

SECTION II -INPATIENT PSYCHIATRIC SERVICES FOR UNDER AGE 21

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200.000 INPATIENT PSYCHIATRIC SERVICES FOR UNDER AGE 21 GENERAL INFORMATION

201.000 Arkansas Medicaid Participation Requirements for Providers of Inpatient Psychiatric Services for Under Age 21 10-27-25

Medicaid (Medical Assistance) is designed to assist eligible Medicaid beneficiaries in obtaining medical care within the guidelines specified in Section I of this manual.

Inpatient psychiatric services for beneficiaries under age 21 are hospital-based. Inpatient psychiatric hospitals/programs in a psychiatric hospital or inpatient psychiatric residential treatment facilities/programs in a psychiatric facility shall be referred to as inpatient psychiatric providers and/or inpatient psychiatric facilities throughout Section II of this manual.

Reimbursement may be made for inpatient psychiatric services when provided to eligible Medicaid beneficiaries by qualified providers who are enrolled in the Arkansas Medicaid Program.

202.000 Arkansas Participation Requirements for Inpatient Psychiatric Providers 10-13-03

Inpatient Psychiatric providers must meet the Provider Participation and enrollment requirements contained within Section 140.000 of this manual to be eligible to participate in the Arkansas Medicaid Program. These requirements apply to all enrolling as inpatient psychiatric providers for under age 21.

The provider must submit copies of all applicable licenses, certifications and accreditations with the provider application.

202.100 Hospital-based Providers 10-13-03

If the program is in an inpatient psychiatric hospital or a residential treatment unit within an inpatient psychiatric hospital, both of the conditions listed below apply to the provider:

- A. The provider must be licensed as a psychiatric hospital by the State agency that licenses psychiatric hospitals and
- B. The provider must be certified by the Medicare Certification Team as meeting the conditions of participation as a psychiatric hospital in the Title XVIII (Medicare) Program.

204.000 Retention of Records 10-13-03

All medical records of inpatient psychiatric beneficiaries must be completed promptly, filed and retained for a minimum of five (5) years from the date of service or until all audit questions, appeal hearings, investigations or court cases are resolved, whichever is longer. The records

must be available, upon request, for audit by authorized representatives of the Arkansas Division of Medical Services, the state Medicaid Fraud Control Unit and representatives of the Department of Health and Human Services.

204.100 Documentation

10-13-03

The provider must develop and maintain sufficient written documentation to support each medical or remedial therapy, service, activity or session for which Medicaid reimbursement is sought. This documentation, at a minimum, must consist of:

- A. The specific services provided,
- B. The date and actual time the services were provided (Time frames may not overlap between services. All services must be outside the time frame of other services),
- C. Name and title of the person who provided the services,
- D. The setting in which the services were provided,
- E. The relationship of the services to the treatment regimen described in the plan of care and
- F. Updates describing the patient's progress.

Documentation must be legible and concise. The name and title of the person providing the service must reflect the appropriate professional level.

All documentation must be available to representatives of the Division of Medical Services at the time of an audit by the Medicaid Field Audit Unit. All documentation must be available at the provider's place of business. No more than thirty (30) days will be allowed after the date on the recoupment notice in which additional documentation will be accepted. Additional documentation will not be accepted after the 30-day period.

210.000 PROGRAM COVERAGE**211.000 Scope**

10-27-25

Inpatient psychiatric services covered by the Arkansas Medicaid Program must be provided:

- A. By an inpatient psychiatric provider enrolled in the Arkansas Medicaid Program;
- B. By an enrolled inpatient psychiatric provider selected by the beneficiary;
- C. To eligible Arkansas Medicaid beneficiaries only after receipt of a primary care physician (PCP) referral except in cases of emergency;
- D. To eligible Arkansas Medicaid beneficiaries who have a certification of need issued by the facility-based and independent teams that the beneficiary meets the criteria for inpatient psychiatric services;
- E. To eligible Arkansas Medicaid beneficiaries who have a prior authorization;
- F. To eligible Arkansas Medicaid beneficiaries before the beneficiary reaches age 21 or, if the beneficiary was receiving inpatient psychiatric services at the time he or she reached age 21, services may continue until the beneficiary no longer requires the services or the beneficiary becomes 22 years of age, whichever comes first and
- G. Under the direction of a physician (contracted physicians are acceptable).

212.000 Covered Services

7-1-04

Coverage of Inpatient Psychiatric Services for Under Age 21 is restricted to services to individuals with a primary diagnosis of mental illness. Coverage includes all medical, psychiatric and social services required of the admitting facility for licensure, certification and accreditation (Section 202.000). This includes, but is not limited to:

- A. Drugs,
- B. Evaluations,
- C. Therapies,
- D. Visits by a physician that are directly related to the remediation of the beneficiary's psychosocial adjustment,
- E. Therapeutic leave days,
- F. Absent without permission days and
- G. Acute care leave days.

212.100 Covered Locations

10-27-25

Inpatient psychiatric services are covered by Arkansas Medicaid only when provided in:

- A. An inpatient psychiatric hospital
- B. A residential treatment unit within a psychiatric hospital

214.000 Medical Services

10-13-03

Medical services that are provided to the beneficiary while in the inpatient psychiatric facility must be billed to the Arkansas Medicaid Program by the performing provider of the services, e.g., physician, hospital etc. The performing provider must be an Arkansas Medicaid provider in order to receive reimbursement from the Arkansas Medicaid Program.

The potential provider may contact the Provider Enrollment Unit by telephone to receive information about the process required to become an Arkansas Medicaid provider. The request for enrollment must be made to the Division of Medical Services, Provider Enrollment Unit. [View or print the Provider Enrollment contact information.](#)

215.000 Certification of Need (CON) for Services

215.100 General Requirements

10-13-03

Each inpatient psychiatric provider must have a facility-based CON Team. In addition, Arkansas Medicaid has contracted with an independent evaluator who will form an independent CON Team. The independent CON Team will evaluate each applicant's or beneficiary's need for inpatient psychiatric services.

There must be a written certification of need (CON) that states that an individual is or was in need of inpatient psychiatric services. The certification must be made at the time of admission, or if an individual applies for Medicaid while in the facility, the certification must be made before Medicaid authorizes payment.

Any admission that is non-emergency or is not a transfer from one hospital to another is an elective admission. **All elective admissions of current Medicaid beneficiaries must be certified prior to admission.** The certification of need (CON) decision must be determined by an independent team under contract with the Arkansas Medicaid Program.

Tests and evaluations used to certify need cannot be more than one (1) year old. All histories and information used to certify need must have been compiled within the year prior to the CON.

In compliance with 42 CFR 441.152, the facility-based and independent CON teams must certify that:

- A. Ambulatory care resources available in the community do not meet the treatment needs of the beneficiary;
- B. Proper treatment of the beneficiary's psychiatric condition requires inpatient services under the direction of a physician and
- C. The services can be reasonably expected to prevent further regression or to improve the beneficiary's condition so that the services will no longer be needed.

215.200 Facility-Based CON Team

10-13-03

The facility-based team must be an interdisciplinary team composed of a physician and other personnel who are employed by, or provide services to, Medicaid beneficiaries in the admitting facility. The team must have competence in diagnosis and treatment of mental illness, preferably in child psychiatry, and must have knowledge of the individual's situation. See 42 CFR 441.153.

215.210 Facility-Based Team Responsibilities

10-13-03

Based on education and experience, preferably including competence in child psychiatry, the facility-based team must be capable of and responsible for:

- A. Assessing the beneficiary's immediate and long range therapeutic needs, developmental priorities, and personal strengths and liabilities;
- B. Assessing the potential resources of the beneficiary's family;
- C. Making a recommendation regarding whether the beneficiary should be admitted to the facility;
- D. Setting treatment objectives;
- E. Prescribing therapeutic modalities to achieve the individual plan of care objectives and
- F. Preparing or reviewing information to be sent to the independent CON Team.

215.220 Composition of the Facility-Based Team (42 CFR 441.156)

7-15-12

- A. The team must include at least one of the following:
 - 1. A board eligible or board certified psychiatrist;
 - 2. A clinical psychologist who has a doctoral degree and a physician licensed to practice medicine or osteopathy or
 - 3. A physician licensed to practice medicine or osteopathy with specialized training and experience in the diagnosis and treatment of mental diseases, and a psychologist who has a master's degree in clinical psychology or who has been certified by the State or by the State Board of Examiners in Psychology.
- B. The team must also include at least one of the following:
 - 1. Psychiatric social worker;
 - 2. A registered nurse with specialized training or one year's experience in treating individuals with mental illness;

3. An occupational therapist who is licensed, if required by the State, and who has specialized training or one year of experience in treating individuals with mental illness or
4. A psychologist who has a master's degree in clinical psychology or who has been certified by the State or by the State Psychological Association.

215.300 Independent Certification of Need (CON) Team 10-14-16

The independent CON Team shall be an interdisciplinary team composed of a physician and other personnel who are employed by (or contracted by) the independent evaluator.

[View or print current contractor contact information.](#)

215.310 Composition of the Independent CON Team 10-13-03

The independent certification team must:

- A. Include a physician;
- B. Have competence in diagnosis and treatment of mental illness, preferably in child psychiatry;
- C. Have knowledge of the beneficiary's situation and
- D. Not be in an employment or consultant relationship with an inpatient psychiatric provider.

215.320 Information Required for Pre-Certification Review 4-1-07

To receive a CON, the admitting facility must initiate a pre-certification review by submitting the required information by facsimile to the independent CON Team.

The admitting facility must submit the following information to the independent CON Team for a pre-certification review:

- A. Beneficiary's name, date of birth, county of residence and sex;
- B. Beneficiary's current Medicaid ID number, if available, and Social Security number;
- C. Admitting facility's name, provider identification number and planned date of admission;
- D. DSM IV diagnosis (Axes I and V are required; Axes II, III and IV will be completed as appropriate);
- E. Description of the initial treatment plan relating to the admitting symptoms;
- F. Current symptoms or chronic behavior requiring inpatient treatment;
- G. Medication history or cautions;
- H. Prior inpatient treatment;
- I. Prior outpatient treatment and
- J. Parent(s) or legal guardian(s) name, address and telephone number, if available.

215.321 Pre-Certification of Need (CON) Process 10-13-03

- A. All Required Information Included with the CON Request:

If the beneficiary meets criteria of medical necessity and need for inpatient treatment, the Independent CON Review Team clinician and psychiatrist will issue an approval of the admission and an initial length of stay not to exceed thirty (30) days.

When certification is made for a length of stay, a certification number will be issued to the admitting facility. The original certification of need form must be maintained in the beneficiary's medical record.

B. Insufficient Information Included with the CON Request:

If the information provided during the pre-certification review is insufficient to justify approval or denial of the CON request, a face-to-face assessment of the beneficiary will be scheduled within forty-eight (48) hours of the initial request for admission. The assessment will be scheduled at a time and place convenient to the beneficiary and will involve a structured clinical interview by a clinical psychologist. In addition, the independent CON Team will request that the facility transmit, at a minimum, pertinent prior psychiatric treatment records, e.g., discharge summaries and psychiatric, social and psychological evaluations, etc.

Based upon the original information provided, the results of the face-to-face assessment and any additional medical records provided, the CON review clinician and psychiatrist will issue a notice of approval or denial along with the appropriate approval/denial codes for inpatient psychiatric services. If the beneficiary meets the criteria of medical necessity and need for inpatient treatment, the form will include an approval for an initial length of stay, not to exceed thirty (30) days. A certification number will be issued to the admitting facility. The original CON form must be maintained in the beneficiary's medical record.

C. Upon approval, the original certification of need must be placed in the beneficiary's records.

D. The certification of need must be renewed every 60 days after certification as per 42 CFR §456.160.

215.500 Emergency Admission

4-1-07

An emergency admission is one in which the sudden onset of a psychiatric condition manifests itself by acute symptoms of such severity that the absence of immediate medical attention could reasonably be expected to result in serious dysfunction of any bodily organ/part, death of the individual, or harm to another person by the individual. The presence of a court order does not in itself justify an emergency admission.

A. For an emergency admission, the certification of need must be:

1. Requested by the facility-based team responsible for the individual plan of care and
2. Requested at the time of admission and before the independent CON Team issues a CON for a specified length of stay.

B. The admitting facility must notify the independent CON Team of all emergency admissions no later than two (2) working days after the admission. If more than two working days lapse, the independent CON Team will not issue a certification of need for the interval between admission and the date the CON is requested by the facility.

C. The facility must transmit a copy of the certification of need completed by the facility-based team. The independent certification of need team will conduct a review using the following information provided by the admitting facility:

1. Beneficiary's name, date of birth, county of residence and sex;
2. Beneficiary's Medicaid ID number or Social Security Number;
3. Facility name, provider identification number and date of admission;

2. Continued care in the mental facility for individuals who apply for Medicaid while in the inpatient psychiatric facility and
- G. Symptoms, complaints and complications indicating the need for admission.

An original written report of each admission evaluation (medical, psychiatric, social) must be prepared by the facility-based team and placed in the beneficiary's records along with the plan of care no later than fourteen (14) days after admission.

218.000 Individual Plan of Care (42 CFR 441.154) 10-13-03

Inpatient psychiatric services must involve "active treatment" as specified in the written plan of care. Implementation of the individual plan of care must be supervised by professional staff. The original of each individual plan of care must be placed in the beneficiary's records.

218.100 Development of the Individual Plan of Care 10-13-03

Individual plan of care means a written plan developed for each beneficiary to improve the condition of the beneficiary to the extent that inpatient care is no longer necessary. The individual plan of care must be:

- A. Developed no later than fourteen (14) days after admission and before prior authorization of services;
- B. Designed to improve the beneficiary's condition to the extent that inpatient psychiatric services will no longer be necessary and to achieve the beneficiary's discharge from inpatient status at the earliest possible time;
- C. Based on a diagnostic evaluation that includes examination of the medical, social, psychological, behavioral and developmental aspects of the beneficiary's situation and reflects the need for inpatient psychiatric services and
- D. Developed:
 1. By the facility-based team and
 2. In consultation with the beneficiary and his or her parent(s), legal guardian(s) or others in whose care he or she will be released after discharge.

218.200 Requirements for the Individual Plan of Care (42 CFR 456.180) 10-13-03

The individual plan of care must:

- A. Include diagnoses, symptoms, complaints and complications indicating the need for admission;
- B. Include a description of the functional level of the beneficiary;
- C. State treatment objectives;
- D. State any orders for medications, diet, treatments, restorative and rehabilitative services or special procedures recommended for the health and safety of the beneficiary;
- E. Contain an integrated program of therapies, social services, activities and experiences designed to meet the treatment objectives;
- F. Include plans for continuing care, including review and modification to the plan of care and
- G. Include discharge plans and, at an appropriate time, post-discharge plans, and also include the coordination of inpatient services with partial discharge plans and related

community services to ensure continuity of care with the beneficiary's family, school and community upon discharge.

218.300 Individual Plan of Care Review 10-13-03

The plan of care must be reviewed every thirty (30) calendar days by the facility-based team as specified in 42 CFR §441.155(c) to:

- A. Determine whether services being provided are or were required on an inpatient basis and
- B. Recommend changes in the plan as indicated by the beneficiary's overall adjustment as an inpatient.

220.000 Medicaid Agency Review Team (MART)

220.100 Prior Authorization Review 10-14-16

No later than the concurrent length of stay review, the admitting facility must transmit copies of the beneficiary's records to the current contractor. [View or print current contractor contact information.](#)

Beneficiary's records to be transmitted must include:

- A. Facility-based certification of need;
- B. Documentation regarding nature of emergency admission (if applicable);
- C. Report of admission evaluation (must include medical, psychiatric or psychological, and social evaluations);
- D. Initial Data Package (IDP);
- E. Individual plan of care;
- F. Continued stay review;
- G. Educational information;
- H. Medical history;
- I. Axis I, II, III, IV and/or V diagnosis;
- J. Basis for diagnosis;
- K. Summary of beneficiary's psychiatric history, emphasizing the chronological development of symptoms and of complications;
- L. Statement of prognosis and identification of beneficiary's strengths and weaknesses in relation to prognosis;
- M. Identification of specific goals and methods for continued inpatient treatment, specific criteria for discharge to a less restrictive setting, and estimate of length of stay required to satisfy these criteria; and
- N. Any additional information pertaining to the beneficiary's medical or psychosocial status and need for inpatient psychiatric services.

The submitted information will be reviewed by the MART. They will determine whether inpatient psychiatric services are warranted and approve or disapprove the inpatient stay. Prior authorization does not guarantee reimbursement. Both the beneficiary and the provider must be

enrolled in Arkansas Medicaid at the time a service is provided and the provider must comply with the regulations set forth in this manual and in official program correspondence.

Within five (5) working days of receipt of all information, the MART will notify the facility by facsimile of whether inpatient psychiatric services are medically necessary and whether coverage is approved or denied. Prior authorizations are effective for a specific period. Prior authorizations cover a minimum of one (1) day up to a maximum of thirty (30) days.

When applicable, the MART will forward a denial notice of action to the admitting facility within fifteen (15) working days of the decision. The original approval notice or denial notice of action must be placed in the beneficiary's records. The MART must retain a copy of all beneficiary records pertaining to the approval or denial of a prior authorization request.

220.200 Concurrent Review of Prior Authorization 10-13-03

If inpatient services are to continue beyond the current prior authorized period and the facility wishes to prevent a lapse in coverage, the facility must transmit copies of the beneficiary's record to the MART no later than five (5) working days before the current prior authorized period ends. An acute care facility must transmit this information within forty-eight (48) hours before the previously prior authorized time period ends. **The Medicaid Agency Review Team will not perform retroactive concurrent reviews.**

The facility will transmit all updates or changes to patient records that were previously submitted to the MART along with the following:

- A. Transmittal sheet;
- B. Individual plan of care, thirty (30) calendar day reviews;
- C. Subsequent continued stay ninety (90) calendar day reviews and
- D. Summary of treatments and response to treatment from date of admission until the current date.

This information will be reviewed by the MART to determine whether inpatient psychiatric services are medically necessary and whether to approve or deny coverage of an additional period.

Within fifteen (15) working days of receipt of all information, the MART must notify the facility whether inpatient psychiatric services are medically necessary and whether coverage is approved or denied for an additional prior authorized period. Authorizations may be effective for a minimum of one (1) day up to a maximum of 180 calendar days.

When applicable, the Medicaid Agency Review Team (MART) will mail a denial notice of action to the facility within fifteen (15) working days. The facility must place the original approval or denial notice of action in the beneficiary's records. The MART must retain a copy of all beneficiary records pertaining to the approval or denial of prior authorization.

220.300 Incomplete Beneficiary Records 10-13-03

If the MART does not receive all necessary records of a beneficiary, they will notify the admitting facility by telephone, followed by a letter. If the MART does not receive the missing information within five (5) working days of the phone notification, prior authorization will be denied and a denial notice of action form will be sent to the admitting facility and the beneficiary.

221.000 Utilization Control

221.100 General Information 10-13-03

All inpatient psychiatric providers must meet federal requirements for utilization control as stated in the Code of Federal Regulations, 42 CFR §§456.150 through 456.245.

221.110 Utilization Review (UR) Plan 10-13-03

Each inpatient psychiatric provider must have in effect a written UR plan which provides for a review of each beneficiary's need for the services provided. Each written UR plan must meet the requirements specified in the Code of Federal Regulations, 42 CFR §§456.201 through 456.245.

221.200 UR Plan Administrative Requirement

221.210 UR Plan Requirements 10-13-03

The UR plan must:

- A. Provide for a committee to perform UR requirements;
- B. Describe the organization, composition and functions of the committee and
- C. Specify the frequency of committee meetings.

221.211 Organization and Composition of UR Committee (§42 CFR 456.206) 10-13-03

The UR committee must be composed of two or more physicians assisted by other professional personnel. At least one of the physicians must be knowledgeable in the diagnosis and treatment of mental diseases.

The UR committee must be constituted as:

- A. A committee of the inpatient psychiatric provider staff;
- B. A group outside the inpatient psychiatric provider staff, established by the local medical or osteopathic society and at least some of the inpatient psychiatric providers in the locality, or
- C. A group capable of performing utilization reviews, established and organized in a manner consistent with 42 CFR §§456.150 through 456.245.

The committee may not include any individual who is directly responsible for the care of a beneficiary whose care is being reviewed or who has a financial interest in any inpatient psychiatric facility. (Financial interest is defined as direct or indirect stock or ownership of 5% or more in any inpatient psychiatric facility.)

221.300 UR Plan Information Requirement

221.310 Beneficiary Information Required for UR 10-13-03

The UR plan must provide that each beneficiary's record includes information needed to perform UR requirements. This information must include:

- A. Identification of the beneficiary;
- B. Name of the beneficiary's physician;
- C. Date of admission;
- D. Dates of application and authorization for Medicaid benefits, if application is made after admission;
- E. Individual plan of care;

- F. Initial and subsequent continued stay review dates;
- G. Reasons and plan for continued stay if the attending physician believes continued stay is necessary or
- H. Other supporting material believed appropriate by the committee.

221.320 **Records and Reports** **10-13-03**

The UR plan must describe the type of records which are kept by the committee, the type and frequency of committee reports and the arrangements for distribution to the appropriate individuals.

221.330 **Confidentiality** **10-13-03**

The plan must provide that the identities of individual beneficiaries in all UR records and reports are kept confidential.

221.400 **Review of Need for Continued Stay**

221.410 **Continued Stay Review Required** **10-13-03**

The UR plan must provide for a review of each beneficiary's continued stay in the inpatient psychiatric facility to decide whether it is needed. See Sections 221.400 through 221.464.

221.420 **Evaluation Criteria for Continued Stay** **10-13-03**

The UR plan must provide that the UR Committee develops:

- A. Written medical care criteria to assess the need for continued stay and
- B. More extensive written criteria for cases which experience shows are:
 - 1. Associated with high costs;
 - 2. Associated with the frequent furnishing of excessive services or
 - 3. Attended by physicians whose patterns of care are frequently found to be questionable.

221.430 **Initial Continued Stay Review Date** **10-13-03**

The UR plan must provide that when a beneficiary is admitted to the inpatient psychiatric facility, the committee will assign a specified date by which the need for continued stay will be reviewed. If an individual applies for Medicaid while in the inpatient psychiatric facility, the committee must assign the initial continued stay review date within one (1) working day after the inpatient psychiatric facility is notified of the application for Medicaid.

The committee must base its assignment of the initial continued stay review date on:

- A. The methods and criteria described in this manual;
- B. The beneficiary's condition and
- C. The beneficiary's projected discharge date.

The committee must use any available appropriate regional medical care appraisal norms, such as those developed by abstracting services or third party payers, to assign the initial continued stay review date. These norms must be based on current and statistically valid data on duration of stay in inpatient psychiatric facilities for beneficiaries whose characteristics, such as age and diagnosis, are similar to those of the beneficiary whose need for continued stay is being

reviewed. If the committee uses norms to assign the initial continued stay review day, the number of days between the beneficiary's admission and the initial continued stay review date must not be greater than the 50th percentile of the norms. However, the committee may assign a later review date if it documents that the later date is more appropriate. The initial continued stay review date is not in any case later than thirty (30) calendar days after admission of the beneficiary or notice to the inpatient psychiatric facility of the beneficiary's application for Medicaid. The committee must ensure that the initial continued stay review date is recorded in the beneficiary's record.

221.440 **Subsequent Continued Stay Review Dates** **10-13-03**

The UR plan must provide:

- A. That the committee assigns subsequent continued stay review dates in accordance with this manual;
- B. That the committee assigns a subsequent continued stay review date at least every ninety (90) days each time it decides that the continued stay is needed and
- C. That the committee ensures that each continued stay review date it assigns is recorded in the beneficiary's record.

221.450 **Description of Methods and Criteria: Continued Stay Review Dates** **10-13-03**

The UR plan must describe:

- A. The methods and criteria, including norms if used, by which the committee assigns initial and subsequent continued stay review dates and
- B. The methods that the committee uses to modify an approved length of stay when the beneficiary's condition or treatment schedule changes.

221.460 **Continued Stay Review Process** **10-13-03**

The UR plan must provide that review of continued stay cases is conducted by:

- A. The UR committee;
- B. A subgroup of the UR committee or
- C. A designee of the UR committee

The UR plan must provide that the committee, subgroup or designee reviews a beneficiary's continued stay on or before the expiration of each assigned continued stay review date.

For each continued stay of a beneficiary in the inpatient psychiatric facility, the committee, subgroup or designee must review and evaluate the information in the beneficiary's record listed in this manual against the criteria provided in the UR plan as listed in this manual and apply close professional scrutiny to cases described in this manual.

221.461 **Continued Stay Approval** **10-13-03**

The UR plan must provide that, if the committee, subgroup or designee finds that a beneficiary's continued stay in the inpatient psychiatric facility is needed, the committee assigns a new continued stay review date.

221.462 **Continued Stay Denial** **10-13-03**

The UR plan must provide that, if the committee, subgroup or designee finds that a continued stay case does not meet the criteria, the committee or a subgroup that includes at least one

physician must review the case to decide the need for continued stay. If the committee or subgroup making the review finds that a continued stay is not needed, it must notify the beneficiary's attending or staff physician and give him or her an opportunity to present his or her views before it makes a final decision on the need for the continued stay.

If the attending or staff physician does not present additional information or clarification of the need for the continued stay, the decision of the committee or subgroup is final. If the attending or staff physician presents additional information or clarification, at least two physician members of the committee, one of whom is knowledgeable in the treatment of mental diseases, must review the need for the continued stay. If they find that the beneficiary no longer needs inpatient psychiatric services, their decision is final.

221.463 Notification of Adverse Action 10-13-03

The UR plan must provide that written notice of any adverse final decision on the need for continued stay is sent to:

- A. The inpatient psychiatric facility administrator;
- B. The attending or staff physician;
- C. The independent CON Team;
- D. The beneficiary and
- E. The next of kin or the sponsor or guardian (if possible).

221.464 Time Limits for Final Decision and Notification 10-13-03

The UR plan must provide that:

- A. The committee will make a final decision on a beneficiary's need for continued stay and will give notice of an adverse action within two (2) working days after the assigned continued stay review date and
- B. If the committee makes an adverse final decision on a beneficiary's need for continued stay before the assigned review date, the committee gives notice within two (2) working days after the date of the final decision.

221.500 UR Plan Medical Care Evaluation Studies

221.510 Purpose and General Description 10-13-03

The purpose of medical care evaluation studies is to promote the most effective and efficient use of available health facilities and services consistent with the beneficiary's needs and professionally recognized standards of health care. Medical care evaluation studies must emphasize identification and analysis of patterns of beneficiary care and suggest appropriate changes needed to maintain consistently high quality beneficiary care and effective and efficient use of services.

221.520 UR Plan Requirements for Medical Care Evaluation Studies 10-13-03

The UR plan must describe the methods the UR committee uses to select and conduct medical care evaluation studies and must provide that the UR committee will:

- A. Determine, for each study, the methods to be used in selecting and conducting medical care evaluation studies in the inpatient psychiatric facility;

- B. Document, for each study, the results and how the results have been used to make changes to improve the quality of care and promote more effective and efficient use of inpatient psychiatric facilities and services;
- C. Analyze the findings for each study and
- D. Take action as needed to correct or investigate further any deficiencies or problems in the review process, or to recommend more effective and efficient care procedures.

221.530 Content of Medical Care Evaluation Studies

10-13-03

Each medical care evaluation study must:

- A. Identify and analyze medical or administrative factors related to the inpatient psychiatric facility beneficiary care and
- B. Include analysis of at least the following:
 - 1. Admissions;
 - 2. Durations of stay;
 - 3. Ancillary services furnished, including drugs and biologicals;
 - 4. Professional services performed in the inpatient psychiatric facility and
 - 5. If indicated, contain recommendations for change beneficial to beneficiaries, staff, the inpatient psychiatric facility and the community.

221.540 Data Sources

10-13-03

Data that the committee uses to perform the studies must be obtained from one or more of the following sources:

- A. Medical records and other appropriate inpatient psychiatric facility data;
- B. External organizations that compile statistics, design profiles and produce other comparative data;
- C. Cooperative endeavors with:
 - 1. Peer Review Organizations (PROs);
 - 2. Fiscal agents;
 - 3. Other inpatient psychiatric facilities or
 - 4. Other appropriate agencies.

221.550 Number of Studies Required

10-13-03

The inpatient psychiatric provider must have at least one study in progress at any time and must complete one study each calendar year.

221.600 Inspection of Care (42 CFR Part 456, Subpart I)

12-1-13

All in-state inpatient psychiatric providers will receive an Inspection of Care (IOC) consistent with the Code of Federal Regulations, 42 CFR §§456.600 through 456.614. An IOC will be performed by an independent contractor or team annually, at a minimum. There must be a sufficient number of teams within the State that an on-site IOC can be made at appropriate intervals in each facility.

The inpatient psychiatric provider will be notified of the time of the inspection no more than forty-eight (48) hours before the scheduled arrival of the inspection team. The inspection must include:

- A. Personal contact and observation of each Medicaid beneficiary in the inpatient psychiatric facility and
- B. Review of each beneficiary's medical record.

See Section 241.000 for more information regarding inspections of care.

221.610 Determinations by the Inspection Team

10-13-03

The team must determine in its inspection whether:

- A. The services available in the facility are adequate to:
 - 1. Meet the health needs of each beneficiary and
 - 2. Promote the maximum physical, mental and psychosocial functioning.
- B. It is necessary and desirable for the beneficiary to remain in the facility,
- C. It is feasible to meet the beneficiary's health needs and
- D. Each beneficiary in an inpatient psychiatric facility is receiving active treatment.

221.620 Reports

10-13-03

- A. Content

The team must submit a report promptly to the agency on each inspection. The report must contain the observations, conclusions and recommendations of the team concerning:

- 1. The adequacy, appropriateness and quality of all services, including physician services, provided in the facility or through other arrangements and
- 2. Specific findings about individual beneficiaries in the facility.

- B. Copies

The agency must send a copy of each inspection report to:

- 1. The facility inspected;
- 2. The facility's utilization review committee;
- 3. The agency responsible for licensing, certification or approval of the facility for purposes of Medicare and Medicaid and
- 4. Other State agencies that use the information in the reports to perform their official function.

- C. Action

The agency must take corrective action as needed based on the report and recommendations of the team.

221.700 The Use of Restraints and Seclusion

8-15-05

The Children's Health Act of 2000 (P.L. 106-310) imposes procedural reporting and training requirements regarding the use of restraints and involuntary seclusion in facilities that provide inpatient psychiatric services for children under the age of 21. Satellite training by the Centers for Medicare and Medicaid Services (CMS) may be accessed on the CMS website at

www.cms.hhs.gov. Federal Regulations are located at 42 CFR Part 483, Subpart G §§483.350 – 483.376.

221.701 Definitions

8-15-05

The following definitions apply:

- A. Drug used as a restraint means any drug that:
 - 1. Is administered to manage a resident's behavior in a way that reduces the safety risk to the resident or others,
 - 2. Has the temporary effect of restricting the resident's freedom of movement and
 - 3. Is not a standard treatment for the resident's medical or psychiatric condition.
- B. *Emergency safety intervention* means the use of restraint or seclusion as an immediate response to an emergency safety situation.
- C. *Emergency safety situation* means unanticipated resident behavior that places the resident or others at serious threat of violence or injury if no intervention occurs and that calls for an emergency safety intervention as defined in this section.
- D. *Mechanical restraint* means any device attached or adjacent to the resident's body that he or she cannot easily remove and that restricts freedom of movement or normal access to his or her body.
- E. *Minor* means a minor as defined under State law and, for the purpose of this subpart, includes a resident who has been declared legally incompetent by the applicable State court.
- F. *Personal restraint* means the application of physical force without the use of any device for the purposes of restraining the free movement of a resident's body. The term personal restraint does not include briefly holding without undue force a resident in order to calm or comfort him or her or holding a resident's hand to safely escort a resident from one area to another.
- G. *Psychiatric Residential Treatment Facility* means a facility other than a hospital that provides psychiatric services, as described in subpart D of part 441 of Title 42 of the Code of Federal Regulations, to individuals under age 21 in an inpatient setting.
- H. *Restraint* means a "personal restraint," "mechanical restraint" or "drug used as a restraint" as defined in this section.
- I. *Serious injury* means any significant impairment of the physical condition of the resident as determined by the provider's qualified medical personnel. This includes, but is not limited to, burns, lacerations, bone fractures, substantial hematoma, and injuries to internal organs, whether self-inflicted or inflicted by someone else.
- J. *Staff* means those individuals with responsibility for managing a resident's health or participating in an emergency safety intervention and who are employed by the facility on a full-time, part-time, or contract basis.

221.702 Protection of Residents

8-15-05

- A. Restraint and seclusion policy for the protection of residents.
 - 1. Each resident has the right to be free from restraint or seclusion, of any form, used as a means of coercion, discipline, convenience, or retaliation.
 - 2. An order for restraint or seclusion must not be written as a standing order or on an as-needed basis.

3. Restraint or seclusion must not result in harm or injury to the resident and must be used only:
 - a. To ensure the safety of the resident or others during an emergency safety situation and
 - b. Until the emergency safety situation has ceased and the resident's safety and the safety of others can be ensured, even if the restraint or seclusion order has not expired.
 4. Restraint and seclusion must not be used simultaneously.
- B. Emergency safety intervention. An emergency safety intervention must be performed in a manner that is safe and proportionate and that is appropriate to the severity of the behavior and to the resident's chronological and developmental age; size; gender; physical, medical, and psychiatric condition; and personal history (including any history of physical or sexual abuse).
- C. Notification of facility policy. At admission, the facility must:
1. Inform both the incoming resident and, in the case of a minor, the resident's parent(s) or legal guardian(s) of the facility's policy regarding the use of restraint or seclusion during an emergency safety situation that may occur while the resident is in the program;
 2. Communicate its restraint and seclusion policy in a language that the resident or his or her parent(s) or legal guardian(s) understands (including American Sign Language, if appropriate) and, when necessary, the facility must provide interpreters or translators;
 3. Obtain an acknowledgment, in writing, from the resident or, in the case of a minor, from the parent(s) or legal guardian(s) that he or she has been informed of the facility's policy on the use of restraint or seclusion during an emergency safety situation. Staff must file this acknowledgment in the resident's record; and
 4. Provide a copy of the facility policy to the resident and, in the case of a minor, to the resident's parent(s) or legal guardian(s).
- D. Contact information. The facility's policy must provide contact information, including the phone number and mailing address, for the appropriate State Protection and Advocacy organization.

221.703**Orders for the Use of Restraints and Seclusion****8-15-05**

- A. Orders for restraint or seclusion must be by a physician or other licensed practitioner permitted by the State and the facility to order restraint or seclusion and who is trained in the use of emergency safety interventions. Federal regulations at 42 CFR 441.151 require that inpatient psychiatric services for beneficiaries under age 21 be provided under the direction of a physician.
- B. If the resident's treatment team physician is available, only he or she can order restraint or seclusion.
- C. A physician or other licensed practitioner permitted by the state and the facility to order restraint or seclusion must order the least restrictive emergency safety intervention that is most likely to be effective in resolving the emergency safety situation based on consultation with staff.
- D. If the order for restraint or seclusion is verbal, the verbal order must be received by a registered nurse or other licensed staff, such as a licensed practical nurse, while the emergency safety intervention is being initiated by staff or immediately after the emergency safety situation ends. The physician or other licensed practitioner permitted by the State and the facility to order restraint or seclusion must verify the verbal order in a signed

written form in the resident's record. The physician or other licensed practitioner permitted by the State and the facility to order restraint or seclusion must be available to the staff for consultation, at least by telephone, throughout the period of the emergency safety intervention.

- E. Each order for restraint or seclusion must:
 - 1. Be limited to no longer than the duration of the emergency safety situation and
 - 2. Under no circumstances exceed 4 hours for residents ages 18 to 21; 2 hours for residents ages 9 to 17; or 1 hour for residents under age 9.
- F. Within 1 hour of the initiation of the emergency safety intervention, a physician or other licensed practitioner trained in the use of emergency safety interventions and permitted by the State and the facility to assess the physical and psychological well-being of residents must conduct a face-to-face assessment of the physical and psychological well-being of the resident, including but not limited to:
 - 1. The resident's physical and psychological status,
 - 2. The resident's behavior,
 - 3. The appropriateness of the intervention measures, and
 - 4. Any complications resulting from the intervention.
- G. Each order for restraint or seclusion must include:
 - 1. The name of the ordering physician or other licensed practitioner permitted by the State and the facility to order restraint or seclusion;
 - 2. The date and time the order was obtained; and
 - 3. The emergency safety intervention ordered, including the length of time for which the physician or other licensed practitioner permitted by the State and the facility to order restraint or seclusion authorized its use.
- H. Staff must document the intervention in the resident's record. That documentation must be completed by the end of the shift in which the intervention occurs. If the intervention does not end during the shift in which it began, documentation must be completed during the shift in which it ends. Documentation must include all of the following:
 - 1. Each order for restraint or seclusion as required in paragraph G of this section.
 - 2. The time the emergency safety intervention actually began and ended.
 - 3. The time and results of the 1-hour assessment required in paragraph F of this section.
 - 4. The emergency safety situation that required the resident to be restrained or put in seclusion.
 - 5. The name of staff involved in the emergency safety intervention.
- I. The facility must maintain a record of each emergency safety situation, the interventions used, and their outcomes.
- J. The physician or other licensed practitioner permitted by the state and the facility to order restraint or seclusion must sign the restraint or seclusion order in the resident's record as soon as possible.

If a physician or other licensed practitioner permitted by the State and the facility to order restraint or seclusion orders the use of restraint or seclusion, that person must contact the

resident's treatment team physician unless the ordering physician is in fact the resident's treatment team physician. The person ordering the use of restraint or seclusion must:

- A. Consult with the resident's treatment team physician as soon as possible and inform the team physician of the emergency safety situation that required the resident to be restrained or placed in seclusion and
- B. Document in the resident's record the date and time the team physician was consulted.

221.705 Monitoring of the Resident in and Immediately After Restraint 8-15-05

- A. Clinical staff trained in the use of emergency safety interventions must be physically present and continually assessing and monitoring the physical and psychological well-being of the resident and the safe use of restraint throughout the duration of the emergency safety intervention.
- B. If the emergency safety situation continues beyond the time limit of the order for the use of restraints, a registered nurse or other licensed staff, such as a licensed practical nurse, must immediately contact the ordering physician or other licensed practitioner permitted by the State and the facility to order restraint or seclusion to receive further instructions.
- C. A physician, or other licensed practitioner permitted by the state and the facility to evaluate the resident's well-being and who is trained in the use of emergency safety interventions, must evaluate the resident's well-being immediately after the restraint is removed.

221.706 Monitoring of the Resident in and Immediately After Seclusion 8-15-05

- A. Clinical staff trained in the use of emergency safety interventions must be physically present in or immediately outside the seclusion room, continually assessing, monitoring, and evaluating the physical and psychological well-being of the resident in seclusion. Video monitoring does not meet this requirement.
- B. A room used for seclusion must:
 - 1. Allow staff a full view of the resident in all areas of the room and
 - 2. Be free of potentially hazardous conditions such as unprotected light fixtures and electrical outlets.
- C. If the emergency safety situation continues beyond the time limit of the order for the use of seclusion, a registered nurse or other licensed staff, such as a licensed practical nurse, must immediately contact the ordering physician or other licensed practitioner permitted by the State and the facility to order restraint or seclusion to receive further instructions.
- D. A physician, or other licensed practitioner permitted by the state and the facility to evaluate the resident's well-being and trained in the use of emergency safety interventions, must evaluate the resident's well-being immediately after the resident is removed from seclusion.

221.707 Notification of Parent(s) or Legal Guardian(s) 8-15-05

If the resident is a minor as defined in this subpart:

- A. The facility must notify the parent(s) or legal guardian(s) of the resident who has been restrained or placed in seclusion as soon as possible after the initiation of each emergency safety intervention.
- B. The facility must also notify the resident's parent(s) or legal guardian(s) as soon as possible and in no case later than 24 hours after the serious occurrence.

2. Medical and other information needed for care of the resident in light of such a transfer will be exchanged between the institutions in accordance with State medical privacy law, including any information needed to determine whether the appropriate care can be provided in a less restrictive setting; and
 3. Services are available to each resident 24 hours a day, 7 days a week.
- C. The staff must document in the resident's record all injuries that occur as a result of an emergency safety intervention, including injuries to staff resulting from that intervention.
 - D. The staff involved in an emergency safety intervention that results in an injury to a resident or staff must meet with supervisory staff and evaluate the circumstances that caused the injury and develop a plan to prevent future injuries.

222.000 Leave Days

222.100 Covered Leave Days

222.110 Therapeutic Leave Days

10-13-03

The Arkansas Medicaid Program covers a maximum of seven (7) consecutive days for therapeutic leave days. Therapeutic leave days must be clearly documented in the beneficiary's record. At a minimum, the beneficiary's record must reflect:

- A. The purpose of the therapeutic leave (therapeutic leave shall be listed in the plan of care along with the objectives, goals and frequency of this therapy);
- B. The destination or location (the place where the beneficiary will go for this therapy must be recorded as well as the date and time of departure and return and the person(s) responsible for the beneficiary during the leave period);
- C. A therapeutic leave evaluation documentation that provides unquestionable support to the plan of care objectives and goals;
- D. Documentation of staff contact with the beneficiary and the person(s) responsible for the beneficiary for those therapeutic leaves in excess of seventy-two (72) consecutive hours and
- E. Progress notes that provide statements that track a beneficiary's actions and reactions, and must clearly reveal the beneficiary's achievements or regressions while on therapeutic leave.

222.200 Non-Covered Leave Days

222.210 Absent Without Permission Days

10-13-03

The Arkansas Medicaid Program does not cover days when a beneficiary is absent without permission. Absent without permission days are those days when a beneficiary is away from the inpatient psychiatric facility without permission. When a beneficiary is absent without permission, the facility must document when the beneficiary left, if possible, why the beneficiary left and where the beneficiary was going, and when applicable, the beneficiary's expected return date to the inpatient psychiatric facility.

When a beneficiary is absent without permission, the inpatient psychiatric provider must:

- A. Formally discharge the beneficiary. If the beneficiary is to be readmitted, the inpatient psychiatric provider must formally admit the beneficiary by following all policies, including the certification of need and prior authorization policies, as stated in this manual.

or

- B. Keep the beneficiary's case on hold for up to 7 consecutive days without Medicaid reimbursement:
1. If the beneficiary returns to the inpatient psychiatric facility within the seven (7) days, the inpatient psychiatric provider must conduct a plan of care review within three (3) days of the beneficiary's return and modify the plan of care as necessary.
 2. If the beneficiary does not return to the inpatient psychiatric facility within the seven (7) days, the provider must formally discharge the beneficiary. If the beneficiary is to be readmitted, the provider must formally admit the beneficiary by following all policies, including the certification of need and prior authorization policies, as stated in this manual.

222.220 Acute Care Leave Days

10-13-03

The Arkansas Medicaid Program covers no inpatient psychiatric services during acute care leave days. Acute care leave days are those days when a beneficiary is an inpatient in an acute care medical facility. When a beneficiary is admitted to an acute care facility, the inpatient psychiatric provider must document when, why and where the beneficiary was admitted and, if applicable, the beneficiary's expected return date.

When a beneficiary is admitted to an acute care facility as an inpatient, the inpatient psychiatric provider must:

- A. Formally discharge the beneficiary. If the beneficiary is to be readmitted, the provider must formally admit the beneficiary by following all policies, including the certification of need and prior authorization policies, as stated in this manual;

or

- B. Keep the beneficiary's case open for up to five (5) consecutive days without Medicaid reimbursement.
1. If the beneficiary returns to the inpatient psychiatric facility within the five (5) days, the provider must conduct a plan of care review within three (3) days of the beneficiary's return and modify the plan of care as necessary.
 2. If the beneficiary does not return to the inpatient psychiatric facility within the five (5) days, the provider must formally discharge the beneficiary. If the beneficiary is to be readmitted, the provider must formally admit the beneficiary by following all policies, including the certification of need and prior authorization policies, as stated in this manual.

223.000 Electronic Signatures

10-8-10

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

230.000 PRIOR AUTHORIZATION

230.010 Prior Authorization Information

10-27-25

Prior authorization (PA) is required for all inpatient psychiatric residential unit services.

The prior authorization function is the responsibility of the patients PASSE.

230.100 Prior Authorization Approvals

10-13-03

Approved PA requests for inpatient psychiatric services will be prior authorized for a specific period. An approval letter will be transmitted to the admitting facility specifying the dates inpatient psychiatric services are authorized, as well as the prior authorization control number and other necessary billing information. Prior authorizations are effective for a minimum of one (1) day up to a maximum of 180 calendar days.

230.200 **Prior Authorization Denials** **10-13-03**

Denied requests for prior authorization will result in the issuance of a denial notice of action form to the admitting facility and the beneficiary. The denial notice of action will specify the reason for denial.

230.210 **Reserved** **6-1-25**

230.220 **Reserved** **6-1-25**

240.000 **PROVIDER REVIEWS**

240.100 **Provider Review Information** **10-14-16**

The Department of Human Services (DHS), Division of Medical Services (DMS) has an agreement with a contractor to complete on-site inspections of care and retrospective reviews of Inpatient Psychiatric Services for Under Age 21 Medicaid enrolled providers. [View or print current contractor contact information.](#)

241.000 **On-Site Inspection of Care (IOC)** **10-27-25**

The Department of Human Services (DHS) requires the contractor to conduct annual On-Site Inspections of Care for acute inpatient services provided to Medicaid beneficiaries under age 21.

The inpatient psychiatric provider will be notified of the time of the inspection no more than forty-eight (48) hours before the schedule arrival of the inspection team.

241.100 **Purpose of the Review** **10-14-16**

The on-site inspections of care of Inpatient Psychiatric Services for Under Age 21 providers are intended to:

- A. Promote Inpatient Psychiatric Services for Under Age 21 that are provided in compliance with federal and state laws, rules and professionally recognized standards of care;
- B. Identify and clearly define areas of deficiency where the provision of services is not in compliance with federal and state laws, rules and professionally recognized standards of care;
- C. Require provider facilities to develop and implement appropriate corrective action plans to remediate all deficiencies identified;
- D. Provide accountability that corrective action plans are implemented and
- E. Determine the effectiveness of implemented corrective action plans.

The review tool, process and procedures are available on the contractor's website at <http://arkansas.beaconhealthoptions.com/>. Any amendments to the review tool will be adopted under the Arkansas Administrative Procedures Act.

241.200 **Information Available Upon Arrival of the IOC Team** **12-1-13**

The provider shall make the following available upon the IOC Team's arrival at the site:

- A. Medical records of all Arkansas Medicaid beneficiaries;
- B. One or more knowledgeable administrative staff member(s) to assist the team;
- C. The opportunity to assess direct patient care in a manner least disruptive to the actual provision of care;
- D. Staff personnel records, complete with hire dates, dates of credentialing and copies of current licenses, credentials, criminal background checks, and similar or related records;
- E. Written policies, procedures and quality assurance committee minutes;
- F. Clinical Administrative, Clinical Services, Quality Assurance, Quality improvement, Utilization Review and Credentialing;
- G. Program descriptions, manuals, schedules, staffing plans and evaluation studies and
- H. If identified as necessary and as requested, additional documents required by a provider's individual licensing board, child maltreatment checks and adult maltreatment checks.

241.300 Written Reports and Follow Up Procedures

12-1-13

The contractor shall provide a written report of the IOC team's findings to the provider, DMS Behavioral Health Unit and Arkansas Office of Medicaid Inspector General within 14 calendar days from the last day of on-site inspection. The written report shall clearly identify any area of deficiency and required submission of a corrective action plan.

The contractor shall provide a notification of either acceptance or requirement of directed correction to the provider, DMS Behavioral Health Unit and Arkansas Office of Medicaid Inspector General within 14 calendar days of receiving a proposed corrective action plan and shall monitor corrective actions to ensure the plan is implemented and results in compliance.

All IOC reviews are subject to policy regarding Administrative Remedies and Sanctions (Section 150.000), Administrative Reconsideration and Appeals (Section 160.000) and Provider Due Process (Section 190.000). DMS will not voluntarily publish the results of the IOC review until the provider has exhausted all administrative remedies. Administrative remedies are exhausted if the provider does not seek a review or appeal within the time period permitted by law or rule.

241.400 Resident Interviews

12-1-13

Each resident who is a Medicaid beneficiary under age 21 must be interviewed by the IOC Team. It is the responsibility of the provider to devise a system that allows access to the residents in a way that is minimally disruptive to the treatment process.

If a Medicaid beneficiary will be discharged during the review, the provider is responsible for arranging for the resident to be interviewed prior to discharge.

Interviews should be conducted in a place and manner that respects the resident's right to privacy. The provider must provide private interview space for the interviews.

241.600 Corrective Action Plans

12-1-13

The provider must submit a Corrective Action Plan designed to correct any deficiency noted in the written report of the IOC. The provider must submit the Corrective Action Plan to the contracted utilization review agency within 14 calendar days of the date of the written report. The contractor shall review the Corrective Action Plan and forward it, with recommendations, to the DMS Behavioral Health Unit, the Arkansas Office of Medicaid Inspector General and Division of Behavioral Health Services.

After acceptance of the Corrective Action Plan, the utilization review agency will monitor the implementation and effectiveness of the Corrective Action Plan via on-site review. DMS, its contractor(s) or both may conduct a desk review of beneficiary records. The desk review will be site-specific and not by organization. If it is determined that the provider has failed to meet the conditions of participation, DMS will determine if sanctions are warranted.

241.700**Actions****9-4-14**

Actions that may be taken following an inspection of care review include, but are not limited to:

- A. Decertification of any beneficiary determined to not meet medical necessity criteria for inpatient mental health services;
- B. Decertification of any provider determined to be noncompliant with the Division of Behavioral Health Services provider certification rules;
- C. On-site monitoring by the utilization review agency to verify the implementation and effectiveness of corrective actions;
- D. The contractor may recommend, and DMS may require, follow-up inspections of care and/or desk reviews. Follow-up inspections may review the issues addressed by the Corrective Action Plans or may be a complete re-inspection of care, at the sole discretion of the Division of Medical Services;
- E. Review and revision of the Corrective Action Plan;
- F. Review by the Arkansas Office of Medicaid Inspector General;
- G. Formulation of an emergency transition plan for beneficiaries including those in custody of DCFS and DYS;
- H. Suspension of provider referrals;
- I. Placement in high priority monitoring;
- J. Mandatory monthly staff training by the utilization review agency;
- K. Provider requirement for one of the following staff members to attend a DMS/DBHS monthly work group meeting: Clinical Director/Designee (at least a master's level mental health professional) or Executive Officer;
- L. Recoupment for services that are not medically necessary or that fail to meet professionally recognized standards for health care or
- M. Any sanction identified in Section 152.000.

241.800**Reserved****12-1-13****242.000****Retrospective Review****10-27-25**

The Division of Medical Services (DMS) of Arkansas Department of Human Services has contracted with a QIO-like entity to perform retrospective (post payment) reviews of acute services to Medicaid beneficiaries by Inpatient Psychiatric Services for Under Age 21 providers. [View or print current contractor contact information.](#) The member's PASSE will complete reviews of residential unit services.

The reviews are conducted by licensed mental health professionals and are based on applicable federal and state standards.

242.100 Purpose of the Review

7-1-04

The purpose of the review is to evaluate the medical necessity of the admission to and continued stay in an inpatient setting. Reviewers will examine the medical record for technical compliance with state and federal regulations. Reviewers will also evaluate the clinical documentation to determine if it is sufficient to support the services billed during the requested period of authorized services.

242.200 Cases Chosen for Review

10-14-16

The notification of retrospective review sent to the provider will contain a list of specific cases that must be submitted to the review team chosen by a case selection procedure that combines random sampling and cases identified as “high utilization” and “outliers.”

- A. High utilizers are beneficiaries with rate of high utilization.
- B. Outliers are defined as providers who are providing services in an amount that is over and above the average amount of services being provided by their peers.

The review period will be specified in the provider notification letter. The letter will also state the date by which all records must be received by the contractor.

The list of cases to be reviewed will be sent to the provider with a request for certain components of the records. The information requested includes:

- A. Face Sheet
- B. Initial Certification of Need (CON) and all subsequent CON decisions
- C. Psychiatric Evaluation and all updates
- D. History & Physical and all updates
- E. Intake Assessment and all updates
- F. Psychosocial Assessment and all updates
- G. Nursing Assessment and all updates
- H. Psychological Testing
- I. Psychosexual Assessment if the beneficiary is in a Sexual Offender Program
- J. Treatment Plans: Initial, Master and updates covering the specified period
- K. Progress Notes: Nursing, M.D., Therapy, Shift/Milieu for specified period
- L. All Physician Orders
- M. All Therapeutic Leave of Absence Forms
- N. All Special Treatment Procedures Forms
- O. Initial and Current PCP Referrals

All records must be mailed to the contractor. [View or print current contractor contact information.](#) Send records to the attention of “Retrospective Review Audits.” Records must not be faxed.

The contractor has the right to request other parts of the health record or the entire record if needed.

242.300 Review Report 7-1-04

The contractor will complete a written report of the audit findings and will deliver the report to the facility and to the Division of Medical Services. If the facility does not request reconsideration of the audit report within 30 calendar days, the results of the audit report will be final.

242.310 Reconsideration 6-1-25

If the audit report is unfavorable, the provider has the right to request reconsideration by the contractor within thirty (30) calendar days from the date on the report. The thirty (30) days begins to run five (5) days after the date on the report.

The provider may furnish the contractor additional documents from the medical record (if additional information is available) or may present a written explanation of why the facility believes any particular audit finding is in error. Following the receipt of the written request for reconsideration, the contractor will review the findings in question. The reconsideration review is completed by a psychiatrist who was not involved in the original decision.

A written response to the request for reconsideration will be forwarded to the facility and to the Division of Medical Services. The decision of the contractor, upon reconsideration, is final.

250.000 REIMBURSEMENT 7-1-04

The Arkansas Medicaid Program reimburses inpatient psychiatric providers for medically necessary services only. Certification of need and prior authorization are prerequisites for reimbursement. The prior authorization number must appear on all claims submitted for reimbursement.

250.100 Inpatient Psychiatric Hospitals 7-1-04

The per diem rates for inpatient psychiatric hospitals are established at the lesser of: 1) the hospital's per diem cost inflated by the consumer price index for all urban consumers (CPI-U), U.S. city average for all items plus a \$69.00 professional component or 2) the upper limit (cap). The \$69 professional component is the average of the Arkansas Medicaid maximum allowable rates for the individual psychotherapy procedure codes. The upper limit (cap) is established annually at the 60th percentile of all in-state inpatient psychiatric hospitals' inflation adjusted per diem rates plus the \$69 professional component. The calculation of the upper limit (cap) will be rounded up (0.5000 or greater) or down (0.4999 or less) if the 60th percentile is not a whole number. This is a prospective rate with no cost settlement.

Rates are calculated annually and are effective for dates of service occurring during the next state fiscal year (July 1st through June 30th). Per diem costs and the upper limit (cap) are calculated from the most recent submitted hospital cost reports with ending dates occurring in the previous calendar year. Less than full year cost reports and out-of-state provider cost reports are not included when calculating the 60th percentile. For hospitals with a cost report period of less than a full six months, the new state fiscal year per diem rate will be calculated by inflating the previous state fiscal year's per diem rate by the *Consumer Price Index for Urban Consumers (CPI-U)*. The upper limit (cap) will not be adjusted after being set should new providers enter the program or late cost reports be received.

New providers are required to submit a full year's annual budget for the current state fiscal year (July 1st through June 30th) at the time of enrollment if no cost report is available. This annual budget is used to set their interim rate at the lesser of the budgeted allowable cost per day or the upper limit (cap) in effect as of the first day of their enrollment. The interim rate for new providers will be retroactively adjusted to the allowable per diem cost as calculated from the provider's first annual submitted cost report for a period of at least a full six months.

250.110 Private Hospital Inpatient Adjustment

7-1-04

All Arkansas private inpatient psychiatric and rehabilitative hospitals (that is, all inpatient psychiatric and rehabilitative hospitals within the State of Arkansas that are neither owned nor operated by state or local government) shall qualify for a private hospital inpatient rate adjustment.

The adjustment shall be equal to each eligible hospital's pro rata share of a funding pool, based on the hospital's Medicaid discharges. The amount of the funding pool shall be determined annually by Arkansas Medicaid, based on available funding. The adjustment shall be calculated as follows:

- A. Arkansas Medicaid shall annually determine the amount of available funding for the private hospital adjustment funding pool.

For each private hospital eligible for the adjustment, Arkansas Medicaid shall determine the number of Medicaid discharges for the hospital for the most recent audited fiscal period.

The most recent **audited fiscal period** is determined per the most recent Medicaid Notice of Provider Reimbursement (NPR) as prepared by the Medicare Intermediary.

For hospitals who, for the most recently audited cost report year filed a partial year cost report, such partial year cost report data shall be annualized to determine their rate adjustment, provided that such hospital was licensed and providing services throughout the entire cost report period. Hospitals with partial year cost reports who were not licensed and providing services throughout an entire cost report year shall receive prorated adjustments based on the partial year data.

For private inpatient psychiatric and rehabilitative hospitals for the SFY 2003 adjustment, discharges will be included as prorated proportional to the August 1, 2002, effective date.

- B. For each eligible private hospital Arkansas Medicaid shall determine its pro rata percentage, which shall be a fraction equal to the number of the hospital's Medicaid discharges divided by the total number of Medicaid discharges of all eligible hospitals.
- C. The amount of each eligible hospital's payment adjustment shall be its pro rata percentage multiplied by the amount of available funding for the private hospital adjustment pool determined by Arkansas Medicaid.

Arkansas Medicaid shall determine the aggregate amount of Medicaid inpatient reimbursement to private hospitals. Such aggregate amount shall include all private hospital payment adjustments, other Medicaid inpatient reimbursement to private hospitals eligible for this adjustment and all Medicaid inpatient reimbursement to private hospitals not eligible for this adjustment, but shall not include the amount of the pediatric inpatient payment adjustment. Such aggregate amount shall be compared to the Medicare-related upper payment limit for private hospitals specified in 42 C.F.R. §447.272. Respective Case Mix Indexes (CMI) shall be applied to both the base Medicare per discharge rates and base Medicaid per discharge rates for comparison to the Medicare-related upper payment limit. These case mix adjustments are necessary in order to neutralize the impact of the differential between Medicare and Medicaid patients.

To the extent that this private hospital adjustment results in payments in excess of the upper payment limit, such adjustments shall be reduced on a pro rata basis according to each hospital's Medicaid discharges. Such reduction shall be no more than the amount necessary to ensure that aggregate Medicaid inpatient reimbursement to private hospitals is equal to but not in excess of the upper payment limit.

- D. Payment shall be made on a quarterly basis within 15 days after the end of the quarter for the previous quarter.

250.120 Arkansas State Operated Psychiatric Hospitals 7-1-07

Effective for dates of service occurring on or after July 1, 2007, Arkansas State Operated Psychiatric Hospitals are reimbursed based on interim per diem rates with year end cost settlements and no per diem cost limits. Services to be reimbursed at cost are (1) inpatient psychiatric services, (2) residential treatment unit services and (3) sexual offender program services.

Arkansas Medicaid will use the lesser of cost or charges to establish cost settlements. The interim per diem rates and cost settlements are calculated in the same manner as are used for Arkansas State Operated Teaching Hospitals, except graduate medical education (GME) costs will not be reimbursed separately.

250.200 Residential Treatment Units 7-1-04

Reimbursement for residential treatment units (RTUs) located within inpatient psychiatric hospitals will be cost settled per provider submitted annual hospital cost reports at the lesser of the audited per diem cost (including the professional component cost) or the upper limit (cap). The professional component cost included in the per diem cost is capped at \$69.00, which is the average of the Arkansas Medicaid maximum allowable rates for the individual psychotherapy procedure codes as of August 8, 1991.

The per diem upper limit (cap) is established annually at the average (mean) budgeted per diem cost of the in-state freestanding residential treatment centers with full twelve month budgets and will be effective for dates of service occurring during the state fiscal year for which the budgets were submitted. The upper limit cap will not be adjusted after being set, should new freestanding residential treatment centers enter the Medicaid Program or late budgets be received.

Interim reimbursement rates will be implemented at the lesser of the per diem cost as calculated from the most recently submitted un-audited cost report or the upper limit (cap) in effect as of the first day after the cost report ending date.

New providers are required to submit a full year’s annual budget for the current state fiscal year (July 1st through June 30th) at the time of enrollment if no cost report is available. This annual budget is used to set their interim rate at the lesser of the budgeted allowable cost per day or the upper limit (cap) in effect as of the first day of their enrollment.

250.300 Suggested Budget Format 10-27-25

Suggested Budget Format for Inpatient Psychiatric Hospitals and Residential Treatment Units

ADMINISTRATIVE AND OPERATING EXPENSES	Total Expenses	Less: Cost NOT Related to Patient Care	Total Cost Related to Patient Care
Salaries – Director	-	-	\$ -
Salaries – Assistant Director	-	-	\$ -
Salaries – Other Administrative	-	-	\$ -
Salaries – Nursing, Other Care Related	-	-	\$ -
Salaries – Professional – MD	-	-	\$ -
Salaries – Housekeeping & Maintenance	-	-	\$ -
Salaries – Teachers, Teacher Aides	-	-	0
SUB-TOTAL SALARIES (1)	-	-	\$ -

ADMINISTRATIVE AND OPERATING EXPENSES	Total Expenses	Less: Cost NOT Related to Patient Care	Total Cost Related to Patient Care
Professional Fees – Nursing, Other Care Related	-	-	\$ -
Professional Fees – MD	-	-	\$ -
Professional Fees – Administrative	-	-	\$ -
SUB-TOTAL FEES (2)	-	-	\$ -
FICA Tax	-	-	\$ -
State Unemployment Tax	-	-	\$ -
Workmen’s Compensation Insurance	-	-	\$ -
Pension Plan	-	-	\$ -
Group Insurance	-	-	\$ -
Professional Liability Insurance	-	-	\$ -
SUB-TOTAL FRINGE BENEFITS (3)	-	-	\$ -
Advertising	-	-	\$ -
Bad Debts	-	-	\$ 0
Cable TV	-	-	\$ 0
Cleaning Service & Grounds	-	-	\$ -
Depreciation	-	-	\$ -
Dues & Subscriptions	-	-	\$ -
Food	-	-	\$ -
Food – USDA	-	-	\$ 0
Fund Raising	-	-	\$ -
Interest	-	-	\$ -
Office Equipment	-	-	\$ -
Postage	-	-	\$ -
Rents & Leases	-	-	\$ -
Repairs and Maintenance	-	-	\$ -
Supplies – Care Related Program	-	-	\$ -
Supplies – Medical	-	-	\$ -
Supplies – Office	-	-	\$ -
Supplies – School	-	-	\$ 0
Travel & Entertainment	-	-	\$ -
Utilities	-	-	\$ -
*Other Expenses	-	-	\$ -
SUB-TOTAL OPERATING EXPENSES (4)			\$ -
TOTAL EXPENDITURES (1 + 2 + 3 + 4)			\$ -

* Please provide a brief description of Other Expenses.

251.000

Cost Report

10-1-17

Inpatient psychiatric hospitals, residential treatment units and Sexual Offender Programs must submit an annual or partial period hospital cost report to the Arkansas Medicaid Program. Providers with less than a full 12-month reporting period are also required to submit a hospital cost report for the shorter period. Cost reports are due no later than five months following the close of the provider’s fiscal year end. Extensions will not be allowed. Failure to file the cost report within the prescribed period may result in suspension of reimbursement until the cost report is filed.

Providers will submit all required hospital cost reports and budgets in accordance with Medicare Principles of Reasonable Cost Reimbursement identified in 42 CFR, Part 413. All cost settlements will be made using these principles.

252.000 Rate Appeal and/or Cost Settlement Process 7-1-04

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

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

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

260.000 BILLING PROCEDURES

261.000 Introduction to Billing 7-1-20

Inpatient psychiatric providers who submit paper claims must use the CMS-1450 claim form, also known as the UB-04 claim form.

A Medicaid claim may contain only one (1) billing provider’s charges for services furnished to only one (1) Medicaid beneficiary.

Section III of every Arkansas Medicaid provider manual contains information about available electronic claim options.

262.000 CMS-1450 (UB-04) Billing Procedures

262.100 Inpatient Psychiatric Revenue Codes 10-1-17

Revenue Code	Revenue Code Description
114	Inpatient Psychiatric Hospital only
124	Residential Treatment Center only
128	Sexual Offender Program only
129	Residential Treatment Unit only

262.300 Billing Instructions—Paper Only 11-1-17

Medicaid does not supply providers with Uniform Billing claim forms. Numerous vendors sell CMS-1450 (UB-04 forms.) [View a sample CMS-1450 \(UB-04\) claim form.](#)

Complete Arkansas Medicaid program claims in accordance the National Uniform Billing Committee UB-04 data element specifications and Arkansas Medicaid’s billing instructions, requirements, and regulations.

The National Uniform Billing Committee (NUBC) is a voluntary committee whose work is coordinated by the American Hospital Association (AHA) and is the official source of information regarding CMS-1450 (UB-04.) [View or print NUBC contact information.](#)

The committee develops, maintains, and distributes to its subscribers the UB-04 Data Element Specifications Manual and periodic updates. The NUBC is also a vendor of CMS-1450 (UB-04) claim forms.

In conjunction with the UB-04 Data Element Specifications Manual (UB-04 Manual), Section 262.310 contains Arkansas Medicaid’s instructions for completing a CMS-1450 (UB-04) claim form.

The original of the completed form may be forwarded to the Claims Department. [View or print the Claims Department contact information.](#) One copy of the claim form should be retained for your records.

NOTE: A provider furnishing services without verifying beneficiary eligibility for each date of service does so at the risk of not being reimbursed for the services. The provider is strongly encouraged to print the eligibility verification and retain it until payment is received.

262.310 Completion of CMS-1450 (UB-04) Claim Form

9-1-14

Field #	Field name	Description
1.	(blank)	<i>Inpatient and Outpatient:</i> Enter the provider’s name, (physical address – service location) city, state, zip code, and telephone number.
2.	(blank)	The address that the provider submitting the bill intends payment to be sent if different from FL 01. (Use this address for provider’s return address for returned mail.)
3a.	PAT CNTL #	<i>Inpatient and Outpatient:</i> The provider may use this optional field for accounting purposes. It appears on the RA beside the letters “MRN.” Up to 16 alphanumeric characters are accepted.
3b.	MED REC #	<i>Inpatient and Outpatient:</i> Required. Enter up to 15 alphanumeric characters.
4.	TYPE OF BILL	<i>Inpatient and Outpatient:</i> See the UB-04 manual. Four-digit code with a leading zero that indicates the type of bill.
5.	FED TAX NO	The number assigned to the provider by the Federal government for tax reporting purposes. Also known as tax identification number (TIN) or employer identification number (EIN).
6.	STATEMENT COVERS PERIOD	Enter the covered beginning and ending service dates. Format: MMDDYY. <i>Inpatient:</i> Enter the dates of the first and last covered days in the FROM and THROUGH fields. The FROM and THROUGH dates cannot span the

Field #	Field name	Description
		<p>State's fiscal year end (June 30) or the provider's fiscal year end.</p> <p>To file correctly for covered inpatient days that span a fiscal year end:</p> <ol style="list-style-type: none"> 1. Submit one interim claim (a first claim or a continuing claim, as applicable) on which the THROUGH date is the last day of the fiscal year that ended during the stay. <p>On a first claim or a continuing claim, the patient status code in field 17 must indicate that the beneficiary is still a patient on the indicated THROUGH date.</p> 2. Submit a second interim claim (a continuing claim or a last claim, as applicable) on which the FROM date is the first day of the new fiscal year. <p>When the discharge date is the first day of the provider's fiscal year or the state's fiscal year, only one (bill type: admission through discharge) claim is necessary, because Medicaid does not reimburse a hospital for a discharge day unless the discharge day is also the first covered day of the inpatient stay.</p> <p>When an inpatient is discharged on the same date he or she is admitted, the day is covered when the TYPE OF BILL code indicates that the claim is for admission through discharge, the STAT (patient status) code indicates discharge or transfer, and the FROM and THROUGH dates are identical.</p> <p><i>Outpatient:</i> To bill on a single claim for outpatient services occurring on multiple dates, enter the beginning and ending service dates in the FROM and THROUGH fields of this field.</p> <p>The dates in this locator must fall within the same fiscal year – the state's fiscal year and the hospital's fiscal year.</p> <p>When billing for multiple dates of service on a single claim, a date of service is required in field 45 for each HCPCS code in field 44 and/or each revenue code in field 42.</p>
7.	Not used	Reserved for assignment by the NUBC.
8a.	PATIENT NAME	<i>Inpatient and Outpatient:</i> Enter the patient's last name and first name. Middle initial is optional.
8b.	(blank)	Not required.
9.	PATIENT ADDRESS	<i>Inpatient and Outpatient:</i> Enter the patient's full mailing address. Optional.
10.	BIRTH DATE	<i>Inpatient and Outpatient:</i> Enter the patient's date of birth. Format: MMDDYYYY.

Field #	Field name	Description
11.	SEX	<i>Inpatient and Outpatient:</i> Enter M for male, F for female, or U for unknown.
12.	ADMISSION DATE	<i>Inpatient:</i> Enter the inpatient admission date. Format: MMDDYY. <i>Outpatient:</i> Not required.
13.	ADMISSION HR	<i>Inpatient and Outpatient:</i> Enter the national code that corresponds to the hour during which the patient was admitted for inpatient care.
14.	ADMISSION TYPE	<i>Inpatient:</i> Enter the code from the Uniform Billing Manual that indicates the priority of this inpatient admission. <i>Outpatient:</i> Not required.
15.	ADMISSION SRC	<i>Inpatient and Outpatient:</i> Admission source. Required. Code 1, 2, 3, or 4 is required when the code in field 14 is 4.
16.	DHR	<i>Inpatient:</i> See the UB-04 Manual. Required except for type of bill 021x. Enter the hour the patient was discharged from inpatient care.
17.	STAT	<i>Inpatient:</i> Enter the national code indicating the patient's status on the Statement Covers Period THROUGH date (field 6). <i>Outpatient:</i> Not applicable.
18.- 28.	CONDITION CODES	<i>Inpatient and Outpatient:</i> Required when applicable. See the UB-04 Manual for requirements and for the codes used to identify conditions or events relating to this bill.
29.	ACDT STATE	Not required.
30.	(blank)	Unassigned data field.
31.- 34.	OCCURRENCE CODES AND DATES	<i>Inpatient and Outpatient:</i> Required when applicable. See the UB-04 Manual.
35.- 36.	OCCURRENCE SPAN CODES AND DATES	<i>Inpatient:</i> Enter the dates of the first and last days approved, per the facility's PSRO/UR plan, in the FROM and THROUGH fields. See the UB-04 Manual. Format: MMDDYY. <i>Outpatient:</i> See the UB-04 Manual.
37.	Not used	Reserved for assignment by the NUBC.
38.	Responsible Party Name and Address	See the UB-04 Manual.
39.	VALUE CODES	<i>Outpatient:</i> Not required. <i>Inpatient:</i>
a.	CODE	Enter 80.
	AMOUNT	Enter number of covered days. Enter number of days (units billed) to the left of the vertical dotted line and enter two zeros (00) to the right of the vertical dotted line.

Field #	Field name	Description
b.	CODE	Enter 81.
	AMOUNT	Enter number of non-covered days. Enter number of days (units billed) to the left of the vertical dotted line and enter two zeros (00) to the right of the vertical dotted line.
40.	VALUE CODES	Not required.
41.	VALUE CODES	Not required.
42.	REV CD	<i>Inpatient and Outpatient:</i> See the UB-04 Manual.
43.	DESCRIPTION	See the UB-04 Manual.
44.	HCCPS/RATE/HIPPS CODE	See the UB-04 Manual.
45.	SERV DATE	<i>Inpatient:</i> Not applicable. <i>Outpatient:</i> See the UB-04 Manual. Format: MMDDYY.
46.	SERV UNITS	Comply with the UB-04 Manual's instructions when applicable to Medicaid.
47.	TOTAL CHARGES	Comply with the UB-04 Manual's instructions when applicable to Medicaid.
48.	NON-COVERED CHARGES	See the UB-04 Manual, line item "Total" under "Reporting."
49.	Not used	Reserved for assignment by the NUBC.
50.	PAYER NAME	Line A is required. See the UB-04 for additional regulations.
51.	HEALTH PLAN ID	Report the HIPAA National Plan Identifier; otherwise report the legacy/proprietary number.
52.	REL INFO	Required when applicable. See the UB-04 Manual.
53.	ASG BEN	Required. See "Notes" at field 53 in the UB-04 Manual.
54.	PRIOR PAYMENTS	<i>Inpatient and Outpatient:</i> Required when applicable. See the UB-04 Manual.
55.	EST AMOUNT DUE	Situational. See the UB-04 Manual.
56.	NPI	Enter the NPI of the billing provider or enter the Medicaid ID.
57.	OTHER PRV ID	Not required.
58. A, B, C	INSURED'S NAME	<i>Inpatient and Outpatient:</i> Comply with the UB-04 Manual's instructions when applicable to Medicaid.
59. A, B, C	P REL	<i>Inpatient and Outpatient:</i> Comply with the UB-04 Manual's instructions when applicable to Medicaid.
60. A, B, C	INSURED'S UNIQUE ID	<i>Inpatient and Outpatient:</i> Enter the patient's Medicaid identification number on first line of field.
61. A, B, C	GROUP NAME	<i>Inpatient and Outpatient:</i> Using the plan name if the patient is insured by another payer or other payers, follow instructions for field 60.

Field #	Field name	Description
62. A, B, C	INSURANCE GROUP NO	<i>Inpatient and Outpatient:</i> When applicable, follow instructions for fields 60 and 61.
63. A, B, C	TREATMENT AUTHORIZATION CODES	<i>Inpatient:</i> Enter any applicable prior authorization, benefit extension, or MUMP certification control number on line 63A. <i>Outpatient:</i> Enter any applicable prior authorization or benefit extension number on line 63A.
64. A, B, C	DOCUMENT CONTROL NUMBER	Field used internally by Arkansas Medicaid. No provider input.
65. A, B, C	EMPLOYER NAME	<i>Inpatient and Outpatient:</i> When applicable, based upon fields 51 through 62, enter the name(s) of the individuals and entities that provide health care coverage for the patient (or may be liable).
66.	DX	Diagnosis Version Qualifier. See the UB-04 Manual. Qualifier Code "9" designating ICD-9-CM diagnosis required on claims. Qualifier Code "0" designating ICD-10-CM diagnosis required on claims. Comply with the UB-04 Manual's instructions on claims processing requirements.
67. A-H	(blank)	<i>Inpatient and Outpatient:</i> Enter the ICD-9-CM or ICD-10-CM diagnosis codes corresponding to additional conditions that coexist at the time of admission, or develop subsequently, and that have an effect on the treatment received or the length of stay. Fields are available for up to 8 codes.
68.	Not used	Reserved for assignment by the NUBC.
69.	ADMIT DX	Required for inpatient. See the UB-04 Manual.
70.	PATIENT REASON DX	See the UB-04 Manual.
71.	PPS CODE	Not required.
72	ECI	See the UB-04 Manual. Required when applicable (for example, TPL and torts).
73.	Not used	Reserved for assignment by the NUBC.
74.	PRINCIPAL PROCEDURE	<i>Inpatient:</i> Required on inpatient claims when a procedure was performed. On all interim claims, enter the codes for all procedures during the hospital stay. <i>Outpatient:</i> Not applicable.
	CODE	Principal procedure code.
	DATE	Format: MMDDYY.
74a-74e	OTHER PROCEDURE	<i>Inpatient:</i> Required on inpatient claims when a procedure was performed. On all interim claims, enter the codes for all procedures during the hospital stay. <i>Outpatient:</i> Not applicable.

Field #	Field name	Description
	CODE	Other procedure code(s).
	DATE	Format: MMDDYY.
75.	Not used	Reserved for assignment by the NUBC.
76.	ATTENDING NPI	Enter NPI of the primary attending physician.
	QUAL	NPI not required.
	LAST	Enter the last name of the primary attending physician.
	FIRST	Enter the first name of the primary attending physician.
77.	OPERATING NPI	Enter NPI of the primary attending physician.
	QUAL	NPI not required.
	LAST	Enter the last name of the operating physician.
	FIRST	Enter the first name of the operating physician.
78.	OTHER NPI	Enter NPI of the primary care physician.
	QUAL	NPI not required.
	LAST	Enter the last name of the primary care physician.
	FIRST	Enter the first name of the primary care physician.
79.	OTHER NPI/QUAL/LAST/FIRS	Not used.
80.	REMARKS	For provider's use.
81.	Not used	Reserved for assignment by the NUBC.

262.400 Special Billing Procedures

7-1-04

Not applicable to this program.