payment equals or exceeds Medicaid's per diem, the days thus paid are counted toward the benefit limit.

213.110 MUMP Applicability 9-1-26

A. Medicaid covers up to ten (10) days of freestanding rehabilitative hospital inpatient service with no certification requirement, except in the case of a transfer (see part B, below). If a beneficiary is not discharged before or during the eleventh day of hospitalization, additional days are covered only if certified by DHS or its designated vendor. **View or print contact information for how to submit the request.**

B. When a beneficiary is transferred from one hospital to another, the receiving facility must certify the stay from the first day.

213.150 Retroactive Eligibility 9-1-26

A. If eligibility is determined while the beneficiary is still an inpatient of the freestanding rehabilitative hospital, the hospital may contact DHS or its designated vendor to request post-certification of freestanding rehabilitative inpatient days beyond the first ten (10) days (or all days if the admission was by transfer) and a concurrent certification of additional days, if needed. **View or print contact information for how to submit the request.**

B. If eligibility is determined after discharge the freestanding rehabilitative hospital may contact DHS or its designated vendor for post-certification of freestanding rehabilitative inpatient days beyond the first ten (10) days (or all days if the admission was by transfer). If certification sought is for a stay longer than thirty (30) days, the provider must submit the

PROPOSED

entire medical record for review. **View or print contact information for how to submit the request.**

213.180 Post Payment Review 9-1-26

A post payment review of a random sample is conducted on all admissions, including freestanding rehabilitative inpatient stays *of ten (10) days or less*, to ensure that medical necessity for the services is substantiated.

PROPOSED

TOC not required

213.000 Admission Criteria

~~3-1-06~~9-1-26

Medicaid beneficiaries are eligible for RSPD services for up to ~~four~~seven (74) days if they meet each of the following admission criteria:

A. Medical necessity (Section 213.100)

B. Medical profile (Section 213.200)

C. Medical diagnosis (Section 213.300)

RSPD admissions are subject to reviews by the Quality Improvement Organization (QIO). If the QIO or the Director of the Medicaid Program later determines that an RSPD admission was not medically necessary, Medicaid will not cover the RSPD services; and the ~~patient~~beneficiary cannot be liable for payment of the services.

(To certify a Medicaid beneficiary for RSPD services beyond seven (7)~~four [4]~~ days, refer to Section 217.100).

214.000 Plan of Care

~~10-13-03~~9-1-26

The plan of care is an individualized plan designed to improve the ~~patient~~beneficiary's condition to the extent that RSPD services are no longer necessary. The plan is developed and written by the facility-based interdisciplinary team, in consultation with the ~~patient~~beneficiary and parents or legal guardian. A supervised individual plan of care must be implemented no later than ~~four~~ seven (74) days after admission and before Medicaid payments are authorized. The plan of care must include the following information:

A. A diagnostic evaluation, reflecting the need for RSPD services. The evaluation must include an examination of the medical, social, psychological, behavioral and developmental aspects of the ~~patient~~ beneficiary's situation.

B. The ~~patient~~beneficiary's diagnosis (es), symptoms, complaints, and complications, indicating the need for admission.

C. A description of the ~~patient~~beneficiary's functional level.

D. The signature of a licensed physician.

E. The ~~patient~~beneficiary's treatment objectives.

F. A prescribed, integrated program of therapies, social services, activities and experiences designed to meet the treatment objectives.

G. Feasible rehabilitation goals.

H. Orders for medications, diet, treatments, restorative and rehabilitative services or special procedures recommended for the health and safety of the ~~patient~~beneficiary.

I. A projected schedule for service delivery - this includes the expected frequency and duration of each type of planned therapeutic session, medications, or other prescribed special procedure.

J. The type of personnel that will be furnishing the services.

K. Plans for continuing care, including review and modification to the plan of care.

MARK-UP

L. Discharge plans.

Revisions to the plan of care must be made by the facility-based interdisciplinary team. A licensed physician must sign and date the revised plan of care verifying continued medical necessity. The plan of care must always be included in the ~~patient~~beneficiary's records.

217.110 MUMP Applicability

~~98-1-21~~1-26

Medicaid beneficiaries are allowed up to ~~four~~ seven (74) days of RSPD services when the admission criteria (refer to Sections 213.000 through 213.300) are met. If a ~~patient~~beneficiary is not discharged before or during the ~~fif~~eighth day of the residential stay, *DHS or its designated vendor must certify any additional days.*

When a ~~patient~~beneficiary is transferred from one RSPD facility to another, the stay must be certified by DHS or its designated vendor from the first day of transfer. (See Transfer Admissions, Section 217.132.) **View or print contact information to obtain the DHS or designated vendor step-by-step process for submitting the request.**

217.131 Extension of RSPD Admissions

~~98-1-21~~1-26

A. When the RSPD provider's neuropsychologist ~~and/~~or physician determines that a ~~patient~~beneficiary ~~(~~age one (1) year or older~~)~~ should not be discharged by the ~~fif~~eighth day of residential stay due to the need for continued services, an RSPD medical staff member must contact DHS or its designated vendor and request an extension of the RSPD admission.

View or print contact information to obtain the DHS or its designated vendor step-by-step process for submitting the request.

1. RSPD providers initiating their request after the ~~fourth~~ seventh day must accept ~~the~~ financial liability should the stay not meet the medical criteria for continued RSPD services.
2. If the provider delays calling for an extension and the services are denied based on the lack of medical necessity, the ~~patient~~beneficiary will not be held liable.

B. For a Medicaid ~~patient~~ beneficiary under age one (1), the days from the admission date through the day before the ~~patient's~~ beneficiary's first birthday are exempt from the MUMP procedures. MUMP procedures become effective on the one-year birthday; the ~~patient~~beneficiary's birthday is the first day of the ~~four~~seven (74) days not requiring MUMP certification. If the stay continues beyond the ~~four~~seventh day following the ~~patient~~beneficiary's first birthday, the RSPD medical staff must apply for MUMP certification to extend the RSPD admission.

C. ~~Medicaid guidelines and the medical judgment of its professional staff are used to determine the number of days to extend the admission.~~

~~D. Additional extensions may be requested if more days are needed beyond the original extension.~~The number of days allowed for an extension will be based on medical judgment utilizing Medicaid guidelines and clinical standards of practice.

~~E~~D. If the extension request is denied by a physician advisor, the RSPD provider may request an expedited reconsideration review by sending the medical record for review and determination. The provider must specify that an expedited reconsideration is being requested. The RSPD provider will be notified of the decision by the next working day.

~~F~~E. Providers may request administrative reconsideration of an adverse decision, or they can appeal as provided in Section 190.003 of the Arkansas Medicaid provider manual.

MARK-UP

~~G~~F. If the denial is because of incomplete documentation, but complete documentation that supports medical necessity is submitted with the reconsideration request, the nurse may approve the extension of benefits without referral to a physician advisor.

~~H~~G. If the denial is because there is no proof of medical necessity or the documentation does not allow for approval by the nurse, the original documentation, reason for denial and new information submitted will be referred to a different physician advisor for reconsideration.

~~I~~H. All parties will be notified in writing of the outcome of the reconsideration.

~~J~~I. Medicaid claims submitted without an approved extension will result in automatic denials of any days billed beyond the ~~four~~seventh day. The only exception is claims involving third party liability. (See Section 217.134.)

217.133 Retroactive Medicaid Eligibility

~~98-1-21~~-1-26

A. If retroactive Medicaid eligibility is determined prior to discharge of the ~~patient~~ beneficiary, the RSPD provider may contact DHS or its designated vendor to request post-certification of the days beyond the first ~~four~~ seven (~~4~~7) days (or all days if the admission was by transfer) and a concurrent extension for additional days, if needed.

B. If the retroactive Medicaid eligibility is determined after discharge, the RSPD provider may contact DHS or its designated vendor to request post-certification of the days beyond the first seven~~four~~ (~~4~~7) days (or all days if the admission was by transfer). If the certification is requested for a length-of-stay longer than thirty (30) days, the provider must submit the entire medical record for review. (Refer to Section 217.200 for the annual benefit limit on the length-of-stays.) **View or print contact information to obtain the DHS or designated vendor step-by-step process for submitting the request**

217.134 Third Party and Medicare Claims

~~98-1-21~~-1-26

If a provider has not requested MUMP certification of an extension of days because there is apparent coverage by private insurance or Medicare Part A, but the other payer has denied the claim for non-covered service, lost eligibility, benefits exhausted, etc., post-certification of days beyond the first ~~four~~seven (~~4~~7) days may be obtained.~~)~~ **View or print contact information to obtain the DHS or designated vendor step-by-step process for submitting the request**.

217.135 Post Payment Review

~~910-13-03~~-1-26

A post payment review of a random sample is conducted on all RSPD admissions, including lengths-of-stay *of ~~four~~ seven (7) days or less,* to ensure that medical necessity for the services is substantiated.

240.000 PRIOR AUTHORIZATION

~~910-13-03~~-1-26

Prior authorization does not apply to RSPD services. Extended RSPD services after the initial ~~four~~ seven (~~4~~7) days must follow the MUMP procedures in Sections 217.100 through 217.135.

MARKUP

TOC not required

213.000 Admission Criteria 9-1-26

Medicaid beneficiaries are eligible for RSPD services for up to seven (7) days if they meet each of the following admission criteria:

A. Medical necessity (Section 213.100)

B. Medical profile (Section 213.200)

C. Medical diagnosis (Section 213.300)

RSPD admissions are subject to reviews by the Quality Improvement Organization (QIO). If the QIO or the Director of the Medicaid Program later determines that an RSPD admission was not medically necessary, Medicaid will not cover the RSPD services; and the beneficiary cannot be liable for payment of the services.

(To certify a Medicaid beneficiary for RSPD services beyond seven (7) days, refer to Section 217.100).

214.000 Plan of Care 9-1-26

The plan of care is an individualized plan designed to improve the beneficiary's condition to the extent that RSPD services are no longer necessary. The plan is developed and written by the facility-based interdisciplinary team, in consultation with the beneficiary and parents or legal guardian. A supervised individual plan of care must be implemented no later than seven (7) days after admission and before Medicaid payments are authorized. The plan of care must include the following information:

A. A diagnostic evaluation, reflecting the need for RSPD services. The evaluation must include an examination of the medical, social, psychological, behavioral and developmental aspects of the beneficiary's situation.

B. The beneficiary's diagnosis (es), symptoms, complaints, and complications, indicating the need for admission.

C. A description of the beneficiary's functional level.

D. The signature of a licensed physician.

E. The beneficiary's treatment objectives.

F. A prescribed, integrated program of therapies, social services, activities and experiences designed to meet the treatment objectives.

G. Feasible rehabilitation goals.

H. Orders for medications, diet, treatments, restorative and rehabilitative services or special procedures recommended for the health and safety of the beneficiary.

I. A projected schedule for service delivery - this includes the expected frequency and duration of each type of planned therapeutic session, medications, or other prescribed special procedure.

J. The type of personnel that will be furnishing the services.

K. Plans for continuing care, including review and modification to the plan of care.

PROPOSED

L. Discharge plans.

Revisions to the plan of care must be made by the facility-based interdisciplinary team. A licensed physician must sign and date the revised plan of care verifying continued medical necessity. The plan of care must always be included in the beneficiary's records.

217.110 MUMP Applicability 9-1-26

Medicaid beneficiaries are allowed up to seven (7) days of RSPD services when the admission criteria (refer to Sections 213.000 through 213.300) are met. If a beneficiary is not discharged before or during the eighth day of the residential stay, *DHS or its designated vendor must certify any additional days.*

When a beneficiary is transferred from one RSPD facility to another, the stay must be certified by DHS or its designated vendor from the first day of transfer. (See Transfer Admissions, Section 217.132.) **View or print contact information to obtain the DHS or designated vendor step-by-step process for submitting the request.**

217.131 Extension of RSPD Admissions 9-1-26

A. When the RSPD provider's neuropsychologist or physician determines that a beneficiary age one (1) year or older should not be discharged by the eighth day of residential stay due to the need for continued services, an RSPD medical staff member must contact DHS or its designated vendor and request an extension of the RSPD admission.

View or print contact information to obtain the DHS or its designated vendor step-by-step process for submitting the request.

1. RSPD providers initiating their request after the seventh day must accept financial liability should the stay not meet the medical criteria for continued RSPD services.
2. If the provider delays calling for an extension and the services are denied based on the lack of medical necessity, the beneficiary will not be held liable.

B. For a Medicaid beneficiary under age one (1), the days from the admission date through the day before the beneficiary's first birthday are exempt from the MUMP procedures. MUMP procedures become effective on the one-year birthday; the beneficiary's birthday is the first day of the seven (7) days not requiring MUMP certification. If the stay continues beyond the seventh day following the beneficiary's first birthday, the RSPD medical staff must apply for MUMP certification to extend the RSPD admission.

C. The number of days allowed for an extension will be based on medical judgment utilizing Medicaid guidelines and clinical standards of practice.

D. If the extension request is denied by a physician advisor, the RSPD provider may request an expedited reconsideration review by sending the medical record for review and determination. The provider must specify that an expedited reconsideration is being requested. The RSPD provider will be notified of the decision by the next working day.

E. Providers may request administrative reconsideration of an adverse decision, or they can appeal as provided in Section 190.003 of the Arkansas Medicaid provider manual.

F. If the denial is because of incomplete documentation, but complete documentation that supports medical necessity is submitted with the reconsideration request, the nurse may approve the extension of benefits without referral to a physician advisor.

G. If the denial is because there is no proof of medical necessity or the documentation does not allow for approval by the nurse, the original documentation, reason for denial and new information submitted will be referred to a different physician advisor for reconsideration.

PROPOSED

H. All parties will be notified in writing of the outcome of the reconsideration.

I. Medicaid claims submitted without an approved extension will result in automatic denials of any days billed beyond the seventh day. The only exception is claims involving third party liability. (See Section 217.134.)

217.133 Retroactive Medicaid Eligibility 9-1-26

A. If retroactive Medicaid eligibility is determined prior to discharge of the beneficiary, the RSPD provider may contact DHS or its designated vendor to request post-certification of the days beyond the first seven (7) days (or all days if the admission was by transfer) and a concurrent extension for additional days, if needed.

B. If the retroactive Medicaid eligibility is determined after discharge, the RSPD provider may contact DHS or its designated vendor to request post-certification of the days beyond the first seven (7) days (or all days if the admission was by transfer). If the certification is requested for a length-of-stay longer than thirty (30) days, the provider must submit the entire medical record for review. (Refer to Section 217.200 for the annual benefit limit on the length-of-stays.) **View or print contact information to obtain the DHS or designated vendor step-by-step process for submitting the request**

217.134 Third Party and Medicare Claims 9-1-26

If a provider has not requested MUMP certification of an extension of days because there is apparent coverage by private insurance or Medicare Part A, but the other payer has denied the claim for non-covered service, lost eligibility, benefits exhausted, etc., post-certification of days beyond the first seven (7) days may be obtained. **View or print contact information to obtain the DHS or designated vendor step-by-step process for submitting the request**.

217.135 Post Payment Review 9-1-26

A post payment review of a random sample is conducted on all RSPD admissions, including lengths-of-stay *of seven (7) days or less,* to ensure that medical necessity for the services is substantiated.

240.000 PRIOR AUTHORIZATION 9-1-26

Prior authorization does not apply to RSPD services. Extended RSPD services after the initial seven (7) days must follow the MUMP procedures in Sections 217.100 through 217.135.

PROPOSED

AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED

CATEGORICALLY NEEDY

Revised: ~~October 1, 2014~~July 1, 2026

1. Inpatient Hospital Services

~~All i~~Inpatient admissions to an acute care/general hospital ~~or rehabilitative hospital~~ will be allowed up to ~~four4)~~ seven (7) days of service per admission when determined inpatient care is medically necessary. On the ~~fifth~~ eighth day of hospitalization, if the physician determines the patient should not be discharged on the ~~fifth~~eighth day of hospitalization, the hospital may ~~contact the Quality Improvement Organization (QIO) and~~ request an extension of inpatient days. ~~.~~.

~~-~~Inpatient admissions to a rehabilitative hospital will be allowed up to ten (10) days of service per admission when determined inpatient care is medically necessary. ~~.~~Extension of benefits will be available when medically necessary. ~~The Quality Improvement Organization will then determine medically necessary days. Calls for extension of days may be made at any point from the fourth~~seventh day of stay through discharge. ~~However, the provider must accept the financial liability should the stay not meet the necessary medical criteria for inpatient services.~~ Medically necessary inpatient days are available to individuals under age 1 without regard to ~~the four~~ corresponding hospital day limit and extension procedures ~~required under the plan~~. ~~Additionally, effective for dates of service on or after November 1, 2001, a benefit limit of 24 days per State Fiscal Year (July 1 through June 30) is imposed for recipients age 21 and older. No extensions will be authorized. The benefit limit does not apply to recipients under age 21 in the Child Health Services (EPSDT) Program or beneficiaries, regardless of age, who meet the following criteria:~~
~~Diagnosis (one of the following)~~

~~the presence of two or more diagnoses on Axis I and/or II is indicative of a serious emotional disorder~~
~~the presence of a diagnosis on Axis I or II and a diagnosis on Axis III~~

~~Poor prognostic factors are as evidenced by~~

~~early age at time of onset~~
~~positive family history for major mental illness~~
~~prior treatment has been ineffective; treatment failure, poor response to treatment~~
~~co-occurring presentation (medical illness, developmental disability, substance abuse/disorder & mental illness)~~
~~non-compliance with treatment~~
~~compromised social support system~~
~~other evidence-based poor prognostic factors (varies by condition or disorder)~~

~~Patient was referred by another behavioral health professional for an expert opinion~~

~~Effective for dates of service on or after October 1, 2014, days over 24 days per State Fiscal Year will be reimbursed for age 21 and older.~~

~~Inpatient hospital services required for pancreas/kidney transplants, liver/bowel transplants and skin transplants for burns are covered for eligible Medicaid recipients in the Child Health Services (EPSDT) Program. Refer to Attachment 3.1-E, Pages 2, 4 and 6~~

MARKUP

1. Inpatient Hospital Services

Inpatient admissions to an acute care/general hospital will be allowed up to seven (7) days of service per admission when determined inpatient care is medically necessary. On the eighth day of hospitalization, if the physician determines the patient should not be discharged on the eighth day of hospitalization, the hospital may request an extension of inpatient days.

Inpatient admissions to a rehabilitative hospital will be allowed up to ten (10) days of service per admission when determined inpatient care is medically necessary. Extension of benefits will be available when medically necessary. Medically necessary inpatient days are available to individuals under age 1 without regard to corresponding hospital day limit and extension procedures

PROPOSED

1. Inpatient Hospital Services

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Inpatient admissions to a rehabilitative hospital will be allowed up to ten (10) days of service per admission when determined inpatient care is medically necessary. Extension of benefits will be available when medically necessary. ~~The Quality Improvement Organization will then determine medically necessary days. Calls for extension of days may be made at any point from the fourth~~ seventh ~~day of stay through discharge. However,; the provider must accept the financial liability should the stay not meet the necessary medical criteria for inpatient services.~~ Medically necessary inpatient days are available to individuals under age 1 without regard to the ~~four~~ corresponding hospital day limit and extension procedures ~~required under the plan~~. ~~Additionally, effective for dates of service on or after November 1, 2001, a benefit limit of 24 days per State Fiscal Year (July 1 through June 30) is imposed for recipients age 21 and older. No extensions will be authorized. The benefit limit does not apply to recipients under age 21 in the Child Health Services (EPSDT) Program.~~

~~Effective for dates of service on or after October 1, 2014, days over 24 days per State Fiscal Year will be reimbursed for age 21 and older.~~

~~Inpatient hospital services required for pancreas/kidney transplants, liver/bowel transplants, and skin transplants~~

~~for burns are covered for eligible Medicaid recipients in the Child Health Services (EPSDT) Program. Refer to Attachment 3.1-E, Pages 2, 4, and 6.~~

MARKUP

1. Inpatient Hospital Services

Inpatient admissions to an acute care/general hospital will be allowed up to seven (7) days of service per admission when determined inpatient care is medically necessary. On the eighth day of hospitalization, if the physician determines the patient should not be discharged on the eighth day of hospitalization, the hospital may and request an extension of inpatient days.

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PROPOSED

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES - INPATIENT HOSPITAL SERVICES

Revised: July 1, 2026

~~Revised: October 1, 2014~~

~~April 1, 2026~~

1. Inpatient Hospital Services (Continued)

Rehabilitative Hospitals

Effective for dates of service on or after August 1, 1991, rehabilitative hospitals are reimbursed hospital-specific prospective per diem rates, subject to an upper limit, with no cost settlement. Rates will be effective July 1 of each year. The rate year is the State fiscal year, July 1 through June 30.

Effective October 1, 2014, for recipients age 21 and older, all in-state and out-of-state rehabilitative hospitals will be reimbursed a $400 prospective per diem rate for hospital days beyond 24 during the State Fiscal Year.

The prospective per diem rates are established using total reimbursable costs under Medicare principles of reasonable cost reimbursement, except that the gross receipts tax is not an allowable cost. The initial per diem rate is calculated from the hospital's most recent unaudited cost report submitted to Medicare prior to July 1, 1991, trended forward for inflation. Arkansas Medicaid will calculate a new per diem rate annually, based on the provider's most recent unaudited cost report, and adjust the per diem rate for inflation.

The inflation factor used will be the Consumer Price Index for all urban consumers (CPI-U), U.S. city average for all items. We will use the change in the CPI-U during the calendar year before the start of the rate year. For example, we will use the 12-month change in the CPI-U as of December 31, 1991, to set the rates that will be effective July 1, 1992. The inflation adjustment will be made at the beginning of each rate year.

The upper limit is set annually at the 70th percentile of all rehabilitative hospitals' inflation-adjusted Medicaid per diem rate. Arkansas Medicaid will negotiate with the Arkansas Hospital Association annually (State fiscal year July 1 through June 30) regarding adjustment of the 70th percentile upper limit.

~~Acute~~ Rehabilitation Services in Acute Care Inpatient Hospitals other than Rehabilitative Hospitals

Effective for dates of service on or after July 1, 2026, all inpatient acute care hospitals, including Pediatric Hospitals, Border City University-Affiliated Pediatric Teaching Hospitals, Arkansas State Operated Teaching Hospitals, Inpatient Psychiatric Hospitals, Out-of-State Hospitals, and Critical Access Hospitals, are reimbursed at the same hospital-specific prospective per diem rates used for ~~R~~rehabilitative hospitals when only rehabilitative services are provided in an acute care setting. These rates are subject to an upper limit with no cost settlement. Rates will be effective July 1 of each year. The rate year is State fiscal year, July 1~~,~~ through June 30.

MARK-UP

1. Inpatient Hospital Services (Continued)

Rehabilitative Hospitals

Effective for dates of service on or after August 1, 1991, rehabilitative hospitals are reimbursed hospital-specific prospective per diem rates, subject to an upper limit, with no cost settlement. Rates will be effective July 1 of each year. The rate year is the State fiscal year, July 1 through June 30.

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The upper limit is set annually at the 70th percentile of all rehabilitative hospitals' inflation-adjusted Medicaid per diem rate. Arkansas Medicaid will negotiate with the Arkansas Hospital Association annually (State fiscal year July 1 through June 30) regarding adjustment of the 70th percentile upper limit.

Rehabilitation Services in Acute Care Inpatient Hospitals other than Rehabilitative Hospitals

Effective for dates of service on or after July 1, 2026, all inpatient acute care hospitals, including Pediatric Hospitals, Border City University-Affiliated Pediatric Teaching Hospitals, Arkansas State Operated Teaching Hospitals, Inpatient Psychiatric Hospitals, Out-of-State Hospitals, and Critical Access Hospitals, are reimbursed at the same hospital-specific prospective per diem rates used for rehabilitative hospitals when only rehabilitative services are provided in an acute care setting. These rates are subject to an upper limit with no cost settlement. Rates will be effective July 1 of each year. The rate year is State fiscal year, July 1 through June 30.

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