



Arkansas Department of Human Services

Division of Medical Services

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TO: Arkansas Medicaid Health Providers - Rehabilitative Services for Persons with Mental Illness

DATE: November 1, 2004

SUBJECT: Provider Manual Update Transmittal No. 50

REMOVE

Section	Date
224.000	10-1-04
228.000 – 228.100	10-13-03

INSERT

Section	Date
224.000	11-1-04
228.000 – 228.335	11-1-04

Explanation of Updates

Section 224.000 is included to delete the term “Medical Director”.

Sections 228.000 through 228.200 are included due to changes in the section numbers.

Effective November 1, 2004, on-site inspections of care and retrospective reviews will be conducted with the possibility of recoupments of reimbursements made to providers due to errors or fraudulent billing practices. The processes for the reviews are now included in this provider manual at Sections 228.300 through 228.335.

Paper versions of this update transmittal have updated pages attached to file in your provider manual. See Section I for instructions on updating the paper version of the manual. For electronic versions, these changes will be automatically incorporated.

If you need this material in an alternative format, such as large print, please contact our Americans with Disabilities Act Coordinator at (501) 682-6789 or 1-877-708-8191. Both telephone numbers are voice and TDD.

If you have questions regarding this transmittal, please contact the EDS Provider Assistance Center at 1-800-457-4454 (Toll-Free) within Arkansas or locally and Out-of-State at (501) 376-2211.

Thank you for your participation in the Arkansas Medicaid Program.

Roy Jeffus, Director

Arkansas Medicaid provider manuals (including update transmittals), official notices and remittance advice (RA) messages are available for downloading from the Arkansas Medicaid website: www.medicaid.state.ar.us.

224.000

Physician's Role

10-1-04

RSPMI providers are required to have a board certified or board eligible psychiatrist who provides appropriate supervision and oversight for all medical and treatment services provided by the agency. A physician will supervise and coordinate all psychiatric and medical functions as indicated in treatment plans. Medical responsibility shall be vested in a physician, preferably one specializing in psychiatry, who is licensed to practice medicine in Arkansas. If medical responsibility is not vested in a psychiatrist, then psychiatric consultation must be available on a regular basis. For RSPMI enrolled recipients, medical supervision responsibility shall include, but is not limited to, the following:

- A. For any individuals certified as being Seriously Mentally Ill (SMI) or Seriously Emotionally Disturbed (SED), the physician will see and evaluate the individual the earlier of 45 days of the individual's entering care or 45 days from the effective date of certification of serious mental illness/serious emotional disturbance. This evaluation is not required if the recipient discontinues services prior to calendar day 45. The SMI/SED recipient must be seen directly by a physician, at least every six months thereafter.
- B. For individuals not certified as having a Serious Mental Illness or Serious Emotional Disturbance, the psychiatrist or physician may determine through review of recipient records and consultation with the treatment staff that it is not medically necessary to directly see the enrolled recipient. By calendar day 45 after entering care, the physician must document in the recipient record that it is not medically necessary to see the recipient. If the recipient continues to be in care for more than six months after program entry, the psychiatrist or physician shall see and evaluate the individual directly by the end of six months, initially, then at least every year, thereafter.
- C. The physician will review and approve the enrolled recipient's RSPMI treatment plan/plan of care and document approval in the enrolled recipient's record. If the treatment plan/plan of care is revised prior to each 90 day interval, the physician must approve the changes within 14 calendar days, as indicated by a dated signature on the revised plan.
- D. Approval of all updated or revised treatment plans/plans of care must be documented by the physician's dated signature on the revised document. The new 90-day period begins on the date of the physician's signature.

228.000 **Provider Reviews** 11-1-04

228.100 **Utilization Review** 11-1-04

The Utilization Review Section of the Arkansas Division of Medical Services has the responsibility for assuring quality medical care for its recipients, along with protecting the integrity of both state and federal funds supporting the Medical Assistance Program.

228.200 **Medicaid Field Audit Unit** 11-1-04

These tasks have been mandated by federal regulations. The **Medicaid Field Audit Team** shall:

- A. Conduct on-site medical audits for the purpose of verifying the nature and extent of service paid for by the Medicaid Program;
- B. Research all inquiries from recipients in response to the Explanation of Medicaid Benefits; and
- C. Retrospectively evaluate medical practice patterns and providers' patterns by comparing each provider's pattern to norms and limits set by all the providers of the same specialty.

228.300 **Record Reviews** 11-1-04

The Division of Medical Services (DMS) of Arkansas Department of Human Services (DHS) has contracted with APS Healthcare and First Health of Arkansas to perform on-site inspections of care (IOC) and retrospective reviews of outpatient mental health services provided by RSPMI providers. [View or print APS Healthcare information.](#) [View or Print First Health of Arkansas information.](#)

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

228.310 **On-Site Inspections of Care (IOC)** 11-1-04

228.311 **Purpose of the Review** 11-1-04

The on-site inspections of care of RSPMI providers are intended to:

- A. Promote RSPMI services being provided in compliance with federal and state standards;
- B. Identify and clearly define areas of deficiency where the provision of services is not in compliance with federal and state standards;
- 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 corrective action plans implemented.

228.312 **Provider Notification of IOC** 11-1-04

The provider will be notified no more than 48 hours before the scheduled arrival of the inspection team. It is the responsibility of the provider to provide a reasonably comfortable place for the team to work. When possible, this location will provide reasonable access to the patient care areas and the medical records.

228.313 Information Available Upon Arrival of the IOC Team 11-1-04

The provider will make the following available to the IOC Team upon arrival at the site:

- A. Medical records of Arkansas Medicaid recipients who are identified by the reviewer.
- B. One or more knowledgeable administrative staff member(s) to assist the team;
- C. The opportunity to assess direct patient care which does not disrupt or distract from 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, etc.;

And, if identified as necessary to clarify specific chart audit questions:

- E. Written policies, procedures and committee minutes.
- F. Data collected for Clinical Administration, Clinical Services, Quality Assurance, Quality improvement, Utilization Review and Credentialing;
- G. Program descriptions, manuals, schedules, staffing plans and evaluation studies.

228.314 Cases Chosen for Review 11-1-04

The cases are chosen by a case selection procedure that combines random sampling and cases identified as "high utilization" and "outliers."

- A. High Utilizers are defined as recipients who meet pre-defined levels of mental health service utilization within an identified period of time.
- B. Outliers shall be defined as any providers or recipients whose provision of services or service utilization meets pre-defined criteria of variance from the norm.
- C. Cases chosen for review for On-Site Inspections of Care (IOC) are subject to the purpose, policies, and procedures specified in sections 228.331 (Purpose of the Review), 228.333 (Review Report), 228.334 (Reconsideration), and 228.335 (Recoupments).

The review period will be specified in the provider notification letter. The list of cases to be reviewed will be given to the provider upon arrival or chosen by the IOC Team from a list for that location with a request for certain components of the records. The information requested includes:

1. All required assessments, including SED/SMI Certifications where applicable
2. Treatment plans (plan of care) and PoC reviews
3. Progress notes, including physician notes
4. Physician orders and lab results
5. Copies of records. The reviewer may request a copy of any record reviewed.

228.315 Program Activity Observation 11-1-04

The reviewer will observe at least one program activity.

228.316 Recipient Interviews 11-1-04

The provider is required to arrange interviews of Medicaid recipients as requested by the reviewer, preferably from the recipients whose records are being reviewed. If the recipients

whose records are being reviewed are not available, interviews will be conducted with recipients on-site whose records are not scheduled for review and the records for those recipients will be added to the review.

228.317 Exit Conference 11-1-04

The Inspection of Care Team will conduct an exit conference summarizing their findings and recommendations. Providers are free to involve staff in the exit conference.

228.318 Written Reports 11-1-04

A written report of the inspection team's conclusions will be forwarded to the facility and to the Field Audit Unit of the Division of Medical Services within 14 calendar days of the last day of inspection. The written report will clearly identify any area of deficiency that requires submission of a corrective action plan.

228.319 Corrective Action Plans 11-1-04

The facility is required to submit a Corrective Action Plan designed to rectify any area of deficiency noted in the written report of the inspection of care. The Corrective Action Plan must be submitted to the contracted utilization review agency within 30 calendar days of the date of the written report. The contractor will review the Corrective Action Plan and forward it, along with recommendations, to the Field Audit Unit of the Division of Medical Services.

228.320 Other Actions 11-1-04

Other actions that may be taken as part of the inspection of care include, but are not limited to:

- A. Decertification of any recipient determined to no longer meet medical necessity criteria for outpatient mental health services.
- B. Follow-up inspections of care may be recommended by the contracted utilization review agency and required by Division of Medical Services to verify the implementation and effectiveness of corrective actions. Follow-up inspections may be focused only on 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.
- C. Review by Field Audit Unit of the Division of Medical Services.

228.330 Retrospective Reviews 11-1-04

The Division of Medical Services (DMS) of Arkansas Department of Human Services has contracted with APS Healthcare and First Health of Arkansas to perform retrospective (post payment) reviews of outpatient mental health services provided by RSPMI providers. [View or print APS Healthcare information.](#) [View or Print First Health of Arkansas information.](#)

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

228.331 Purpose of the Review 11-1-04

The purpose of the review is to evaluate the medical necessity of services provided to Medicaid recipients of all ages. 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.

228.332 Cases Chosen for Review

11-1-04

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

- A. High Utilizers are defined as recipients who meet pre-defined levels of mental health service utilization within an identified period of time.
- B. Outliers shall be defined as any providers or recipients whose provision of services or service utilization meets pre-defined criteria of variance from the norm.

The review period will be specified in the provider notification letter. The list of cases to be reviewed will be included in the letter with a request for certain components of the records. The information requested includes:

1. All required assessments, including SED/SMI Certifications where applicable
2. Treatment plans (plan of care) and PoC reviews
3. Progress notes, including physician notes
4. Physician orders and lab results

At the discretion of the contractor, the retrospective review may also include:

5. Agency policy, procedure and program description related to the content of RSPMI services, including daily schedules and descriptions of service content

and

6. Credentials of staff providing services

All records must be mailed to the contractor. [View or print APS Healthcare information.](#) [View or Print First Health of Arkansas 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.

228.333 Review Report

11-1-04

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 of the date on the report, the results of the audit report will be final. The contractor will mail the report the same date as that on the report.

228.334 Reconsideration

11-1-04

If the audit report is unfavorable, the provider has the right to request reconsideration by the contractor within 30 calendar days from 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 provider 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. 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.

228.335 Recoupments

11-1-04

The final report complete with an analysis of payments made for services the contractor determines were not medically necessary will be sent to DMS. The provider will be notified by DMS of the amount to be recouped by Medicaid and the methods available for repayment.