

SECTION II -REHABILITATIVE SERVICES FOR PERSONS WITH PHYSICAL DISABILITIES (RSPD)

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200.000 REHABILITATIVE SERVICES FOR PERSONS WITH PHYSICAL DISABILITIES (RSPD) GENERAL INFORMATION

201.000 Arkansas Medicaid Participation Requirements for Providers of Rehabilitative Services for Persons with Physical Disabilities (RSPD) 9-01-05

The following types of facilities may be enrolled in the Arkansas Medicaid Program as RSPD providers:

- A. Residential rehabilitation centers.
- B. Extended rehabilitative hospitals.
- C. State-operated extended rehabilitative hospitals.

RSPD providers must meet the Provider Participation and enrollment requirements contained within Section 140.000 of this manual as well as the following criteria to be eligible to participate in the Arkansas Medicaid Program.

201.100 Residential Rehabilitation Centers 3-1-06

Residential rehabilitation centers must meet licensure, accreditation and enrollment requirements to participate as RSPD providers in the Arkansas Medicaid Program.

- A. A residential rehabilitation center must meet the following licensure requirements:
 - 1. Licensed by the Arkansas Department of Health and Human Services, Office of Long Term Care, as a Post Acute Head Injury Retraining and Residential Care Facility and
 - 2. Licensed by the Arkansas Department of Health and Human Services, Division of Children and Family Services, as a Residential Child Care Facility
 - or**
 - 3. Licensed as a Long-Term Care Facility that:
 - a. Provides transitional rehabilitation of pediatric patients as defined in Ark. Code Ann § 20-8-101(7) and
 - b. Operates a designated section of the facility for pediatric patients whose anticipated stay at the time of admission is six months or less.
- B. A residential rehabilitation center must meet one of the following accreditation requirements:
 - 1. Accredited by the Commission on Accreditation of Rehabilitation Facilities (CARF).
 - or**
 - 2. Accredited by the Joint Commission on Accreditation of Healthcare Organization (JCAHO) as a Residential Treatment Program for Post Acute Head Injury Rehabilitation.

A copy of the current licenses and accreditation must accompany the provider application and the Medicaid contract.

201.200 Extended Rehabilitative Hospital 4-1-07

The extended rehabilitative hospital must meet the following participation requirements in order to be enrolled as an RSPD provider in the Arkansas Medicaid Program:

- A. The extended rehabilitative hospital must be licensed by the Division of Health, Arkansas Department of Health and Human Services, as a Rehabilitative Hospital. A copy of the current license must accompany the provider application and the Medicaid contract.
- B. The extended rehabilitative hospital must be certified as a Title XVIII (Medicare) Rehabilitative Hospital provider.

201.300 State-Operated Extended Rehabilitative Hospitals

4-1-07

The state-operated extended rehabilitative hospital must meet the following participation requirements in order to be enrolled as an RSPD provider in the Arkansas Medicaid Program:

- A. The state-operated extended rehabilitative hospital must be licensed by the Division of Health, Arkansas Department of Health and Human Services, as a Rehabilitative Hospital. A copy of the current license must accompany the provider application and the Medicaid contract.
- B. The state-operated extended rehabilitative hospital must be certified as a Title XVIII (Medicare) Rehabilitative Hospital provider. A copy of the current certification must accompany the provider application and the Medicaid contract.
- C. The state-operated extended rehabilitative hospital must be operated by an Arkansas state agency.

202.000 Out-of-State Providers

10-13-03

Rehabilitative Services for Persons with Physical Disabilities (RSPD) are limited to in-state providers only. RSPD providers physically located outside the State of Arkansas are not eligible for participation in the Arkansas Medicaid Program.

203.000 Records Requirement

10-13-03

RSPD providers must maintain medical records to support the levels of service billed to the Medicaid Program. Documentation must be legible and concise. RSPD providers are required to keep and maintain the following records on each Medicaid patient:

- A. The patient's medical history and the results of his or her physical examination at the time of admission.
- B. The chief complaint of the patient at the time of admission, including admitting diagnosis.
- C. Tests and results during the patient's stay.
- D. Progress notes, updating the patient's progress, must be entered daily.
 - 1. Daily notes may be brief; however, they must contain sufficient detail to document the patient's progress.
 - 2. Providers must also enter weekly progress notes that summarize the patient's progress in relation to the plan of care.
- E. Signature or initials of the patient's service provider after each visit.
- F. Plan of care, signed and dated by a physician.
- G. The specific services rendered and the date of service.
- H. The name and title of the individual who rendered the service.

- I. The relationship of the services rendered to the treatment regimen described in the plan of care.
- J. Discharge plan.
- K. Pharmacy and drug records.
- L. Discharge summary.
- M. All utilization review documentation made by the facility's coordinator and/or physician advisor during the patient's stay.

203.100

Reserved

11-1-09

210.000 PROGRAM COVERAGE

210.100

Introduction

3-1-06

The Medical Assistance Program (Medicaid) is designed to assist eligible Medicaid beneficiaries in obtaining medical care within the guidelines specified in Section I of this manual. *All Medicaid benefits are based upon medical necessity.*

211.000

Scope

3-1-06

Rehabilitative Services for Persons with Physical Disabilities (RSPD) services are provided for Medicaid-eligible beneficiaries when prescribed by a licensed physician and deemed medically necessary by the Quality Improvement Organization (QIO).

"Rehabilitative services" include medical or remedial services recommended by a physician or other licensed practitioner of the healing arts, within the scope of his or her practice under state law, for maximum reduction of physical or mental disability and restoration of a beneficiary to his or her best possible functional level. (Throughout this manual, "physician" also includes "other licensed practitioners of the healing arts.")

RSPD services require a medical referral from the beneficiary's primary care physician (PCP), unless the beneficiary's is exempted from the PCP requirements.

RSPD services covered under the Arkansas Medicaid Program must be provided:

- A. By a qualified RSPD provider enrolled in the Arkansas Medicaid Program.
- B. By an RSPD provider selected by the beneficiary.
- C. With certification from the facility-based interdisciplinary team that the beneficiary meets the criteria for RSPD services (see Section 212.000).
- D. As prescribed by a licensed physician.
- E. According to a written plan of care.
- F. By a facility that is not part of a hospital. The facility must be organized and operated to provide rehabilitative services to residential patients.
- G. To an eligible Medicaid beneficiary who is not an inpatient (see below) of a hospital, nursing facility (NF), intermediate care facility for individuals with intellectual disabilities (ICF/IID) or other institution.

"Inpatient" means a patient who has been admitted to a medical institution on the recommendation of a physician or dentist and is receiving room, board and professional

services in the institution on a continuous 24 hours a day basis or who is expected by the institution to receive room, board and professional services for a 24 hour period or longer.

Residential rehabilitation centers provide RSPD services only to individuals who are under age 21 years. There is no age restriction for RSPD services provided in extended rehabilitative hospitals and state-operated extended rehabilitative hospitals.

When the admission criteria and the Medicaid Utilization Management Program (MUMP) procedures have been met, the Medicaid Program will cover RSPD services from the date of admission through the last day before the Medicaid patient is discharged from the facility. The date of the discharge is not covered by Medicaid.

212.000 The Facility-Based Interdisciplinary Team 3-1-06

The RSPD provider must have a facility-based interdisciplinary team consisting of the following medical personnel:

- A. Neuropsychologist and/or physician, licensed to practice in the State of Arkansas.
- B. At a minimum, at least one of the following must be employed or contracted by the facility to provide services to Medicaid beneficiaries who are admitted to the facility:
 1. Registered Nurse, licensed to practice in the State of Arkansas, with at least one year's experience or specialized training in the rehabilitation treatment setting.
 2. Occupational Therapist, licensed to practice in the State of Arkansas.
 3. Physical Therapist, licensed to practice in the State of Arkansas.

212.100 Responsibilities of the Facility-Based Interdisciplinary Team 3-1-06

The responsibilities of the facility-based interdisciplinary team include the following:

- A. Assessing the beneficiary's immediate and long range therapeutic needs.
- B. Assessing the beneficiary's developmental priorities, personal strengths and liabilities.
- C. Assessing the potential social resources of the beneficiary and the beneficiary's family.
- D. Developing the beneficiary's plan of care.
- E. Setting treatment objectives.
- F. Prescribing therapeutic modalities to achieve the objectives of the individual plan of care.

213.000 Admission Criteria 3-1-06

Medicaid beneficiaries are eligible for RSPD services for up to four (4) days if they meet each of the following admission criteria:

- A. Medical necessity (Section 213.100)
- B. Medical profile (Section 213.200)
- C. Medical diagnosis (Section 213.300)

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

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

213.100 Medical Necessity

7-1-20

RSPD services are covered by Medicaid for eligible beneficiaries when medically necessary. The medical necessity criteria include:

- A. A prescription from a licensed physician stating that the Medicaid beneficiary needs RSPD services. An individualized plan of care may serve as the prescription for services. The prescription or plan of care must be signed and dated by the physician.
- B. The physician must have examined the patient within the thirty (30) days preceding the date of the written prescription or plan of care.
- C. The prescription or plan of care will be effective for up to three (3) months from the prescription date and must be renewed before services may continue beyond three (3) months.

Persons needing rehabilitative services on a less intensive basis than those provided in the inpatient setting may receive outpatient rehabilitative services through other appropriate Medicaid services, e.g., outpatient hospital, physical therapy, occupational therapy, speech-language therapy, Outpatient Behavioral Health Services (OBHS), and home health.

213.200 Medical Profile

3-1-06

Medicaid beneficiaries must meet the following medical profile prior to admission to an RSPD facility:

- A. Ability to communicate through spoken, written, gestural/environmental cues.
- B. Absence of acute medical problems.
- C. Adequate nutrition maintained without intravenous (IV) administration.
- D. Does not require treatment for drug or alcohol abuse, unless secondary to their injury.
- E. Does not require a ventilator.
- F. Free from any communicable disease that would require total isolation.
- G. Mentally and physically able to participate in an intensive rehabilitation program (minimum of 3 hours daily).
- H. Motivated to live in the community.
- I. Must be medically stable.
- J. Must depend on others for self-care, mobility or safety.
- K. Requires at least two (2) rehabilitation services, one of which must be a restorative therapy. (Refer to Section 215.000.)

213.300 Medical Diagnosis

3-1-06

As part of the admission process to an RSPD facility, Medicaid beneficiaries must meet the medical diagnosis criteria specified below.

- A. Residential Rehabilitation Center

Persons eligible for admission to a residential rehabilitation center must have at least one of the following neurological conditions:

Post acute traumatic or acquired brain injury. This includes and is limited to viral encephalitis, meningitis, aneurysms, cerebral vascular accident/stroke, post-operative tumors, anoxia, hypoxias, toxic encephalopathies, refractory seizure disorders and congenital neurological brain disorders. These conditions can be with or without moderate to severe behavioral disorders secondary to a brain injury.

B. Extended Rehabilitative Hospital

Persons eligible for admission must have at least one of the following neurological conditions:

Post acute traumatic or acquired brain injury. This includes and is limited to viral encephalitis, meningitis, aneurysms, cerebral vascular accident/stroke, post-operative tumors, anoxia, hypoxias, toxic encephalopathies, refractory seizure disorders and congenital neurological brain disorders. These conditions can be with or without moderate to severe behavioral disorders secondary to a brain injury.

C. State-Operated Extended Rehabilitative Hospital

Persons eligible for admission must have at least one of the following neurological conditions:

1. Post acute traumatic or acquired brain injury. This includes and is limited to viral encephalitis, meningitis, aneurysms, cerebral vascular accident/stroke, post-operative tumors, anoxia, hypoxias, toxic encephalopathies, refractory seizure disorders and congenital neurological brain disorders. These conditions can be with or without moderate to severe behavioral disorders secondary to a brain injury.
2. Post acute traumatic injuries or congenital disorders of the spinal cord.

214.000

Plan of Care

10-13-03

The plan of care is an individualized plan designed to improve the patient's condition to the extent that RSPD services are no longer necessary. The plan is developed and written by the facility-based interdisciplinary team, in consultation with the patient and parents or legal guardian. A supervised individual plan of care must be implemented no later than four (4) days after admission and before Medicaid payments are authorized. The plan of care must include the following information:

- A. A diagnostic evaluation, reflecting the need for RSPD services. The evaluation must include an examination of the medical, social, psychological, behavioral and developmental aspects of the patient's situation.
- B. The patient's diagnosis (es), symptoms, complaints and complications, indicating the need for admission.
- C. A description of the patient's functional level.
- D. The signature of a licensed physician.
- E. The patient's treatment objectives.
- F. A prescribed, integrated program of therapies, social services, activities and experiences designed to meet the treatment objectives.
- G. Feasible rehabilitation goals.

- H. Orders for medications, diet, treatments, restorative and rehabilitative services or special procedures recommended for the health and safety of the patient.
- I. A projected schedule for service delivery - this includes the expected frequency and duration of each type of planned therapeutic session, medications or other prescribed special procedure.
- J. The type of personnel that will be furnishing the services.
- K. Plans for continuing care, including review and modification to the plan of care.
- L. Discharge plans.

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

214.100 Periodic Review of Plan of Care

10-13-03

The plan of care must be periodically reviewed by the facility-based interdisciplinary team in order to determine the patient's progress toward the rehabilitative treatment and care objectives, the appropriateness of the rehabilitative services provided and the need for the patient's continued participation in the RSPD Program. The reviews must be performed every thirty (30) days. Detailed documentation of the review must be entered in the patient's record and made available, as requested, for state and federal purposes.

215.000 Covered Services

3-1-06

RSPD is a global service, covering all rehabilitative, psychological and/or social services required of the admitting facility for licensure, certification and/or accreditation. This includes evaluations, therapies and visits by a licensed practitioner that are directly related to the beneficiary's rehabilitative adjustment.

Licensed practitioners visiting the beneficiary for reasons related to the beneficiary's rehabilitation treatment and/or the plan of care might not bill Medicaid for the services separately. However, medical visits and treatment not related to the beneficiary's rehabilitation and/or plan of care might be billed separately by the practitioner, if the service is a Medicaid covered service.

Specialty services are not included in the RSPD global service coverage. Therefore, Medicaid-enrolled specialists, such as neurologists, who see a beneficiary due to an injury may bill the Medicaid Program for any Medicaid covered service rendered.

A provider who renders medical services (e.g., physician, hospital, etc.) that are not included in the RSPD global service coverage must be an Arkansas Medicaid provider and bill the Arkansas Medicaid Program before they can be reimbursed.

The following services are included in the RSPD global coverage:

- A. Restorative Therapies – Restorative therapies include physical, occupational, speech and cognitive therapy. These therapies are provided in an individual or group setting.
- B. Behavioral Rehabilitation – Behavioral rehabilitation includes diagnosis, evaluation and treatment of aggression, depression, denial and other common behavioral problems. Behavioral rehabilitation shall address the needs of individuals who have experienced significant personality changes as a result of stroke, illness or serious accident. These services help decrease and control disruptive behaviors and improve coping skills.
- C. Life Skills Training – Activities of daily living that are rehabilitative in nature.

- D. Individual and Group Counseling – These services shall be provided for individuals who are suffering from psychological/adjustment disorders, or substance abuse secondary to their injury or illness. Family counseling may be included in this service when the services are directed exclusively to the effective treatment of the beneficiary and are included in the beneficiary's plan of care.
- E. Assessment Services – These services assess an individual's potential for functional improvement. Under the direction of a neuropsychologist and/or physician, a team of specialists provides an evaluation of the beneficiary. The team provides continuous testing during the residential stay as determined medically necessary by the neuropsychologist and/or physician.
- F. Nursing Care – This service provides the availability of registered nursing services 24 hours a day.

216.000**Exclusions****10-13-03**

The following is a list of services that are excluded from payment in the RSPD Program. The list also includes services that are included in the RSPD global coverage and, therefore, cannot be billed as a separate Medicaid service.

- A. Beauty or barber shop services.
- B. Clothing and personal allowances.
- C. Cost for visitors, including meals and/or guest trays.
- D. Dietary or nutritional consultation or plan.
- E. Discharge plan.
- F. Durable medical equipment.
- G. Educational services, including evaluations.
- H. Habilitation.
- I. Inpatient or outpatient hospital services.
- J. Leave days, including leave days for therapeutic or acute care, which are taken with or without permission from the RSPD medical staff.
- K. Occupational therapy tools, such as leather-working tools, scissors and construction paper.
- L. Private duty nursing services.
- M. Prosthetics.
- N. Recreational services.
- O. Room and board costs.
- P. RSPD services provided in a residential rehabilitation center to Medicaid patients who are 21 years of age and older.
- Q. Services found not to be medically necessary, reasonable or necessary for the treatment of an illness or injury.
- R. Social Services.
- S. Take home drugs and supplies.

- T. Telephone.
- U. Television.
- V. Therapies that are included in the RSPD global service coverage.
- W. Vocational services and/or training.

217.000 **Benefit Limits** **10-13-03**

Benefit limits are the limitations to covered services that Medicaid-eligible patients may receive. The benefit limits in the RSPD Program are explained in detail in the following sections:

- A. Coverage Limitation – Medicaid Utilization Management Program. (Sections 217.100 through 217.135)
- B. Facility Limitation. (Section 217.200)
- C. Services Limitation. (Section 217.300)

217.100 **Coverage Limitation—Medicaid Utilization Management Program** **8-1-21**

The Medicaid Utilization Management Program (MUMP) is designed to manage the appropriateness and duration of RSPD services. The MUMP procedures apply to all RSPD providers.

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

217.110 **MUMP Applicability** **8-1-21**

Medicaid beneficiaries are allowed up to four (4) days of RSPD services when the admission criteria (refer to Sections 213.000 through 213.300) are met. If a patient is not discharged before or during the fifth day of the residential stay, *DHS or its designated vendor must certify any additional days.*

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

217.120 **MUMP Exemption** **3-1-06**

Individuals in all Medicaid eligibility categories and all age groups, except beneficiaries under age 1, are subject to MUMP procedures. Medicaid beneficiaries under age 1 at the time of admission are exempt from the MUMP procedures for dates of service before their first birthday. (For MUMP procedures *on* and *after* a child's first birthday, see Section 217.131, item D.)

217.130 **MUMP Procedures** **10-13-03**

MUMP procedures are detailed in the following sections of this manual:

- A. Extension of RSPD admissions (non-transfer admissions). (Section 217.131)
- B. Transfer admissions. (Section 217.132)
- C. Certifications of residential stays involving retroactive Medicaid eligibility. (Section 217.133)
- D. Patients with third party or Medicare coverage. (Section 217.134)

217.131 Extension of RSPD Admissions 8-1-21

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

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

1. RSPD providers initiating their request after the fourth day must accept the financial liability should the stay not meet the medical criteria for continued RSPD services.
 2. If the provider delays calling for an extension and the services are denied based on the lack of medical necessity, the patient will not be held liable.
- B. For a Medicaid patient under age one (1), the days from the admission date through the day before the patient's first birthday are exempt from the MUMP procedures. MUMP procedures become effective on the one-year birthday; the patient's birthday is the first day of the four (4) days not requiring MUMP certification. If the stay continues beyond the fourth day following the patient's first birthday, the RSPD medical staff must apply for MUMP certification to extend the RSPD admission.
- C. Medicaid guidelines and the medical judgment of its professional staff are used to determine the number of days to extend the admission.
- D. Additional extensions may be requested if more days are needed beyond the original extension.
- E. If the extension request is denied by a physician advisor, the RSPD provider may request an expedited reconsideration review by sending the medical record for review and determination. The provider must specify that an expedited reconsideration is being requested. The RSPD provider will be notified of the decision by the next working day.
- F. Providers may request administrative reconsideration of an adverse decision or they can appeal as provided in Section 190.003 of the Arkansas Medicaid provider manual.
- G. If the denial is because of incomplete documentation, but complete documentation that supports medical necessity is submitted with the reconsideration request, the nurse may approve the extension of benefits without referral to a physician advisor.
- H. If the denial is because there is no proof of medical necessity or the documentation does not allow for approval by the nurse, the original documentation, reason for denial and new information submitted will be referred to a different physician advisor for reconsideration.
- I. All parties will be notified in writing of the outcome of the reconsideration.
- J. Medicaid claims submitted without an approved extension will result in automatic denials of any days billed beyond the fourth day. The only exception is claims involving third party liability. (See Section 217.134.)

217.132 Transfer Admissions 8-1-21

If a patient is transferred from one RSPD facility to another, the receiving facility must contact DHS or its designated vendor within twenty-four (24) hours to certify the residential stay. **[View or print the contact information to obtain the DHS or designated vendor step-by-step process for submitting the request.](#)**

217.133 Retroactive Medicaid Eligibility 8-1-21

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

217.134 Third Party and Medicare Claims

8-1-21

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

217.135 Post Payment Review

10-13-03

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

217.136 Administrative Reconsideration and Appeals

6-1-25

- A. Medicaid allows only one (1) reconsideration of an adverse decision. Reconsideration requests must be submitted in accordance with Section 160.000 of Section I of this Manual.
- B. When the state Medicaid agency or its designee denies a reconsideration request or issues any adverse decision, the beneficiary may appeal and request a fair hearing. A request for a fair hearing must be submitted in accordance with Sections 160.000, 190.000, and 191.000 of Section I of this Manual.

217.137 Reserved

6-1-25

217.200 Facility Limitation

3-1-06

The benefit limits will apply to each of the RSPD facilities as specified below:

- A. Residential Rehabilitation Center
 1. RSPD services provided in a residential rehabilitation center are limited to Medicaid-eligible beneficiaries who are under the age of 21 years.
 2. Medicaid beneficiaries who are under the age of 21 years and in the Child Health Services (EPSDT) Program are not limited to a thirty (30) day annual benefit limit.
- B. Extended Rehabilitative Hospital
 1. RSPD services provided in an extended rehabilitative hospital are not age limited.
 2. RSPD services provided in an extended rehabilitative hospital are limited to thirty (30) days per state fiscal year, July 1 through June 30, for ages 21 and older. **No extensions will be considered.** However, beneficiaries who are under the age of

- 21 years and in the Child Health Services (EPSDT) Program are not limited to the thirty (30) day annual benefit limit.
3. The thirty (30) day annual benefit limit only applies to services provided in an RSPD facility and does not include days counted toward any other Medicaid Program benefit limit, e.g., hospital, nursing home, etc.
- C. State-Operated Extended Rehabilitative Hospital
1. RSPD services provided in a state-operated extended rehabilitative hospital are not age limited.
 2. RSPD services provided in a state-operated extended rehabilitative hospital are limited to thirty (30) days per state fiscal year, July 1 through June 30, for ages 21 and older. **No extensions will be considered.** However, beneficiaries who are under the age of 21 years and in the Child Health Services (EPSDT) Program are not limited to the thirty (30) day annual benefit limit.
 3. The thirty (30) day annual benefit limit only applies to services provided in an RSPD facility and does not include days counted toward any other Medicaid Program benefit limit, e.g., hospital, nursing home, etc.

217.300**Services Limitation****7-1-20**

Because certain services would either result in a duplication (i.e., the service is included in the RSPD global coverage) or would not be appropriate for persons residing in an RSPD facility, services in the below listed Medicaid Programs are not available to Medicaid beneficiaries who have received RSPD services on the same date of service. These include:

- A. Adult Developmental Day Treatment (ADDT).
- B. Developmental Disabilities Services (DDS) Community and Employment Support (CES) Waiver.
- C. ARChoices in Homecare.
- D. Home Health.
- E. Hospice.
- F. Hyperalimentation (Parenteral Nutrition).
- G. Individual or Group Psychological Therapy/Counseling or Testing.
- H. Inpatient Hospital (Acute Care/General or Rehabilitative).
- I. Inpatient Psychiatric Services for Under Age Twenty-one (21).
- J. Nursing Home.
- K. Personal Care.
- L. Occupational, Physical, or Speech-Language Therapy, including evaluations.
- M. Private Duty Nursing Services.
- N. Outpatient Behavioral Health Services (OBHS).
- O. Targeted Case Management.
- P. Ventilator Equipment.

218.000 Absent Days from the RSPD Facility 3-1-06

The Arkansas Medicaid Program will not cover the days the beneficiary is absent from the facility, regardless of the reason for absenteeism. When a beneficiary is absent from the facility, the RSPD provider must document when the beneficiary left the facility, if possible, why the beneficiary left, where the beneficiary was going and, when applicable, the beneficiary's expected return date.

When a beneficiary is absent, the RSPD provider must follow one of the following procedures:

- A. Formally discharge the beneficiary, regardless of the length of absenteeism. If the beneficiary is to be readmitted, the RSPD provider must formally admit the beneficiary upon return by following all normal admission policies as stated in this manual.

or

- B. Allow the beneficiary up to seven (7) days to return to the RSPD facility.
1. If the beneficiary returns to the RSPD facility within seven (7) days, the RSPD 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 RSPD facility within seven (7) days, the RSPD provider must formally discharge the beneficiary. If the beneficiary is to be readmitted, the RSPD provider must formally admit the beneficiary by following the normal procedures, as stated in this manual.

219.000 Reserved 6-1-25**220.000 Electronic Signatures 10-8-10**

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

240.000 PRIOR AUTHORIZATION 10-13-03

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

250.000 REIMBURSEMENT**251.000 Method of Reimbursement for RSPD Services 10-13-03**

Listed below are the methods of reimbursement to RSPD providers for RSPD services.

- A. Reimbursement for RSPD Services Administered in Residential Rehabilitation Centers

The per diem reimbursement for RSPD services provided by a residential rehabilitation center will be based on the provider's fiscal year end 1994 audited cost report as submitted by an independent auditor plus a percentage increase equal to the Centers for Medicare and Medicaid Services (CMS), formerly HCFA, Market Basket Index published for the quarter ending in March. A cap has been established at \$395.00. This is a prospective rate with no cost settlement. Room and board is not an allowable program cost. The criteria utilized to exclude room and board are as follows: The total Medicaid ancillary cost was divided by total Medicaid inpatient days, which equal the RSPD prospective per diem. The ancillary cost was determined based on the Medicare Principles of Reimbursement. There is no routine cost included.

B. Reimbursement for RSPD Services Administered in Extended Rehabilitative Hospitals

Extended rehabilitative hospitals are reimbursed hospital-specific prospective rates, subject to an upper limit with no cost settlement. Rates will be effective July 1, of each year. The rate year is the state fiscal year, July 1 through June 30.

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

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

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

C. Reimbursement for RSPD Services Administered in State Operated Extended Rehabilitative Hospitals

The per diem reimbursement for RSPD services provided by a state operated extended rehabilitative hospital will be a prospective rate with no cost settlement based on the most recent, available, unaudited cost report. Room and board is not an allowable program cost. The per diem rate will be capped at \$232.00. Arkansas Medicaid will calculate a new per diem rate annually based on the provider's most recent unaudited cost report, plus a percentage increase for inflation. The inflation factor will be based on the CMS (formerly HCFA) Market Basket Index for the quarter ending in September.

252.000**Rate Appeal Process****10-13-03**

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

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

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 7-1-07

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

A Medicaid claim may contain only one billing provider's charges for services furnished to only one 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 RSPD Procedure Code 10-13-03

Providers must use Revenue Code **249** when billing the Medicaid Program for RSPD services.

262.200 Place of Service and Type of Service Codes 10-13-03

Not applicable to this program.

262.300 Billing Instructions—Paper Only 8-1-21

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 with the National Uniform Billing Committee UB-04 data element specifications and Arkansas Medicaid's billing instructions, requirements, and regulations for claim form CMS-1450.

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.

Following are Arkansas Medicaid's instructions for completing, in conjunction with the UB-04 Data Element Specifications Manual (UB-04 Manual), a CMS-1450 (UB-04) claim form.

Forward the original of the completed form to the Fiscal Agent's Claims Department. [View or print DHS or its designated Fiscal Agent's contact information.](#) One (1) 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 the 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	<p>Enter the covered beginning and ending service dates. Format: MMDDYY.</p> <p><i>Inpatient:</i> Enter the dates of the first and last covered days in the FROM and THROUGH fields.</p> <p>The FROM and THROUGH dates cannot span the 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> <ol style="list-style-type: none"> 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</p>

Field #	Field name	Description
		<p>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.	(blank)	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.
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.

Field #	Field name	Description
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.
b.	CODE	Enter 81.
	AMOUNT	Enter number of noncovered days.
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.	HCPCS/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.

Field #	Field name	Description
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 NPI of 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.
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 in field 63A. <i>Outpatient:</i> Enter any applicable prior authorization or benefit extension number in field 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.

Field #	Field name	Description
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.
	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 or enter the Medicaid ID.
	QUAL	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 operating physician or enter the Medicaid ID.
	QUAL	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	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 required.
80.	REMARKS	For provider's use.
81.	Not used	Reserved for assignment by the NUBC.

262.400 Special Billing Procedures

10-13-03

Not applicable to this program.