

SECTION II - DIAGNOSTIC AND EVALUATION SERVICES

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200.000 DIAGNOSTIC AND EVALUATION SERVICES GENERAL INFORMATION

201.000 Arkansas Medicaid Participation Requirements 1-1-23

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

202.000 Eligible Clients for this Manual 1-1-23

- A. Clients who have received a mental health diagnostic assessment by an allowable licensed professional, and have begun mental health counseling services, can receive a psychological evaluation to confirm the diagnosis in order to guide continued behavioral health counseling services.
- B. Clients who have a DMS-693 prescription specifying an Autism diagnosis from their primary care provider or attending licensed physician and display symptoms of Autism Spectrum Disorder and require an adaptive behavior and/or intellectual assessment to complete one of the two clinical prongs for a diagnosis of Autism.
- C. Clients who either have a diagnosis of a developmental or intellectual disability or display symptoms of a qualifying developmental or intellectual disability and have a referral from their primary care provider or attending licensed physician who require an adaptive behavior and/or intellectual assessment to either establish or confirm that the diagnosis meets the criteria for Institutional Level of Care.

210.000 REQUIREMENTS FOR CONFIRMING BEHAVIORAL HEALTH DIAGNOSIS**210.100 Client Requirements 1-1-23**

- A. The client has completed a mental health diagnostic evaluation by a licensed professional enrolled as an Arkansas Medicaid behavioral health service provider;
- B. The client is currently engaged in mental health counseling services through an Arkansas Medicaid behavioral health service provider;
- C. The client is currently being treated to address symptoms of the diagnosed condition; and
- D. The client is forty-eight (48) months or older.

210.200 Evaluator Requirements 1-1-23

- A. To perform a Psychological Evaluation to Confirm a Behavioral Health Diagnosis, the clinician must be one of the following:
 - 1. A Licensed Psychologist (LP)
 - 2. A Licensed Psychological Examiner (LPE)
 - 3. A Licensed Psychological Examiner-Independent (LPEI)
- B. If the evaluator, through psychological testing leads to a diagnosis of Autism, the Evaluator must have a referral to the Division of Developmental Disabilities Services (DDS).

210.300 Evaluation Requirements 1-1-23

- A. A Psychological Evaluation (includes psychodiagnostic assessment of emotionality, intellectual abilities, personality, and psychopathology, e.g. MMPI, Rorschach®, WAIS®) is allowed if the following criteria is met:
 - 1. The Evaluation is conducted in person;
 - 2. The Evaluation is necessary to establish a differential diagnosis of behavioral or psychiatric conditions;
 - 3. The Evaluation is necessary because the client's history and symptomatology are not readily attributable to a particular psychiatric condition; and
 - 4. The Evaluation is necessary because questions to be answered by the Evaluation could not be resolved by a psychiatric or diagnostic interview, observation in therapy, or an assessment for level of care at a mental health facility.
- B. Minimum Documentation Requirements must be met and are as follows:
 - 1. Date of Service;
 - 2. Start and stop times of actual encounter with the client;
 - 3. Start and stop times of scoring, interpretation, and report preparation;
 - 4. Place of Service;
 - 5. Identifying information;
 - 6. Rationale for referral;
 - 7. Presenting problem(s);
 - 8. Culturally and age-appropriate psychosocial history and assessment;
 - 9. Mental status and clinical observations and impressions;

10. Tests used, results, and interpretations, as indicated;
 11. DSM diagnostic impressions to include in all axes, if applicable;
 12. Treatment recommendations and findings related to rationale for service and guided by test results; and
 13. Staff signature/credentials/date of signature(s).
- C. If psychological testing leads to a diagnosis of Autism Spectrum Disorder, the treating licensed professional must document referral to appropriate autism treatment provider.

220.000 REQUIREMENTS FOR ESTABLISHING A DIAGNOSIS OF AUTISM SPECTRUM DISORDER

220.100 Client Requirements 1-1-23

- A. The client is less than 21 years of age; and
- B. The client is an enrolled in Arkansas Medicaid; and
- C. The client has a DMS-693 prescription specifying an Autism diagnosis from their primary care provider or attending licensed physician and displays symptoms of Autism Spectrum Disorder.

220.200 Evaluator Requirements 1-1-23

- A. To perform an adaptive behavior and/or intellectual assessment to establish an Autism Spectrum Diagnosis, the clinician must be one of the following:
 1. A Licensed Psychologist (LP)
 2. A Licensed Psychological Examiner (LPE)
 3. A Licensed Psychological Examiner-Independent (LPEI)
 4. A Licensed Speech Language Pathologist

220.300 Evaluation Requirements 1-1-23

- A. An adaptive behavior and/or intellectual assessment to establish a diagnosis of Autism Spectrum Disorder is allowed if the following criteria is met:
 1. The adaptive behavior and/or intellectual assessment is conducted in person; and
 2. The adaptive behavior and/or intellectual assessment is necessary to establish a diagnosis of Autism Spectrum Disorder; and
 3. The assessment administered is within the clinician's scope of practice and is on **the approved assessment list**.
- B. Minimum Documentation Requirements must be met and are as follows:
 1. Date of Service;
 2. Start and stop times of actual encounter with the client;
 3. Start and stop times of scoring, interpretation and report preparation;
 4. Place of Service;
 5. Identifying information;
 6. Rationale for referral;
 7. Presenting problem(s);

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

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

230.100 Client Requirements

1-1-23

- A. In order to confirm Institutional Level of Care for clients with IDD, the client has a diagnosis of the following developmental disabilities and an evaluation(s) is needed:
 1. Epilepsy
 2. Cerebral Palsy
 3. Down Syndrome
 4. Spina Bifida
 5. Autism Spectrum Disorder
- B. In order to establish Institutional Level of Care for clients with IDD, the client displays symptoms of the following qualifying intellectual disabilities and has a referral or DMS 693 prescription from their primary care provider or attending licensed physician and an evaluation(s) is needed:
 1. Intellectual Disability or related condition

230.200 Evaluator Requirements

1-1-23

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

230.300 Evaluation Requirements

1-1-23

- A. An adaptive behavior and/or intellectual assessment to establish or confirm Institutional Level of Care is allowed if the following criteria is met:
 1. The adaptive behavior and/or intellectual assessment is conducted in person;
 2. The adaptive behavior and/or intellectual assessment is necessary to establish or confirm Institutional Level of Care; and
 3. The assessment administered is within the clinician's scope of practice and is on [the approved assessment list](#).
- B. Minimum Documentation Requirements must be met and are as follows:
 1. Date of Service;

2. Start and stop times of actual encounter with the client;
3. Start and stop times of scoring, interpretation, and report preparation;
4. Place of Service;
5. Identifying information;
6. Rationale for referral;
7. Presenting problem(s);
8. Culturally and age-appropriate psychosocial history and assessment;
9. Clinical observations and impressions;
10. Tests used, results, and interpretations, as indicated;
11. DSM diagnostic impressions to include in all axes, if applicable;
12. Treatment recommendations and findings related to rationale for service and guided by test results; and
13. Staff signature/credentials/date of signature(s).

240.000 REIMBURSEMENT

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

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

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

- A. Time spent providing services for a single client may be accumulated during a single, 24-hour calendar day. Providers may accumulatively bill for a single date of service, per client, per Evaluation service. Providers are not allowed to accumulatively bill for spanning dates of service.
- B. All billing must reflect a daily total, per Evaluation service, based on the established procedure codes. No rounding is allowed.
- C. The sum of the days' time, in minutes, per service will determine how many units are allowed to be billed. That number must not be exceeded.

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

- A. Documentation in the client's record must reflect exactly how the number of units is determined.
- B. No more than four (4) units may be billed for a single hour per client or provider of the service.

240.100 Fee Schedules

1-1-23

Arkansas Medicaid provides [fee schedules on the DMS website](#). The fees represent the fee-for-service reimbursement methodology.

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

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

241.000**Rate Appeal Process****1-1-23**

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

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

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