P.O. Box 25010
Little Rock, AR 72221

1915 (i) and 1915 (c) Waiver Services Manual
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100.000 GENERAL PROGRAM OVERVIEW

101.000 Overview

The Medicaid Home and Community-Based Services (HCBS) waiver program is authorized in §1915(c) of the Social Security Act. The program permits a State to furnish an array of home and community-based services that assist Medicaid beneficiaries to live in the community and avoid institutionalization. The State has broad discretion to design its waiver program to address the needs of the waiver's target population. Waiver services complement and/or supplement the services that are available to participants through the Medicaid State plan and other federal, state and local public programs as well as the supports that families and communities provide. The Centers for Medicare & Medicaid Services (CMS) recognizes that the design and operational features of a waiver program will vary depending on the specific needs of the target population, the resources available to the State, service delivery system structure, State goals and objectives, and other factors. A State has the latitude to design a waiver program that is cost-effective and employs a variety of service delivery approaches, including participant direction of services

101.100 1915 (c) Waiver Services

The purpose of Community and Employment Support (CES) Waiver services are to support individuals of all ages who have a developmental disability, meet ICF level of care and require waiver support services to live in the community and prevent institutionalization.

The goals of the CES Waiver are to support beneficiaries in all major life activities, promote community inclusion through integrated employment options and community experiences, and provide comprehensive care coordination and service delivery under the 1915(b) PASSE Waiver Program.

101.200: Overview

The 1915(i) waiver program is authorized in §1915(i) of the Social Security Act and works concurrently with other §1915 authorities. The program permits a State to furnish an array of enhanced home and community based behavioral health services and are management services in an effort to better address individual needs.

101.300: 1915(i) Waiver Services

The purpose of the 1915(i) State Plan Amendment for Home and Community-Based Services is threefold: to improve the health of the population, to improve the experience of care of individuals receiving services and to improve the quality of care while reducing the growth of health care costs.

101.400: Authorizations

All HCBS are required to be documented in the member's PCSP and are subject to review and authorization.

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101.500: Providers

All providers must be an approved Arkansas Medicaid providers with the appropriate Medicaid designation to render services.

200.000 COMMUNITY AND EMPLOYMENT SUPPORTS (CES) WAIVER GENERAL INFORMATION

201.000 Overview

ARTC is committed to ensuring that all Home and Community Based Services (HCBS) Members have access to item(s) and service(s) for which has been prescribed as necessary. The goal is to create a flexible array of services that will allow people to reach their maximum potential in decision making, employment and community integration while always ensuring member choice. ARTC is committed to ensuring that all HCBS services under the 1915(c) CMS Arkansas Medicaid Waiver Program are deemed necessary for the member who the service is being requested and are aligned with the Person Centered Service Plan (PCSP) goals/objectives and services. The purpose of the CES Waiver is to support members of all ages who have a developmental disability and meet the institutional level of care and require support services to live in the community and thus prevent institutionalization.

All CES Waiver Providers have the responsibility of recruiting, hiring and training Direct Support Professional Staff. The CES Provider will ensure the member/parent/guardian has a choice in the decision making process, should they choose. It will be at the responsibility of the CES Provider to ensure ongoing training and support is provided to all Direct Support Professionals.

Eligibility Process-When an individual/parent/guardian decides to access the CES Waiver Program, the individual will make contact with DHS/DDS to complete the required application process, to determine eligibility. This process begins with DHS/DDS and the DDS psychological team determines eligibility. Once a member has been determined eligible for services, DHS attributes the member to Arkansas Total Care.

All services notated in Section 200.000 through 240.000 relates to the CES Waiver Program and will be reviewed as such.

201.100 Providers of CES Waiver Services in Arkansas and Bordering States Trade Area Cities

CES waiver services are limited to Arkansas and bordering state trade area cities. The DDS must certify all providers as CES waiver providers before services may be provided for Arkansas Medicaid beneficiaries and the waiver providers must maintain an active status

201.200 Pass Through Providers Requirements

Pass Through providers must guarantee that any sub-contractor will abide by all Medicaid regulations and provides that the provider assumes all liability for contract noncompliance. The provider must also have a written contract that sets forth specifications and assurances that work will be completed timely, satisfactorily to the beneficiary being served and with quality maintained. The provider is responsible for ensuring that services were delivered and proper documentation, including a signed customer satisfaction statement, has been submitted prior to billing.

As long as the provider delivers at least one waiver service directly utilizing its own employees, an provider may provide any other CES waiver service via a sub-contract with an entity qualified to furnish the service. The subcontract must ensure financial accountability and that services were delivered, properly documented and billed. The primary use of pass through services is consultation, adaptive equipment, environmental modifications, supplemental support and specialized medical supplies.

The provider furnishes the services as the beneficiary's provider of choice as described in that beneficiary's person-centered service plan.

202.000 Documentation Requirements

CES waiver providers must keep and properly maintain written records. The following records must be included in the beneficiary's case files maintained by the provider.

202.100 Documentation in Beneficiary's Case Files

CES waiver providers must develop and maintain sufficient written documentation to support each service for which billing is made. This documentation, at a minimum, must consist of:

A. A copy of the beneficiary's person-centered service plan, including any amendments thereto.

B. The specific services rendered.

C. The date and actual start and end time the services were rendered.

D. The name of the individual who provided the service.

E. The relationship of the service to the treatment regimen of the beneficiary's person-centered service plan.

F. Updates describing the beneficiary's progress or lack thereof. Updates should be maintained on a daily basis or at each contact with or on behalf of the beneficiary. Progress notes must be signed and dated by the DSP/staff who delivered the service, the CES waiver provider, supervisor/and authorized designee/member/parent/guardian.

G. Certification statements, narratives and proofs that support the cost-effectiveness and medical necessity of the service to be provided as outlined in this manual.

Additional documentation and information may be required dependent upon the service to be provided.

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202.200 HCBS Settings Requirements

Home and Community-Based Services (HCBS) Settings

All providers must meet the following Home and Community-Based Services (HCBS) Settings regulations as established by CMS. The federal regulation for the new rule is 42 CFR 441.301(c) (4)-(5).

HCBS settings must be integrated in and support full access of beneficiaries receiving Medicaid HCBS to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources and receive services in the community, to the same degree of access as beneficiaries not receiving Medicaid HCBS.

HCBS settings must have the following characteristics:

A. Chosen by the individual from among setting options including non-disability-specific settings (as well as an independent setting) and an option for a private unit in a residential setting.
   1. Choice must be included in the person-centered service plan.
   2. Choice must be based on the individual's needs, preferences and, for residential settings, resources available for room and board.

B. Ensures an individual's rights of privacy, dignity and respect and freedom from coercion and restraint.

C. Optimizes, but does not regiment, individual initiative, autonomy and independence in making life choices, including but not limited to, daily activities, physical environment, and with whom to interact.

D. Facilitates individual choice regarding services and supports and who provides them.

F. In a provider-owned or -controlled residential setting (e.g., Group Homes), in addition to the qualities specified above, the following conditions must be met:
   1. The unit or dwelling is a specific physical place that can be owned, rented, or occupied under a legally enforceable agreement by the individual receiving services, and the individual has, at a minimum, the same responsibilities and protections from eviction that tenants have under the landlord/tenant law of the State, county, city, or other designated entity. For settings in which landlord/tenant laws do not apply, the State must ensure that a lease, residency agreement or other form of written agreement will be in place for each HCBS participant and that the document provides protections that address eviction processes and appeals comparable to those provided under the jurisdiction's landlord/tenant law.
   2. Each individual has privacy in their sleeping or living unit:
      a. Units have entrance doors lockable by the individual, with only appropriate staff having keys to doors.
      b. Beneficiaries sharing units have a choice of roommates in that setting.

c. Beneficiaries have the freedom to furnish and decorate their sleeping or living units within the lease or other agreement.

3. Beneficiaries have the freedom and support to control their own schedules and activities and have access to food at any time.
4. Beneficiaries are able to have visitors of their choosing at any time.
5. The setting is physically accessible to the individual.
6. Any modification of the additional conditions specified in items 1 through 4 above must be supported by a specific assessed need and justified in the person-centered service plan. The following requirements must be documented in the person-centered service plan:
   a. Identify a specific and individualized assessed need.
   b. Document the positive interventions and supports used prior to any modifications to the person-centered service plan.
   c. Document less intrusive methods of meeting the need that have been tried but did not work.
   d. Include a clear description of the condition that is directly proportionate to the specific assessed need.
   e. Include regular collection and review of data to measure the ongoing effectiveness of the modification.
   f. Include established time limits for periodic reviews to determine if the modification is still necessary or can be terminated.
   g. Include the informed consent of the individual.
   h. Include an assurance that interventions and supports will cause no harm to the individual.

210.000 PROGRAM COVERAGE

211.000 Scope

The CES waiver program offers certain home and community-based services (HCBS) as an alternative to institutionalization. These services are available for eligible beneficiaries with a developmental disability who would otherwise require an intermediate care facility for the intellectually disabled/developmentally disabled (ICF/ID/DD)level of care. This waiver does not provide education or therapy services.

The purpose of the CES waiver is to support beneficiaries of all ages who have a developmental disability, meet the institutional level of care, and require waiver support services to live in the community and thus prevent institutionalization.

The goal is to create a flexible array of services that will allow people to reach their maximum potential in decision-making, employment and community integration; thus giving their lives the meaning and value they choose.

The objectives are as follows:

A. To transition eligible persons who choose the waiver option from residential facilities into the community

B. To provide priority services to persons who meet criteria for the third tier of service (requiring supports 24 hours a day, seven (7) days a week)

C. To enhance and maintain community living for all persons participating in the waiver program

CES waiver services may require prior authorized and be based on an independent assessment and functional evaluations. All services must be delivered based on the approved person-centered service plan. Refer to our prior auth tool on www.arkansastotalcare.com for more information on what services require a prior authorization.

212.000 Description of Services

CES services provide the support necessary for a beneficiary to live in the community. Without these services, the beneficiary would require institutionalization.

Services provided under this program are as follows:

A. Supportive Living
B. Respite Services
C. Supported Employment
D. Adaptive Equipment
E. Environmental Modifications
F. Specialized Medical Supplies
G. Supplemental Support Service
H. Care Coordination Services
I. Consultation Services
J. Crisis Intervention Services
K. Community Transition Services

213.000 Supportive Living

Supportive living is an array of individually tailored services and activities provided to enable eligible beneficiaries to reside successfully in their own homes, with their family, or in an alternative living residence or setting. Alternative living residences include apartments, leased or owned homes, or provider group homes. Supportive living services must be provided in an integrated community setting. The services are designed to assist beneficiaries in acquiring, retaining and improving the self-help, socialization and adaptive skills necessary to reside successfully in the home- and community-based setting. Services are flexible to allow for unforeseen changes needed in schedules and times of service delivery. Services are approved as maximum days that can be adjusted within the annual plan year to meet changing needs. The total number of units cannot be increased or decreased without a revision. Care and supervision for which payment will be made are those activities that directly relate to active treatment goals and objectives.

A. Residential Habilitation Supports

Supports to assist the beneficiary to acquire, retain or improve skills in a wide variety of areas that directly affect their ability to reside as independently as possible in the community. The supports that may be provided to a beneficiary include:

1. Decision making, including the identification of and response to dangerously threatening situations, making decisions and choices affecting the person's life and initiating changes in living arrangement or life activities.
2. Money management, including training, assistance or both in handling personal finances, making purchases and meeting personal financial obligations.
3. Daily living skills, including habilitative training in accomplishing routine housekeeping tasks, meal preparation, dressing, personal hygiene, administration of medications (to the extent permitted under state law) and other areas of daily living including proper use of adaptive and assistive devices, appliances, home safety, first aid and emergency procedures.
4. Socialization, including training, assistance or both, in participation in general community activities, and establishing relationships with peers. Activity training includes assisting the person to continue to participate on an ongoing basis.
5. Community integration experiences, including activities intended to instruct the beneficiary in daily living and community living skills in an integrated setting. Included are such activities as shopping, church attendance, sports, participation in clubs, etc. Community experiences include activities and supports to accomplish individual goals or learning areas including recreation and specific training or leisure activities. Each activity is then adapted according to the beneficiary's individual needs.
6. Non-medical transportation to or from community integration experiences is an integral part of this service. DDS will assure duplicate billing between waiver services and other Medicaid state plan services will not occur. The habilitation objectives to be served by such training must be documented in the beneficiary's treatment plan and all charged travel should be clearly associated with those objectives. Mileage will be limited to a maximum of 6,000 miles per year. The signature of the DSP provider and member is required on the mileage form. Any request for additional miles beyond the annual allocated amount will be reviewed by the PASSE. Justification for additional miles must be submitted with the request and clearly indicate the reason an extension is warranted. Whenever possible, family, neighbors, friends or community agencies that can provide this service without charge must be utilized.

Exclusions: Transportation to and from medical, dental and professional appointments inclusive of therapists. Transportation provided by the provider to and from EIDT and ADDT. Non-medical transportation does not include transportation for other household members.

7. Mobility, including training, assistance or both aimed at enhancing movement within the person's living arrangement, mastering the use of adaptive aids and

equipment, accessing and using public transportation, independent travel or movement within the community.

8. Communication, including training in vocabulary building, use of augmentative communication devices and receptive and expressive language.
9. Behavior shaping and management, including training, assistance or both in appropriate expressions of emotions or desires, compliance, assertiveness, acquisition of socially appropriate behaviors or reduction of inappropriate behaviors.
10. Reinforcement of therapeutic services, including conducting exercises or reinforcing physical, occupational, speech and other therapeutic programs.
11. Health maintenance activities may be provided by a supportive living worker. All health maintenance activities, except injections and IV's, can be done in the home by a designated care aide, such as a supportive living worker. With the exception of injectable medication administration, tasks that beneficiaries would otherwise do for themselves, or have a family member do, can be performed by a paid designated care aide at their direction, as long as the criteria specified in the Arkansas Nurse Practices Consumer Directed Care Act has been met. Health maintenance activities are available in the Arkansas Medicaid State Plan as self-directed services. State plan services must be exhausted before accessing waiver funding for health maintenance activities.
12. Health and Safety Monitoring - used to monitor the member during sleep hours

B. Companion and Activities Therapy

Companion and activities therapy services provide reinforcement of habilitative training. This reinforcement is accomplished by using animals as modalities to motivate beneficiaries to meet functional goals. Through the utilization of an animal's presence, enhancement and incentives are provided to beneficiaries to practice and accomplish such functional goals as:

1. Language skills
2. Increased range of motion
3. Socialization by developing the interpersonal relationships skills of interaction, cooperation and trust and the development of self-respect, self-esteem, responsibility, confidence and assertiveness

   Exclusions: This service does not include the cost of veterinary or other care, food, shelter or ancillary equipment that may be needed by the animal that is providing reinforcement.

C. Direct Care Supervision

The direct care supervisor employed by the supportive living provider is responsible for assuring the delivery of all supportive living direct care services including the following activities:

1. Coordinating all direct service workers who provide care through the direct service provider
2. Serving as liaison between the beneficiary, parents, legal representatives, care coordination entity and officials

3. Coordinating schedules for both waiver and generic service categories
4. Providing direct planning input and preparing all direct service provider segments of any initial plan of care and annual continued stay review
5. Assuring the integrity of all services billed under the Medicaid waiver program
6. Arranging for staffing of all alternative living settings
7. Assuring transportation as identified in beneficiary's person-centered service plan specific to supportive living services
8. Assuring timely collaboration with the care coordination entity to obtain comprehensive behavior and assessment reports, continued person-centered case plans with revisions as needs change and information and documents required for ICF/IDD level of care and waiver Medicaid eligibility determination
9. Reviewing the person's records and environments in which services are provided by accessing appropriate professional sources to determine whether the person is receiving appropriate support in the management of medication. Minimum components are as follows:
    a. The direct care supervisor has an on-going responsibility for monitoring beneficiary medication regimens. While the provider may not staff a person on a 24/7 schedule, the provider is responsible around the clock to ensure that the person-centered service plan identifies and addresses all the needs with other supports as necessary to assure the health and welfare of the beneficiary.
    b. Staff, at all times, are aware of the medications being used by the beneficiary.
    c. Staff are knowledgeable of potential side effects of the medications being used by the beneficiary through the prescribing physician, nurse and pharmacist at the time medications are ordered.
    d. All medications consumed are prescribed or approved by the beneficiary's physician or other health care practitioner.
    e. The beneficiary or legally responsible person is informed by the prescribing physician about the nature and effect of medication being consumed and consents to the consumption of those medications prior to consumption.
    f. Staff are implementing the service provider's policies and procedures as to medication management, appropriate to the beneficiary's needs as monitored by the direct care supervisor in accordance with acceptable personnel policies and practices at least monthly.
    g. If psychotropic medications are being used for behavior, the direct care supervisor is responsible to assure appropriate positive behavior programming is present and in use with programming reviews at least monthly.
    h. The consumption of medications is monitored at least monthly by the direct care supervisor to ensure that they are accurately consumed as prescribed.
    i. Any administration of medication or other nursing tasks or activities are

performed in accordance with the Nurse Practice and Consumer Directed Care Acts and are monitored by the direct care supervisor in accordance with acceptable personnel practices at least monthly.

j. Medications are regularly reviewed to monitor their effectiveness, to address the reason for which they were prescribed and for possible side effects.

k. Medication errors are effectively detected by the direct care supervisor by review of the medication log and with appropriate response up to and inclusive of incident reporting and reporting to the Nursing Board.

l. Frequency of monitoring is based on the physician's prescription for administration of medication.

m. The physician approving the service level of support and the person-centered service plan is responsible for monitoring and determining contraindications when multiple medications are prescribed. A minimum review is at the annual continued stay review of the person-centered service plan for approval and recertification.

Direct care staff are required to complete daily activity logs for activities that occur during the work timeframe with such activities linked to the person-centered service plan objectives. The direct care supervisor is required to monitor the work of the direct care staff and to sign off on timesheets maintained to document work performed. All monitoring activities, reviews and reports must be documented and available upon request from authorized personnel or ARTC staff.

NOTE: Failure to satisfactorily document activities according to ARTC requirements may result in non-payment or recoupment of payment of services.

Beneficiaries may access both supportive living and respite on the same date as long as the two services are distinct and do not overlap time that each respective service was actually provided. ARTC monitors this provision through retrospective annual review with providers responsible for maintaining adequate time records and activity case notes or activity logs that support the service deliveries. Controls in place to assure payments are made only for services rendered include requirement by assigned staff to complete daily activity logs for activities that occurred during the work timeframe with such activities linked to the person-centered service plan objectives; supervision of staff by the direct care supervisor with sign-off on timesheets maintained weekly; audits and reviews conducted by ARTC at random; random visits to the home; and oversight by the chosen and assigned care coordinator.

213.100 Supportive Living Arrangements (Provider owned group homes or apartments)

Persons residing in supportive living arrangements are eligible for the same services and service level as any other waiver participant. Staff working in such arrangements must have hours of compensation prorated according to the number of individuals, waiver and non-waiver,

residing in the supportive living arrangement. Additional one-on-one staffing may be provided when the need is justified.

213.200 Supportive Living Exclusions

Only hired caregivers may be reimbursed for supportive living services provided.

The payments for these services exclude the costs of room and board, including general maintenance, upkeep or improvement to the beneficiary's own home or that of his or her family.

Routine care and supervision for which payment will not be made are defined as those activities that are necessary to assure a person's well-being but are not activities that directly relate to active treatment goals and objectives.

It is the responsibility of the provider to assure compliance with state and federal Department of Labor wage and hour laws.

213.300 Benefit Limits for Supportive Living

For the supportive living array, which includes both supportive living and respite services is based upon the tier of support identified in the beneficiary's person-centered service plan after completion of the independent assessment. This includes provider-indirect costs for each component of service. ARTC must prior authorize for all tiers of support.

213.400 Documentation Required for Supportive Living Requests

A. Updated budget sheet reflecting the most current proposed hours.
B. Documentation showing efforts made to recruit, train and retain staff, if significant overtime is being requested.
C. Documentation of the last 3 to 12 months of all Supportive Living Progress notes remitted by all DSP staff. DSP notes should include the following:
    1. Date of Service
    2. Member Name
    3. DSP Name
    4. Goals worked on during shift, progress/regression for each goal, level of independence and an overall summary of what was worked during the shift including details of any transportation incurred
    5. Time in/out and signature of member/parent/guardian
    6. DSP signature
    7. Direct Care Supervisor's signature with an attestation indicating the services documented were delivered

D. Completed treatment plan (goals & objectives) for the upcoming plan year.
E. Justification of fringe amount if request exceeds 25 percent.
F. Hours and days of natural supports that are in place.
G. Justification for increased salary requests

H. Documentation that additional resources that have been explored (ADDT programs, family members, employment opportunities, volunteer opportunities, etc.)
I. Transportation logs for the most current 3 months to demonstrate how transportation has been utilized during the current plan year. Transportation logs should include the following:
    1. Daily odometer readings and destination from point A to point B, including beginning location and ending location. All documented and billed miles must be linked to one of the member's goals.
    2. The date and actual time the service was rendered.
    3. The relationship of the service to the treatment regimen of the member's person centered service plan.
    4. All transportation notes must be signed and dated by the provider of the services, the DSP and the member/parent/guardian.

J. Total number of miles utilized during the current plan year.
K. Justification as to why public transportation or natural supports cannot be accessed.
L. Any additional information that could be used in a favorable determination.
M. Reimbursement information for Arkansas Total Care can be found in Payment Policy: ARTC Supportive Living Prior Auth Rate Justification on www.arkansastotalcare.com

214.000 Respite Services

Respite services are provided on a short-term basis to beneficiaries unable to care for themselves due to the absence of or need for relief of non-paid primary caregivers. Receipt of respite services does not necessarily preclude a beneficiary from receiving other services on the same day. For example, a beneficiary may receive day services, such as supported employment, on the same day as respite services.

When respite is furnished for the relief of a foster care provider, foster care services may not be billed during the period that respite is furnished. Respite may not be furnished for the purpose of compensating relief or substitute staff for supportive living services. Respite services are not to supplant the responsibility of the parent or guardian.

Respite may be provided in the following locations:

A. Beneficiary's home or private place of residence
B. The private residence of a respite care provider
C. Foster home
D. Group home.
E. Licensed respite facility
F. Other community residential facility approved by the state, not a private residence
G. Licensed or accredited residential mental health facility

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214.100 Benefit Limits for Respite Services

For the supportive living array, which includes both supportive living and respite services is based upon the tier of support identified in the beneficiary's person-centered service plan after completion of the independent assessment. This includes provider-indirect costs for each component of service. ARTC must prior authorize for all tiers of support.

214.200 Documentation Requirement for Respite Services Requests

A. Updated budget sheet reflecting the most current proposed hours.
B. Documentation as to why natural supports cannot support this request.
C. Any additional information that could be used in a favorable determination.
D. Documentation as to what Respite activities will be performed during the time services are rendered

215.000 Supported Employment

Supported employment is a tailored array of services that offers ongoing support to beneficiaries with the most significant disabilities to assist in their goal of working in competitive integrated work settings for at least minimum wage. It is intended for individuals for whom competitive employment has not traditionally occurred, or has been interrupted or intermittent as a result of a significant disability, and who need ongoing supports to maintain their employment.

The supported employment service array includes:

A. Discovery Career Planning: Information is gathered about a beneficiary's interests, strengths, skills, the types of supports that are the most effective and the types of environments and activities where the participant is at his or her best. These services should result in the development of the Individual Career Profile which includes specific recommendations regarding the beneficiary's employment support needs, preferences, abilities and characteristics of optimal work environment. The following activities may be a component of Discovery/Career Planning: review of the beneficiary's work history, interest and skills; job exploration; job shadowing; informational interviewing, including mock interview; job and task analysis activities; situational assessments to assess the beneficiary's interest and aptitude in a particular type of job; employment preparation (i.e. resume development); benefits counseling; business plan development for self-employment; and volunteerism.

B. Employment Path: Beneficiary receiving these services must have goals related to employment in integrated community settings in their person-center service plan. Activities must be designed and developed to support the employment goals outlined in the person-centered service plan. Such activities should develop and teach soft skills utilized in integrated employment including, but not limited to, following directions, attending to tasks, problem-solving skills and strategies, mobility training, effective and appropriate communication (verbal and nonverbal) and time management.

Employment Path is a time-limited service and requires prior authorization for the first 12 months. One reauthorization of up to twelve months is possible, but only if the beneficiary is also receiving job development services that indicate the beneficiary is actively seeking employment.

C. Employment Supports.

1. Job Development: Individualized services that are specific in nature to obtaining a certain employment opportunity. The initial outcome of Job Development is the Job Development Plan. The Job Development Plan must be created and incorporated with the individual Career Profile no later than 30 days after Job Development services begin. The Job Development Plan must, at a minimum, specify:
    a. Short- and long-term employment goals
    b. Target wages
    c. Task hours
    d. Special conditions that apply to the worksite for the beneficiary
    e. Jobs that will be developed or tasks that will be customized through negotiations with potential employers
    f. Initial list of employer contacts
    g. Plan for how many employers will be contacted each week
    h. Conditions for use of on-site job coaching
2. Job Coaching: On-site activities that may be provided to a beneficiary once employment is obtained. Activities provided under this service may include, but are not limited to, completing job duty and task analysis; assisting the beneficiary to learn to do the job by the least intrusive method available; developing compensatory strategies if needed to cue beneficiary to complete the job; analyzing the work environment during initial training/learning of the job and making determinations regarding modifications or assistive technology. Services are authorized for twelve months. A fading plan must be developed for Job Coaching services that show how the goals of this service will be achieved in 12 months. Additional authorizations of Job Coaching with no additional fading gains will require additional documentation of level of need for service.

    Job Coaching may also be utilized when the beneficiary chooses self-employment. Activities such as assisting the beneficiary to identify potential business opportunities, develop a business plan, as well as develop and launch a business are included. Waiver funds may not be used to defray expenses associated with starting or operating a business, such as capital expenses, advertising, hiring or training of employees.
3. Extended Services: The expected outcome of extended services is sustained paid employment at or above minimum wage with associated benefits and the opportunity for advancement in a job that meets the beneficiary's personal and career planning goals. Employment supports: Extended Services allows for the continued monitoring of employment outcomes through regular contact with the beneficiary and the employer. A minimum of one contact per quarter with the employer is required.

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215.100 Supported Employment Exclusions

Supported employment requires related activities to be identified and included in outcomes with an accompanying work plan submitted as documentation of need for service.

Payment for employment services excludes:

A. Incentive payments made to an employer of waiver beneficiaries to encourage or subsidize an employer's participation in the program.

B. Payments that are passed through to waiver beneficiaries.

C. Payments for training that are not directly related to the waiver beneficiary's employment.

D. Reimbursement if the beneficiary is not able to perform the essential functions of the job. The functions of a job coach are to "coach," not to do the work for the person.

E. CES waiver supported employment services when the same services are otherwise funded under the Rehabilitation Act of 1973 or Public Law 94-142. This means that such services must be exhausted before waiver-supported employment services can be approved or reimbursement can be claimed.

F. Services provided in a sheltered workshop or other similar type of vocational service furnished in a specialized facility.

215.200 Documentation Requirements for Supported Employment Requests

A. Supported employment providers must maintain documentation in each waiver beneficiary's file to demonstrate the service is not available under a program funded under Section 110 of the Rehabilitation Act of 1973 or Individual with Disabilities Education Act (20 U.S.C. 1401 et. seq).

B. Documentation must include proof from the funded provider where services were exhausted.

C. For Discovery Career Planning, the provider must create and maintain an individual Career Profile-Discovery Staging Record to demonstrate compliance and delivery of service.

D. For Employment Path Services, the provider must maintain the person-centered service plan, the beneficiary's progress notes, and the Arkansas Rehabilitation Services Referral to demonstrate compliance and delivery of service.

E. For Job Development Plan Services, the provider must maintain the Job Development Plan and beneficiary's remuneration statement.

F. For Extended Services, the provider must maintain the Arkansas Rehabilitation Services letter of closure, beneficiary's remuneration statement (paycheck stub) and

beneficiary's work schedule, if available, to demonstrate compliance with and delivery of this service.

215.300 Benefit Limits for Supported Employment

Discovery/Career Planning: Allowed maximum is 50 hours per week over a six-week period to complete the activities and create the Individual Career Profile. There is an outcome payment upon submission of the Profile and required documentation.

Employment Path: Allowed maximum is 25 hours per week alone or combined with Employment Supports in small group. Only twelve months of service may be authorized with one reauthorization allowed if the beneficiary is receiving Job Development Services that indicate he or she is actively seeking employment. A milestone payment is available if the beneficiary obtains individualized, competitive integrated employment or self-employment during the first 12-month authorization.

Employment Supports Job Development: This is outcome-based reimbursement, payable in stages to incentivize retention of the job. The payment schedule is as follows:

A. 60% at the end of the beneficiary's first pay period.
B. 25% when the beneficiary has completed four (4) weeks on the job.
C. 15% when the beneficiary has completed eight (8) weeks on the job.

Employment Supports—Job Coaching: Allowed maximum of 40 hours per week. Twelve months of services are authorized, and the provider must have a fading plan. The provider must document necessity of additional services to have additional services authorized without a fading plan.

Employment Supports—Extended Services: Allowed maximum of 20% of the beneficiary's weekly scheduled work hours.

216.000 Adaptive Equipment

The adaptive equipment service includes an item or a piece of equipment that is used to increase, maintain or improve functional capabilities of individuals to perform daily life tasks that would not be possible otherwise. Adaptive equipment is a piece of equipment, or product system that is used to increase, maintain, or improve functional capabilities of members, whether commercially purchased, modified, or customized. The adaptive equipment service provides for the purchase, leasing, and as necessary, repair of adaptive, therapeutic and augmentative equipment that enables individuals to increase, maintain or improve their functional capacity to perform daily life tasks that would not be possible otherwise.

Adaptive equipment needs for supportive employment are included. This service may include specialized equipment such as devices, controls or appliances that will enable the person to perceive, to control or to communicate with the environment in which they are competitively employed.

Adaptive equipment includes “enabling technology,” that empowers the beneficiary to gain independence through customizable technologies to allow them to safely perform activities of daily living without assistance, while still providing for monitoring and response for those beneficiaries, as needed. Enabling technology must be shown to meet a goal of the beneficiary’s person-centered service plan, ensure beneficiary’s health and safety, and provide for adequate monitoring and response for beneficiary’s needs. Before enabling technology will be provided, it must be documented that an assessment was conducted and a plan was created to show how the enabling technology will meet those requirements.

Equipment may only be covered if not available to the beneficiary from any other source. Professional consultation must be accessed to ensure that the equipment will meet the needs of the beneficiary when the purchase will at a minimum exceed $500.00. Consultation must be conducted by a medical professional as determined by the beneficiary’s condition for which the equipment is needed. All items must meet applicable standards of manufacture, design, installation and ADA standards.

All adaptive equipment must be solely for the waiver beneficiary. All purchases must meet the conditions for desired quality at the least expensive cost. any modifications over $1,000.00 will require three bids with the lowest bid with comparable quality being awarded; however, ARTC may require three bids for any requested purchase.

Computer equipment, including software, can be included as adaptive equipment. Specifically, computer equipment may be approved when it allows the beneficiary control of his or her environment, assists in gaining independence or when it can be demonstrated that it is necessary to protect the health and safety of the beneficiary. The waiver does not cover supplies..

Communication boards are allowable devices. Computers may be approved for communication when there is substantial documentation that a computer will meet the needs of the beneficiary more appropriately than a communication board.

If property not owned by member/guardian the form must be completed and submitted to ARTC by property owner before services will be completed.

Software will be approved only when required to operate the accessories included for environmental control or to provide text-to-speech capability.

Note: Adaptive equipment must be an item that is modified to fit the needs of the beneficiary. Items such as toys, gym equipment, sports equipment, etc. are excluded as not meeting the service definition.

Conditions: The care and maintenance of adaptive equipment, vehicle modifications, and personal emergency response systems are entrusted to the beneficiary or legally responsible person for whom the aids are purchased. Negligence (defined as failure to properly care for or perform routine maintenance of) shall mean that the service will be denied for a minimum of two plan years. Any unauthorized use or selling of aids by the beneficiary or legally responsible person shall mean the aids will not be replaced using waiver funding.

Exclusions:

A. Swimming pools (in-ground or above-ground) and hot tubs are not allowable as either an environmental modification or adaptive equipment.

B. Therapeutic tools similar to those therapists employ during the course of therapy are not included.
C. Educational aids are not included.
D. Computers will not be purchased to improve socialization or educational skills.
E. Computer supplies.
F. Computer desks or other furniture items are not covered.
G. Medicaid-purchased equipment cannot be donated if the equipment being donated is needed by another waiver beneficiary residing in the residence.

216.100 Adaptive Equipment: Vehicle Modifications

Vehicle modifications are adaptations to an automobile or van to accommodate the special needs of the beneficiary. Vehicle adaptations are specified by the service plan as necessary to enable the beneficiary to integrate more fully into the community and to ensure the health, welfare and safety of the beneficiary.

Payment for permanent modification of a vehicle is based on the cost of parts and labor, which must be quoted and paid separately from the purchase price of the vehicle to which the modifications are or will be made.

Transfer of any part of the purchase price of a vehicle, including preparation and delivery, to the price of a modification is a fraudulent activity. All suspected fraudulent activity will be reported to the Office of Medicaid Inspector General for investigation.

Reimbursement for a permanent modification cannot be used or considered as down payment for a vehicle.

Lifts that require vehicle modification and the modifications themselves are, for purposes of approval and reimbursement, one project and cannot be separated by plan-of-care years in order to obtain up to the maximum amount allowed.

Age and condition of the vehicle will be considered when being reviewed for modification.

Exclusions:

A. Adaptations or improvements to the vehicle that are of general utility and are not of direct medical or remedial benefit to the beneficiary
B. Purchase, down payment, monthly car payment, or lease cost of a vehicle;
C. Regularly scheduled upkeep and maintenance of a vehicle and the modification to the vehicle.

216.200 Adaptive Equipment: Personal Emergency Response System (PERS)

A PERS may be approved when it can be demonstrated as necessary to protect the health and safety of the beneficiary. A PERS is a stationary or portable electronic device that is used in the beneficiary's place of residence that allows the beneficiary to secure help in an emergency. The system must be connected to a response center staffed by trained professionals who respond

upon activation of the PERS. The beneficiary may also wear a portable “help” button to allow for mobility. PERS services are limited to beneficiaries who live alone or who are alone for significant parts of the day and have no regular caregiver for extended periods of time and who would otherwise require extensive routine supervision. Included in this service are assessment, purchase, installation, testing, and monthly rental fees. A PERS shall include cost of installation and testing as well as monthly monitoring performed by the response center.

216.300 Benefit Limits for Adaptive Equipment

The adaptive equipment is based upon the tier of support identified in the beneficiary’s person-centered service plan after completion of the independent assessment. This includes provider-indirect costs for each component of service. ARTC must prior authorize for all tiers of support.

216.400 Documentation Requirements for Adaptive Equipment Requests

A. Documentation of how adaptive equipment will increase, maintain or approve functional capabilities of the member to perform daily task that would not be possible otherwise.
B. Details of how the equipment will ensure the members health and safety.
C. Three separate bids if request exceeds $1,000 dollars.
D. Letter of necessity from prescribing provider, including clinical justification for the request.
E. Any additional information that could be used in a favorable determination.
F. Other avenues for accessing these items must be explored prior to accessing under the waiver.

217.000 Environmental Modifications

Environmental modifications are made to or at the waiver beneficiary’s home, required by the person-centered service plan and are necessary to ensure the health, welfare and safety of the beneficiary or that enable the beneficiary to function with greater independence and without which the beneficiary would require institutionalization.

Environmental modification may include the installation of ramps and grab-bars, widening of doorways, modification of bathroom facilities, installation of specialized electric and plumbing systems to accommodate medical equipment, installation of sidewalks or pads to accommodate ambulatory impairments, and home property fencing when medically necessary to assure non-elopement, wandering or straying of persons who have dementia, Alzheimer’s disease or other causes of memory loss or confusion as to location, or decreased mental capacity or aberrant behaviors.

Expenses for the installation of the environmental modification and any repairs made necessary by the installation process are allowable. Portable or detachable modifications that can be relocated with the beneficiary and that have a written consent from the property owner or legal representative will be considered. Requests for modification must include an original photo of

the site where modifications will be done; to-scale sketch plans of the proposed modification project; identification of other specifications relative to materials, time for project completion and expected outcomes; labor and materials breakdown and assurance of compliance with any local building codes. Final inspection for the quality of the modification and compliance with specifications and local codes is the responsibility of the waiver care coordinator. Payment to the contractor is to be withheld until the work meets specifications including a signed customer satisfaction statement.

All services must be provided as directed by the beneficiary's person-centered service plan and in accordance with all applicable state or local building codes.

Environmental modifications must be made within the existing square footage of the residence and cannot add to the square footage of the building.

Modifications are considered and approved as single, all-encompassing projects and, as such, cannot be split whereby a part of the project is submitted in one service plan year and another part submitted in the next service plan year. Any such activity is prohibited. All modifications must be completed within the plan-of-care year in which the modifications are approved.

All purchases must meet the conditions for desired quality at the least expensive cost. Generally, any modifications over $1,000.00 will require three bids, with the lowest bid with comparable quality being awarded. However, ARTC may require three bids for any requested modification.

Environmental modifications may only be funded through the waiver if not available to the beneficiary from any other source. If the beneficiary may receive environmental modifications through the Medicaid State Plan, a denial by Utilization Review will be required prior to approval for funding through the waiver.

217.100 Environmental Modifications Exclusions

Modifications or improvements made to or at the beneficiary's home which are of general utility and are not of direct medical or remedial benefit to the beneficiary (e.g., carpeting, roof repair, central air conditioning, etc.) are excluded as covered services. Also excluded are modifications or improvements that are of aesthetic value such as designer wallpaper, marble counter tops, ceramic tile, etc.

All Environmental Home Modification requests made to a home/property in which the member/parent/guardian rents or leases, must accompany a release from the leasing agent/management company, indicating the home modification to be made is authorized."

Home modifications are intended to improve access for the member. They are not intended to improve the overall value, appearance or structural deficiencies of the home.

Reimbursement for a permanent modification cannot be used or considered as down payment for a home.

Outside fencing is limited to one fence per lifetime. Total perimeter fencing is excluded.

Expenses for remodeling or landscaping which are cosmetic, designed to hide the existence of the modification, or result from erosion are not allowable.

Environmental modifications that are permanent fixtures will not be approved for rental property without prior written authorization and a release of current or future liability by the residential property owner.

Environmental modifications may not be used to adapt living arrangements that are owned or leased by providers of waiver services.

Swimming pools (both in- and out-of-ground) and hot tubs (spas) are not allowable.

The moving of modifications, such as fencing or ceiling tracks and adaptive equipment that may be permanently affixed to the structure or outside premises, is not allowable.

217.200 Benefit Limits for Environmental Modifications

The environmental modification is based upon the tier of support identified in the beneficiary's person-centered service plan after completion of the independent assessment. This includes provider-indirect costs for each component of service. ARTC must prior authorize for all tiers of support.

217.300 Documentation Requirements for Environmental Modification Requests

A. Documentation of how modification will increase, maintain or approve functional capabilities of the member to perform daily task that would not be possible otherwise.
B. Original photos of the site to be modified.
C. Proposed sketch of current space to be modified
D. Identification of other specifications relative to materials, time for project completion and expected outcomes; labor and materials, and assurance of compliance with local building codes.
E. Three separate bids if request exceeds $1,000.
F. Any additional information that could be used in a making determination.
G. Completion of the ARTC Home Owner Release Form
H. Completion of the ARTC Provider Release Form
I. Completion of the ARTC Member Release Form

218.000 Specialized Medical Supplies

A physician must order or document the need for all specialized medical equipment. All items must be included in the person-centered service plan. Specialized medical equipment and supplies include:

A. Must also be documented in the PCP chart should it relate to a medical condition for which the item(s) are being requested

B. ARTC reserves the right to find comparable products to meet the needs of the member.

C. . Items necessary for life support or to address physical conditions along with the ancillary supplies and equipment necessary for the proper functioning of such items.

B. Durable and non-durable medical equipment not available under the Arkansas Medicaid State Plan that is necessary to address beneficiary functional limitations.

C. Necessary medical supplies not available under the Arkansas Medicaid State Plan. Items reimbursed with waiver funds are in addition to any medical equipment and supplies furnished under the state plan and exclude those items that are not of direct medical or remedial benefit to the beneficiary. All items shall meet applicable standards of manufacture, design and installation. The most cost-effective item will be considered first.

Additional supply items are covered as a waiver service when they are considered essential and necessary for home and community care. Covered items include:

A. Nutritional supplements

B. Non-prescription medications. Alternative medicines not Federal Drug Administration-approved are excluded from coverage.

C. Prescription drugs (not including the cost of Medicare Part D covered medications for dual-eligible beneficiaries) when extended benefits available under state plan are exhausted, if limits are in place restricting the number of prescriptions a beneficiary can receive per month

When the items are included in Arkansas Medicaid State Plan services, a denial of extension of benefits by ARTC Utilization Review will be required prior to approval for waiver funding by.

ARTC may request medical records from the prescribing provider to ensure the medical necessity of specialized medical supplies. ARTC expects the following information to be contained in the medical records:

a. Signed progress note(s) for all dates of service
b. Medical condition(s), for which each product has been prescribed
c. Referrals to specialty providers for diagnosis and treatment of conditions
d. Lab Test Reports_- clearly indicating lab result and date of service, if applicable
e. Documented baseline in member condition and how the member has benefited from using this product over the past year
f. Quantity prescribed, per month
g. Other documentation from the face-to-face encounter, if applicable

218.100 Benefit Limits for Specialized Medical Supplies

The specialized medical supplies are based upon the tier of support identified in the beneficiary's person-centered service plan after completion of the independent assessment. This includes provider-indirect costs for each component of service. ARTC must prior authorize for all tiers of support.

218.200 Documentation Requirements for Specialized Medical Supplies Requests

A. Name and description of the item, along with other identifying information if applicable. For nutritional supplements and OTC medications, include National Drug Code (NDC). For other products, please include Universal Product Code (UPC) if available.

B. Expected supplier of the item.
C. Justification that the item(s) are necessary for life support or to address physical conditions along with ancillary supplies and equipment necessary for proper functioning of such items.
D. Letter of medical necessity from prescribing provider, including clinical justification for the request including quantity.
E. Supporting documentation indicating that this item is covered by the Federal Drug Administration.
F. Documentation on how the member has benefited from using this product this past year.
G. Any additional information that could be used in a making determination.
H. Lack of other available resources must be proven.

219.000 Supplemental Support Service

The supplemental support service helps improve or enable the continuance of community living. Supplemental support service will be based on demonstrated needs as identified in a beneficiary's person-centered service plan as unforeseen problems arise that, unless remedied, could cause disruptions in the beneficiary's services, placement, or place him or her at risk of institutionalization. Waiver funds will be used as the payer of last resort.

219.100 Supplemental Support Services Benefit Limits

This service can be accessed only as a last resort. Lack of other available resources must be proven.

219.200 Documentation Requirements for Supplemental Support Service Supplies Requests

A. Describe how this service will improve and enable the member's continuance of community living and assurance of health and safety. And prevent disruption of community placement
B. Any additional information that could be used in a making determination.

220.000 Care Coordination Services

Care coordination services are the responsibility of ARTC and is no longer a covered services when provided by a CES Waiver provider.

221.000 Consultation Services

Consultation services are clinical and therapeutic services that assist waiver beneficiaries, parents, guardians, legally responsible individuals, and service providers in carrying out the beneficiary's person-centered service plan.

A. Consultation activities may be provided by professionals who are licensed as:

1. Psychologists
2. Psychological examiners
3. Mastered social workers
4. Professional counselors
5. Speech pathologists
6. Occupational therapists
7. Physical therapists
8. Registered nurses
9. Certified parent educators or provider trainers
10. Certified communication and environmental control specialists
11. Dietitians
12. Rehabilitation counselors
13. Recreational therapists
14. Qualified Developmental Disabilities Professionals (QDDP)
15. Positive Behavioral Supports (PBS) Specialists
16. Behavior Analysts

These services are indirect in nature. The parent educator or provider trainer is authorized to provide the activities identified below in items 2, 3, 4, 5, 7, and 13. The provider agency will be responsible for maintaining the necessary information to document staff qualifications. Staff who meet the certification criteria necessary for other consultation functions may also provide these activities. Selected staff or contract individuals may not provide training in other categories unless they possess the specific qualifications required to perform the other consultation activities. Use of this service for provider training cannot be used to supplant provider trainer responsibilities included in provider indirect costs.

B. Activities involved in consultation services include:

1. Providing updated psychological and adaptive behavior assessments
2. Screening, assessing and developing therapeutic treatment plans
3. Assisting in the design and integration of individual objectives as part of the overall individualized service planning process as applicable to the consultation specialty
4. Training of direct services staff or family members in carrying out special community living services strategies identified in the person-centered service plan as applicable to the consultation specialty
5. Providing information and assistance to the individuals responsible for developing the beneficiary's person-centered service plan as applicable to the consultation specialty
6. Participating on the interdisciplinary team, when appropriate to the consultant's specialty
7. Consulting with and providing information and technical assistance with other service providers or with direct service staff and/or family members in carrying

out a beneficiary's person-centered service plan specific to the consultant's specialty

8. Assisting direct services staff or family members in making necessary program adjustments in accordance with the beneficiary's person-centered service plan as applicable to the consultation specialty
9. Determining the appropriateness and selection of adaptive equipment to include communication devices, computers and software consistent with the consultant's specialty
10 Training and/or assisting beneficiaries, direct services staff or family members in the set-up and use of communication devices, computers and software consistent with the consultant's specialty
11. Screening, assessing and developing positive behavior support plans; assisting staff in implementation, monitoring, reassessment and modification of the positive behavior support plan consistent with the consultant's specialty
12. Training of direct services staff and/or family members by a professional consultant in:
    a. Activities to maintain specific behavioral management programs applicable to the beneficiary
    b. Activities to maintain speech pathology, occupational therapy or physical therapy program treatment modalities specific to the beneficiary
    c. The provision of medical procedures not previously prescribed but now necessary to sustain the beneficiary in the community
13. Training or assisting by advocacy to beneficiaries and family members on how to self-advocate
14. Rehabilitation counseling for the purposes of supported employment supports that do not supplant the Federal Rehabilitation Act of 1973 and PL 94-142 and the supports provided through Arkansas Rehabilitation Services
15. Training and assisting beneficiaries, direct services staff or family members in proper nutrition and special dietary needs

221.100 Benefit Limits for Consultation Services

The consultation services are based upon the tier of support identified in the beneficiary's person-centered service plan after completion of the independent assessment. This includes provider-indirect costs for each component of service. ARTC must prior authorize for all tiers of support.

221.200 Documentation Requirements for Consultation Services Requests

A. Justification for clinical and therapeutic services that assist the waiver member, parents, guardian, legally responsible individual, & services provider in caring out the members person centered service plan.
B. Name of the licensed professional providing the service.

C. Provide how this will be a part of the individual objectives for the member as applicable to the consultation specialty.
D. Justification on how training of direct services staff and family members will carry out this request in the PCSP as applicable to the consultation specialty.
E. Cost, resource, justification and desired outcome and how this will be monitored and reported.
F. Schedule and frequency of the training(s).
G. Credentials of trainer and supporting documentation of how this training has provided outcomes for this service related to the person's disability.
H. Any additional information that could be used in a favorable determination.

222.000 Crisis Intervention Services

Crisis intervention services are defined as services delivered in the beneficiary's place of residence or other local community site by a mobile intervention team or professional.

Intervention services must be available 24 hours a day, 365 days a year and must be targeted to provide technical assistance and training in the areas of behavior already identified. Services are limited to a geographic area conducive to rapid intervention as defined by the provider responsible to deploy the team or professional. Services may be provided in a setting as determined by the nature of the crisis, i.e., residence where behavior is happening, neutral ground, local clinic or school setting, etc. The following criteria must be met:

A. The beneficiary is receiving waiver services.
B. The beneficiary needs non-physical intervention to maintain or re-establish behavior management or positive programming plan.
C. Intervention is on-site in the community.

222.100 Documentation Requirements for Crisis Intervention Requests

A. Justification why the member needs nonphysical intervention or reestablished behavior management or a positive program plan is needed
B. Proof that intervention is being provided on site in the community.

223.000 Community Transition Services

Community transition services are non-recurring set-up expenses for beneficiaries who are transitioning from an institutional or another provider-operated living arrangement to a living arrangement in a private residence where the beneficiary or his or her guardian is directly responsible for his or her own living expenses. Waiver funds can be accessed once it has been determined that the waiver is the payer of last resort.

Allowable expenses are those necessary to enable a person to establish a basic household that do not constitute room and board and may include:

A. Security deposits that are required to obtain a lease on an apartment or home

B. Essential household furnishings and moving expense required to occupy and use a community domicile, including furniture, window coverings, food preparation items, and bed/bath linens

C. Set-up fees or deposits for utility or service access, including telephone, electricity, heating and water

D. Services necessary for the beneficiary's health and safety such as pest eradication and one-time cleaning prior to occupancy

E. Moving expenses

Community transition services are furnished only to the extent that they are reasonable and necessary as determined through the person-centered service plan development process, clearly identified in the person-centered service plan and the person is unable to meet such expense or when the services cannot be obtained from other sources.

Duplication of environmental modifications will be prevented through control of prior authorizations for approvals.

Costs for community transition services furnished to beneficiaries returning to the community from a Medicaid institutional setting through entrance to the waiver are considered to be incurred and billable when the person is determined to be eligible for the waiver services. The beneficiary must be reasonably expected to be eligible for and to enroll in the waiver. If for any unseen reason the beneficiary does not enroll in the waiver (e.g., due to death or a significant change in condition), transitional services may be billed to Medicaid.

Exclusions: Community transition services may not include payment for room and board, monthly rental or mortgage expense, food, regular utility charges, and/or household appliances or items that are intended for purely diversional or recreational purposes. Community transition services may not be used to pay for furnishing living arrangements that are owned or leased by a waiver provider where the provision of these items and services are inherent to the service they are already providing.

Diversionary or recreational items such as televisions, cable TV access, VCRs or DVD players are not allowable.

223.100 Benefit Limits for Community Transition Services

The community transition services are based upon the tier of support identified in the beneficiary's person-centered service plan after completion of the independent assessment. This includes provider-indirect costs for each component of service. ARTC must prior-authorize for all tiers of support.

223.200 Documentation Requirements for Community Transition Services Requests

A. Detailed Itemization to demonstrate how the dollars requested will be spent.
B. Proof or attestation that items/services cannot be obtained from other sources.
C. Any additional information that could be used in a making determination.

224.000 Payment to Relatives or Legal Guardians

Payment for waiver services will not be made to the adoptive or natural parent, step-parent or legal representative or legal guardian of a beneficiary less than 18 years old. Payments will not be made to a spouse or a legal representative for a beneficiary 18 years of age or older. When documentation is submitted it needs to identify the relationship of the staff to the member.

Payment to relatives, other than parents of minor children, legal guardians, custodians of minors or adults, or the spouse of adults, must be prior approved by ARTC to provide services. For purposes of exclusion, "parent" means natural or adoptive parents and step-parents. For any service provider, all ARTC qualifications and standards must be met before the person can be approved as a paid service provider. Qualified relatives, other than as specified in the foregoing, can provide any service.

In no case will a parent or legal guardian be reimbursed for the provision of transportation.Controls for services rendered: All care staff are required to document all services provided daily according to their work schedules, direct-care support service supervisors are responsible for day-to-day supervision and monitoring of the direct-care staff; care coordinators are responsible for periodically reviewing with the beneficiary any problems in care delivery and reporting any deficiencies to their supervisor. ARTC conducts both random Quality Assurance audits and audits specific to the financial integrity of services delivered.

220.000 PRIOR AUTHORIZATION

CES waiver services require prior authorization by Arkansas Total Care. **In the absence of prior authorization, reimbursement will be denied and may not be approved retroactively.**

See the Arkansas Total Care Provider Manual for instructions on how to submit authorization for service requests to ARTC. This manual can be found at www.arkansastotalcare.com.

230.000 REIMBURSEMENT

231.000 Method of Reimbursement

The reimbursement rates for CES waiver services will be according to the lesser of the billed amount or the Title XIX (Medicaid) maximum for each procedure.

P.O. Box 25010
Little Rock, AR 72221

240.000 BILLING PROCEDURES

241.000 Introduction to Billing

CES waiver providers use the CMS-1500 claim form to bill ARTC. See the Arkansas Total Care Provider Manual for instructions on how to submit claims for services rendered to ARTC. This manual can be found at www.arkansastotalcare.com.

400.000: 1915(i) WAIVER GENERAL INFORMATION

401.000 Overview

ARTC is committed to ensuring that all Members have access to item(s) and service(s. The goal is to create a flexible array of services that will allow members to reach their maximum level of wellness. ARTC is committed to ensuring that all Behavioral Health services under the 1915(i) Home and Community Based Services State Plan Amendment are provided with the intention to prevent or delay entry into an institutional setting or to assist or prepare an individual to leave an institutional setting, meaning the service should assist the individual to live safely and successfully in his/her own home or in the community. These services are aligned with the member's Person Centered Service Plan (PCSP) goals/objectives and services. The purpose of the 1915(i) State Plan Amendment for Home and Community-Based Services is threefold: to improve the health of the population, to improve the experience of care of individuals receiving services and to improve the quality of care while reducing the growth of health care costs.

401.100 Providers of 1915(i) Waiver Services in Arkansas and Bordering States Trade Area Cities

1915(i) waiver services are limited to Arkansas and bordering state trade area cities. The DHS must certify all providers as 1915(i) waiver providers before services may be provided for Arkansas Medicaid beneficiaries.

402.00 Documentation Requirements

1915(i) waiver providers must keep and properly maintain written records. The following records must be included in the member's case files maintained by the provider.

402.100 Documentation in Beneficiary's Case Files

CES waiver providers must develop and maintain sufficient written documentation to support each service for which billing is made. This documentation, at a minimum, must consist of:

A. A copy of the member's person-centered service plan, including any amendments thereto.
B. The specific services rendered.
C. The date and actual timeframe the services were rendered.
D. The name of the individual who provided the service.
E. The relationship of the service to the treatment regimen of the member's person-centered service plan.
F. Updates describing the member's progress or lack thereof. Updates should be maintained on a daily basis or at each contact with or on behalf of the member. Progress notes must be signed and dated by the staff who delivered the service.
G. Certification statements, narratives and proofs that support the cost-effectiveness and medical necessity of the service to be provided.
H. Additional documentation and information may be required dependent upon the service to be provided.

402.200 Setting Requirements

1915(i) service settings must be fully compliant with the home and community-based settings rules or be covered under the statewide transition plan under another authority where they have been in operation before March of 2014.

410.000: PROGRAM COVERAGE

411.000 Scope

The 1915(i) waiver program offers certain home and community-based services (HCBS). These services are available for eligible beneficiaries with qualifying diagnosis and level of need. This waiver does not provide education services.

The purpose of the 1915(i) waiver is to support beneficiaries of all ages to address their behavioral health needs in a home or community-based setting.

The goal is to create a flexible array of services that will allow people to reach their maximum potential.

The objectives are as follows:

A. To improve the health of the population.
B. To improve the experience of care of individuals receiving services.
C. To improve the quality of care while reducing the growth of health care costs.

All 1915(i) waiver services must be prior authorized (unless otherwise stated below). All services must be delivered based on the approved person-centered service plan.

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Little Rock, AR 72221

412.000 Description of Services

1915(i) State Plan Amendment for Home and Community-Based Services are intended to improve the health of the population, improve the experience of care of individuals receiving services and to improve the quality of care while reducing the growth of health care costs.

Services provided under this program are as follows:

A. Supportive Employment
B. Behavioral Assistance
C. Adult Rehabilitation Day Treatment
D. Peer Support
E. Family Support Partners
F. Individual/Group Pharmaceutical Counseling
G. Supportive Life Skills Development
H. Child and Youth Support Services
I. Therapeutic Communities
J. Residential Community Reintegration
K. Respite
L. Mobile Crisis Intervention
M. Therapeutic Host Homes
N. Recovery Support Partners
O. Substance Abuse Detoxification
P. Partial Hospitalization
Q. Supportive Housing

413.000 Supported Employment

Supportive Employment is designed to help beneficiaries acquire and keep meaningful jobs in a competitive job market. The service actively facilitates job acquisition by sending staff to accompany beneficiaries on interviews and providing ongoing support and/or on-the-job training once the member is employed. This service replaces traditional vocational approaches that provide intermediate work experiences (prevocational work units, transitional employment, or sheltered workshops), which tend to isolate beneficiaries from mainstream society.

Service settings may vary depending on individual need and level of community integration, and may include the member's home. Services delivered in the home are intended to foster independence in the community setting and may include training in menu planning, food preparation, housekeeping and laundry, money management, budgeting, following a medication regimes and interacting with the criminal justice system.

Allowable performing providers include Qualified Behavioral Health Providers – Bachelors, Qualified Behavioral Health Providers – Non-Degreed and Registered Nurses.

Guidelines/Requirements

1. A written recommendation from a therapist.
2. Member is engaged in and attending necessary outpatient behavioral health services.
a. Individual Therapy – Minimum of 1-2 visits per month
b. For non-adults services: Family Therapy – Minimum of 1 visit quarterly
c. Documentation must be sent in with specific encounters per each service code
d. There is adequate documentation from the provider that the service rendered is addressing member's identified needs and meets specific service description.

413.100 Supported Employment Exclusions

This service must be delivered face-to-face and is intended for the adult population. A provider cannot bill any H2017 or H2015 codes on the same date of service. All other provider standards and requirements in accordance with the 1915(b) requirements as defined in the currently approved 1915(b) waiver program.

413.200 Documentation Requirements for Supported Employment Requests

The minimum documentation requirements are as listed:

- Date of Service
- Names and relationship to the member of all persons involved
- Start and stop times of actual encounter with collateral contact
- Place of Service (If 99 is used, specific location and rationale for location must be included)
- Member diagnosis necessitating intervention
- Document how interventions used addresses goals and objectives from the master treatment plan
- Information gained from collateral contact and how it relates to master treatment plan objectives
- Impact of information received/given on the member's treatment
- Any changes indicated for the master treatment plan which must be documented and communicated to the supervising MHP for consideration
- Plan for next contact, if any
- Staff signature/credentials/date of signature
-
- On Initial Review:
  1. Intake Assessment
  2. Current PCSP identifying services – As outlined by the PASSE
  3. Three most recent outpatient notes for therapy
  4. Treatment Plan

  Continuation of Services:

1. Psych Assessment (CPT Codes 90791 or 90792)
2. Current PCSP review/ planning – As outlined by the PASSE
3. If applicable, most recent medication note
4. Two most recent notes for each therapy service member is attending
5. Treatment plan containing SMART goals that are within the scope of the service being provided and addresses the member needs and skill sets.
    a. Minimum of every 6 months.
    b. Progress or lack of progress toward goals within the last 30 days if the treatment plan was created more than 30 days prior to request.

413.300 Benefit Limits for Supported Employment

The supported employment is based upon the tier of support identified in the beneficiary's person-centered service plan after completion of the independent assessment. This includes provider-indirect costs for each component of service. ARTC must prior authorize for all tiers of support.

414.000 Behavioral Assistance

Behavioral Assistance is a specific outcome oriented intervention provided individually or in a group setting with the child/youth and/or his/her caregiver(s) that will provide the necessary support to attain the goals of the treatment plan. Services involve applying positive behavioral interventions and supports within the community to foster behaviors that are rehabilitative and restorative in nature. The intervention should result in sustainable positive behavioral changes that improve functioning, enhance the quality of life and strengthen skills in a variety of life domains.

Allowable performing providers include Qualified Behavioral Health Providers – Bachelors, Qualified Behavioral Health Providers – Non-Degreed and Registered Nurses.

414.100 Behavioral Assistance Exclusions

This services is intended to be provided face-to-face for children and youth. All other provider standards and requirements in accordance with the 1915(b) requirements as defined in the currently approved 1915(b) waiver program.

This services is intended to be provided face-to-face for children and youth. All other provider standards and requirements in accordance with the 1915(b) requirements as defined in the currently approved 1915(b) waiver program.

Guidelines/Requirements
1. A written recommendation from a therapist.
2. Member is engaged in and attending necessary outpatient behavioral health services.
a. Individual Therapy – Minimum of 1-2 visits per month
b. For non-adults services: Family Therapy – Minimum of 1 visit quarterly

c. Documentation must be sent in with specific encounters per each service code
d. There is adequate documentation from the provider that the service rendered is addressing member's identified needs and meets specific service description.

414.200 Documentation Requirements for Behavioral Assistance

The minimum documentation requirements are as listed:

- Date of Service
- Names and relationship to the beneficiary of all persons involved
- Start and stop times of actual encounter with collateral contact
- Place of Service (When 99 is used, specific location and rationale for location must be included)
- Client diagnosis necessitating treatment
- Document how treatment used address goals and objectives from the master treatment plan
- Information gained from contact and how it relates to master treatment plan objectives
- Impact of information received/given on the beneficiary's treatment
- Any changes indicated for the master treatment plan which must be documented and communicated to the supervising MHP for consideration
- Plan for next contact, if any
- Staff signature/credentials/date of signature

On Initial Review:
1. Intake Assessment
2. Current PCSP identifying services – As outlined by the PASSE
3. Three most recent outpatient notes for therapy
4. Treatment Plan

Continuation of Services:
1. Psych Assessment (CPT Codes 90791 or 90792)
2. Current PCSP review/ planning – As outlined by the PASSE
3. If applicable, most recent medication note
4. Two most recent notes for each therapy service member is attending
5. Treatment plan containing SMART goals that are within the scope of the service being provided and addresses the member needs and skill sets.
    a. Minimum of every 6 months.
    b. Progress or lack of progress toward goals within the last 30 days if the treatment plan was created more than 30 days prior to request.

414.300 Benefit Limits for Behavioral Assistance

The behavioral assistance is based upon the tier of support identified in the beneficiary's person-centered service plan after completion of the independent assessment. This includes provider-indirect costs for each component of service. ARTC must prior authorize for all tiers of support.

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415.000 Adult Rehabilitation Day Treatment

A continuum of care provided to recovering individuals living in the community based on their level of need. This service includes educating and assisting the individual with accessing supports and services needed. The service assists the recovering individual to direct their resources and support systems. Activities include training to assist the person to learn, retain, or improve specific job skills, and to successfully adapt and adjust to a particular work environment. This service includes training and assistance to live in and maintain a household of their choosing in the community.

In addition, transitional services to assist individuals adjust after receiving a higher level of care. The goal of this service is to promote and maintain community integration.

An array of face-to-face rehabilitative day activities providing a preplanned and structured group program for identified beneficiaries that aimed at long-term recovery and maximization of self-sufficiency, as distinguished from the symptom stabilization function of acute day treatment. These rehabilitative day activities are person- and family-centered, recovery-based, and culturally competent, provide needed accommodation for any disability and must have measurable outcomes. These activities assist the member with compensating for or eliminating functional deficits and interpersonal and/or environmental barriers associated with their chronic mental illness. The intent of these services is to restore the fullest possible integration of the member as an active and productive member of his/her family, social and work community and/or culture with the least amount of ongoing professional intervention. Skills addressed may include: emotional skills, such as coping with stress, anxiety or anger; behavioral skills, such as proper use of medications, appropriate social interactions and managing overt expression of symptoms like delusions or hallucinations; daily living and self-care skills, such as personal care and hygiene, money management and daily structure/use of time; cognitive skills, such as problem solving, understanding illness and symptoms and reframing; community integration skills and any similar skills required to implement a member's master treatment plan.

The staff to member ratio maximum is 1:15 with the provision that the member ration must be reduced when necessary to accommodate significant issues related to acuity, developmental status and clinical needs.

Guidelines/Requirements

1. A written recommendation from a therapist.
2. Member is engaged in and attending necessary outpatient behavioral health services.

a. Individual Therapy – Minimum of 1-2 visits per month
b. For non-adults services: Family Therapy – Minimum of 1 visit quarterly
c. Documentation must be sent in with specific encounters per each service code
d. There is adequate documentation from the provider that the service rendered is addressing member's identified needs and meets specific service description.

415.100 Adult Rehabilitation Day Treatment Exclusions

This service is intended to be provided to adults. The following codes cannot be billed on the Same Date of Service:

- H2015 – Individual Recovery Support, Bachelors
- H2015 – Individual Recovery Support, Non-Degreed
- H2015 – Group Recovery Support, Bachelors
- H2015 – Group Recovery Support, Non-Degreed

All other provider standards and requirements in accordance with the 1915(b) requirements as defined in the currently approved 1915(b) waiver program.

415.200 Documentation Requirement for Adult Rehabilitation Day Treatment Services Requests

The minimum documentation requirements are as listed:

- Date of Service
- Names and relationship to the member of all persons involved
- Start and stop times of actual encounter with collateral contact
- Place of Service (If 99 is used, specific location and rationale for location must be included)
- Member diagnosis necessitating intervention
- Document how interventions used addresses goals and objectives from the master treatment plan
- Information gained from collateral contact and how it relates to master treatment plan objectives
- Impact of information received/given on the member's treatment
- Any changes indicated for the master treatment plan which must be documented and communicated to the supervising MHP for consideration
- Plan for next contact, if any
- Staff signature/credentials/date of signature

On Initial Review:
1. Intake Assessment
2. Current PCSP identifying services – As outlined by the PASSE
3. Three most recent outpatient notes for therapy
4. Treatment Plan

Continuation of Services:
1. Psych Assessment (CPT Codes 90791 or 90792)
2. Current PCSP review/ planning – As outlined by the PASSE
3. If applicable, most recent medication note
4. Two most recent notes for each therapy service member is attending
5. Treatment plan containing SMART goals that are within the scope of the service being provided and addresses the member needs and skill sets.
    a. Minimum of every 6 months.

b. Progress or lack of progress toward goals within the last 30 days if the treatment plan was created more than 30 days prior to request.

415.300 Benefit Limits for Adult Rehabilitation Day Treatment Services

The adult rehabilitation day treatment services is based upon the tier of support identified in the beneficiary's person-centered service plan after completion of the independent assessment. This includes provider-indirect costs for each component of service. ARTC must prior authorize for all tiers of support.

416.000 Peer Support Services

Peer Support is a consumer centered service provided by individuals (ages 18 and older) who self-identify as someone who has received or is receiving behavioral health services and thus is able to provide expertise not replicated by professional training. Peer providers are trained and certified peer specialists who self-identify as being in recovery from behavioral health issues. Peer support is a service to work with beneficiaries to provide education, hope, healing, advocacy, self-responsibility, a meaningful role in life, and empowerment to reach fullest potential. Specialists will assist with navigation of multiple systems (housing, supportive employment, supplemental benefits, building/rebuilding natural supports, etc.) which impact beneficiaries' functional ability. Services are provided on an individual or group basis, and in either the member's home or community environment.

Peer Support (PS) services are member centered services with a rehabilitation and recovery focus designed to promote skills for coping with and managing psychiatric symptoms while facilitating the utilization of natural resources and the enhancement of community living skills. Activities included must be intended to achieve the identified goals or objectives as set forth in the member's individualized treatment plan. The structured, scheduled activities provided by this service emphasize the opportunity for members to support each other in the restoration and expansion of skills and strategies necessary to move forward in recovery. Peer Support is a face-to-face intervention with the member present. Services can be provided individually (H0038) or in a group setting (H0038HQ). The majority of Peer Support contacts must occur in the community locations where the person lives, works, attends school and/or socializes. The services may include the following components:

A. Helping the member to develop a network of information and support from others who have been through similar experiences.
B. Assisting the members with regaining the ability to make independent choices and to take a proactive role in treatment including discussing questions and concerns about medications, diagnoses, or working with their current treating clinician.

C. Assisting member with the identifying and effectively responding to or avoiding identified precursors or triggers that result in functional impairments.

D. Provider qualifications: Must be at least 18 years old, and have a high school diploma or equivalent. Certification in the State of Kansas to provide the service, which includes criminal, abuse/neglect registry and professional background checks, and completion of a standardized basic training program. Self-identify as a present or former consumer of mental health services.

Allowable performing providers include Certified Peer Support Specialist and Certified Youth Support Specialist.

Guidelines/Requirements

Adults only
1. A written recommendation from a therapist.
2. Member is engaged in and attending necessary outpatient behavioral health services.
a. Individual Therapy – Minimum of 1-2 visits per month
b. For non-adults services: Family Therapy – Minimum of 1 visit quarterly
c. Documentation must be sent in with specific encounters per each service code
d. There is adequate documentation from the provider that the service rendered is addressing member's identified needs and meets specific service description.

416.100 Peer Support Services Exclusions

All other provider standards and requirements in accordance with the 1915(b) requirements as defined in the currently approved 1915(b) waiver program.

416.200 Documentation Requirement for Peer Support Services Requests

The minimum documentation requirements are as listed:

- Date of Service
- Names and relationship to the member of all persons involved
- Start and stop times of actual encounter with collateral contact
- Place of Service (If 99 is used, specific location and rationale for location must be included)
- Member diagnosis necessitating intervention
- Document how interventions used addresses goals and objectives from the master treatment plan
- Information gained from collateral contact and how it relates to master treatment plan objectives
- Impact of information received/given on the member's treatment
- Any changes indicated for the master treatment plan which must be documented and communicated to the supervising MHP for consideration
- Plan for next contact, if any
- Staff signature/credentials/date of signature

On Initial Review:
1. Intake Assessment
2. Current Personalized Care Service Plan (PCSP) identifying services – As outlined by the Provider-led Arkansas Shared Savings Entity (PASSE)
3. Three most recent outpatient notes for therapy
4. Treatment Plan

Continuation of Services:
1. Psych Assessment (CPT Codes 90791 or 90792)
2. Current PCSP review/ planning – As outlined by the PASSE
3. If applicable, most recent medication note
4. Two most recent notes for each therapy service member is attending
5. Treatment plan containing SMART goals that are within the scope of the service being provided and addresses the member needs and skill sets.
    a. Minimum of every 6 months.
    b. Progress or lack of progress toward goals within the last 30 days if the treatment plan was created more than 30 days prior to request.

416.300 Benefit Limits for Peer Support Services

The peer support services are based upon the tier of support identified in the beneficiary's person-centered service plan after completion of the independent assessment. This includes provider-indirect costs for each component of service. ARTC must prior authorize for all tiers of support.

417.000 Family Support Partners Services

Family Support Partners is a service provided by peer counselors, or Family Support Partners (FSP), who model recovery and resiliency for caregivers of children or youth with behavioral health care needs. Family Support Partners come from legacy families and use their lived experience, training, and skills to help caregivers and their families identify goals and actions that promote recovery and resiliency. A FSP may assist, teach, and model appropriate child-rearing strategies, techniques, and household management skills. This service provides information on child development, age-appropriate behavior, parental expectations, and childcare activities. It may also assist the family in securing community resources and developing natural supports.

Family Support Partners serve as a resource for families with a child, youth, or adolescent receiving behavioral health services. Family Support Partners help families identify natural supports and community resources, provide leadership and guidance for support groups, and work with families on: individual and family advocacy, social support for assigned families, educational support, systems advocacy, lagging skills development, problem solving technics and self-help skills.

Allowable performing providers for this service are Certified Family Support Partners.

Guidelines/Requirements

1. A written recommendation from a therapist.
2. Member is engaged in and attending necessary outpatient behavioral health services.
a. Individual Therapy – Minimum of 1-2 visits per month
b. For non-adults services: Family Therapy – Minimum of 1 visit quarterly
c. Documentation must be sent in with specific encounters per each service code
d. There is adequate documentation from the provider that the service rendered is addressing member's identified needs and meets specific service description

417.100 Family Support Partners Exclusions

This service is intended to be provided to children and youth. All other provider standards and requirements in accordance with the 1915(b) requirements as defined in the currently approved 1915(b) waiver program.

417.200 Benefit Limits for Family Support Partners Services

The family support partners services are based upon the tier of support identified in the beneficiary's person-centered service plan after completion of the independent assessment. This includes provider-indirect costs for each component of service. ARTC must prior authorize for all tiers of support.

417.300 Documentation Required for Family Support Partners Services Requests

The minimum documentation requirements are as listed:

- Date of Service
- Names and relationship to the member of all persons involved
- Start and stop times of actual encounter with collateral contact
- Place of Service (If 99 is used, specific location and rationale for location must be included)
- Member diagnosis necessitating intervention
- Document how interventions used addresses goals and objectives from the master treatment plan
- Information gained from collateral contact and how it relates to master treatment plan objectives
- Impact of information received/given on the member's treatment
- Any changes indicated for the master treatment plan which must be documented and communicated to the supervising MHP for consideration
- Plan for next contact, if any
- Staff signature/credentials/date of signature

On Initial Review:
1. Intake Assessment
2. Current PCSP identifying services – As outlined by the PASSE
3. Three most recent outpatient notes for therapy

4. Treatment Plan

Continuation of Services:
1. Psych Assessment (CPT Codes 90791 or 90792)
2. Current PCSP review/ planning – As outlined by the PASSE
3. If applicable, most recent medication note
4. Two most recent notes for each therapy service member is attending
5. Treatment plan containing SMART goals that are within the scope of the service being provided and addresses the member needs and skill sets.
    a. Minimum of every 6 months.
    b. Progress or lack of progress toward goals within the last 30 days if the treatment plan was created more than 30 days prior to request.

418.000 Individual/Group Pharmaceutical Counseling Services

A specific, time limited one-to-one intervention by a nurse with a member and/or caregivers, related to their psychopharmological treatment. Individual Pharmaceutical counseling involves providing medication information orally or in written form to the member and/or caregivers. The service should encompass all the parameters to make the member and/or family understand the diagnosis prompting the need for the medication and any lifestyle modification required. Should include:

A. Purpose of taking psychotropic medication.

B. Psychotropic medications, effects, side effects, and adverse reactions.

C. Self-administration of medications.

D. Storage and safeguarding of medications.

E. How to communicate with mental health professionals regarding medication issues.

F. How to communicate with family/caregiver regarding medication issues.

For the member's parents, guardian or caregiver, meetings with provider staff to train them to monitor dosages and side effects can also occur. Allowed performing providers for this service are Registered Nurses.

Admission Criteria

Criteria A -C must be met to satisfy criteria for admission.

A. The member has received a mental health evaluation by a licensed mental health professional, which includes a current DSM-diagnosis and is prescribed psychotropic medication.

B. Member must have an active Individualized Treatment Plan which includes this service.

C. Service is to be provided face-to-face with member and/or member's guardian/family member. Services to the family on behalf of the member may occur.

Continued Stay Criteria

Criteria A-C must be met to satisfy criteria for continued stay.

A. There is adequate documentation from the provider that the member is receiving the scope and intensity of services required to meet the program goals stated in the Description of Services.
B. The member can be expected to benefit from the service, and the service remains appropriate to meet the member's needs.
C. The member continues to meet the admission criteria.

Discharge Criteria
Criterion A, B, or C must be met to satisfy criteria for discharge.

A. The member no longer meets continued stay criteria (e.g., treatment goals have been completed).
B. The member has failed to engage in services despite assertive outreach efforts that are documented in the Member's treatment record.
C. Severity of illness requires a higher level of care.

418.100 Individual/Group Pharmaceutical Counseling Exclusions

This service in intended to be provided face-to-face. All other provider standards and requirements in accordance with the 1915(b) requirements as defined in the currently approved 1915(b) waiver program.

418.200 Documentation Requirement for Individual/Group Pharmaceutical Counseling Services Requests

The minimum documentation requirements are as listed:

- Date of Service
- Start and stop times of actual encounter with member
- Place of service
- Diagnosis and pertinent interval history
- Brief mental status and observations
- Rationale for and treatment used that must coincide with the master treatment plan
- Member's response to treatment that includes current progress or regression and prognosis
- Revisions indicated for the master treatment plan, diagnosis or medication(s)
- Plan for follow-up services, including any crisis plans
- Staff signature/credentials/date of signature

418.300 Benefit Limits for Pharmaceutical Counseling Services

The pharmaceutical counseling services are based upon the tier of support identified in the beneficiary's person-centered service plan after completion of the independent assessment.

This includes provider indirect costs for each component of service. ARTC must prior authorize for all tiers of support.

419.000 Supportive Life Skills Development Services

Individual Life Skills Development is a service that provides support and training for transitional aged youth (ages 16 to 21) on a one-on-one basis. This service should be a strength-based, culturally appropriate process that integrates the youth into their community as they develop their recovery plan. This service is designed to assist youth in acquiring the skills needed to support an independent lifestyle and promote a strong sense of self-worth. In addition, it aims to assist youth in setting and achieving goals, learning independent life skills, demonstrating accountability, and making goal-oriented decisions related to independent living. Topics may include: educational or vocational training, employment, resource and medication management, self-care, household maintenance, health, wellness, and nutrition.

Group Life Skills Development is a service that provides support and training for transitional aged youth (ages 16 to 21) in a group setting of up to six (6) beneficiaries with one staff member or up to ten (10) beneficiaries with two staff members. This service should be a strength-based, culturally appropriate process that integrates the youth into their community as they develop their recovery plan. This service is designed to assist youth in acquiring the skills needed to support an independent lifestyle and promote a strong sense of self-worth. In addition, it aims to assist youth in setting and achieving goals, learning independent life skills, demonstrating accountability, and making goal-oriented decisions related to independent living. Topics may include: educational or vocational training, employment, resource and medication management, self-care, household maintenance, health, wellness, and nutrition.

Allowable performing providers include Certified Peer Support Specialist and Certified Youth Support Specialist.

Guidelines/Requirements

1. A written recommendation from a therapist.
2. Member is engaged in and attending necessary outpatient behavioral health services.
a. Individual Therapy – Minimum of 1-2 visits per month
b. For non-adults services: Family Therapy – Minimum of 1 visit quarterly
c. Documentation must be sent in with specific encounters per each service code
d. There is adequate documentation from the provider that the service rendered is addressing member's identified needs and meets specific service description.

419.100 Supportive Life Skills Development Exclusions

This service is intended for transitional age youth (ages 16-20). All other provider standards and requirements in accordance with the 1915(b) requirements as defined in the currently approved 1915(b) waiver program.

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419.200 Documentation Requirement for Supportive Life Skills Development Services Requests

The minimum documentation requirements are as listed:

- Date of Service
- Names and relationship to the member of all persons involved
- Start and stop times of actual encounter with collateral contact
- Place of Service (If 99 is used, specific location and rationale for location must be included)
- Member diagnosis necessitating intervention
- Document how interventions used addresses goals and objectives from the master treatment plan
- Information gained from collateral contact and how it relates to master treatment plan objectives
- Impact of information received/given on the member's treatment
- Any changes indicated for the master treatment plan which must be documented and communicated to the supervising MHP for consideration
- Plan for next contact, if any
- Staff signature/credentials/date of signature

On Initial Review:
1. Intake Assessment
2. Current PCSP identifying services – As outlined by the PASSE
3. Three most recent outpatient notes for therapy
4. Treatment Plan

Continuation of Services:
1. Psych Assessment (CPT Codes 90791 or 90792)
2. Current PCSP review/ planning – As outlined by the PASSE
3. If applicable, most recent medication note
4. Two most recent notes for each therapy service member is attending
5. Treatment plan containing SMART goals that are within the scope of the service being provided and addresses the member needs and skill sets.
    a. Minimum of every 6 months.
    b. Progress or lack of progress toward goals within the last 30 days if the treatment plan was created more than 30 days prior to request.

419.300 Benefit Limits for Supportive Life Skills Development Services

The supportive life skills development is based upon the tier of support identified in the beneficiary's person-centered service plan after completion of the independent assessment. This includes provider-indirect costs for each component of service. ARTC must prior authorize for all tiers of support.

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420.000 Child and Youth Support Services

Child and Youth Support Services are clinical, time-limited services for principal caregivers designed to increase a child's positive behaviors and encourage compliance with parents at home; working with teachers/schools to modify classroom environment to increase positive behaviors in the classroom; and increase a child's social skills, including understanding of feelings, conflict management, academic engagement, school readiness, and cooperation with teachers and other school staff. This service is intended to increase parental skill development in managing their child's symptoms of their illness and training the parents in effective interventions and techniques for working with the schools.

Services might include an In-Home Case Aide. An In-Home Case Aide is an intensive, time-limited therapy for youth in the member's home or, in rare instances, a community based setting. Youth served may be in imminent risk of out-of-home placement or have been recently reintegrated from an out of-home placement. Services may deal with family issues related to the promotion of healthy family interactions, behavior training, and feedback to the family.

Allowable performing providers include Qualified Behavior Health Providers –Bachelors, Qualified Behavioral Health Providers, - Non-degreed and Registered Nurses.

When an individual has a mental disorder that requires professional evaluation and treatment, he/she should be treated at the least-intensive level appropriate for the condition, such as outpatient individual, or partial hospital programs, etc. Comprehensive community support services facilitate the development of an individual's independent living and social skills, including the ability to make decisions regarding self-care, management of illness, life work, and community participation. The services promote the use of resources to integrate the individual into the community. Services may be provided onsite in a rehabilitation facility or offsite in a setting most conducive to promoting the individual's participation in the community. This may include the individual's home, rehabilitation residence, job site, education setting, community setting, etc. Level of intensity may vary depending upon changes in the individual's environment or the individual's needs.
Medical necessity for comprehensive community support services is established by satisfying the following admission and continued care guidelines. The guidelines contained here apply to programs and services that are less intensive than partial hospitalization. Satisfaction of all admission and continued care guidelines must be documented in the individual's medical record, based upon the condition and factors identified below, before rehabilitation services will be authorized.

This service is intended for children and youth and to be provided face-to-face. No other H2015 code can be billed on the same date of service. All other provider standards and requirements in accordance with the 1915(b) requirements as defined in the currently approved 1915(b) waiver program

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420.100 Child and Youth Support Exclusions

This service is intended for children and youth and to be provided face-to-face. No other H2015 code can be billed on the same date of service. All other provider standards and requirements in accordance with the 1915(b) requirements as defined in the currently approved 1915(b) waiver program.

420.200 Documentation Requirement for Child and Youth Support Services Requests

The minimum documentation requirements are as listed:

- Date of Service
- Start and stop times of actual encounter with member
- Place of service
- Diagnosis and pertinent interval history
- Brief mental status and observations
- Member's response to treatment that includes current progress or regression and prognosis
- Revisions indicated for the master treatment plan, diagnosis or medication(s)
- Plan for follow-up services, including any crisis plans
- Staff signature/credentials/date of signature

On Initial Review:
1. Intake Assessment
2. Current PCSP identifying services – As outlined by the PASSE
3. Three most recent outpatient notes for therapy
4. Treatment Plan

Continuation of Services:
1. Psych Assessment (CPT Codes 90791 or 90792)
2. Current PCSP review/ planning – As outlined by the PASSE
3. If applicable, most recent medication note
4. Two most recent notes for each therapy service member is attending
5. Treatment plan containing SMART goals that are within the scope of the service being provided and addresses the member needs and skill sets.
    a. Minimum of every 6 months.
    b. Progress or lack of progress toward goals within the last 30 days if the treatment plan was created more than 30 days prior to request.

420.300 Benefit Limits for Child and Youth Support Services

The child and youth support services are based upon the tier of support identified in the beneficiary's person-centered service plan after completion of the independent assessment.

This includes provider-indirect costs for each component of service. ARTC must prior authorize for all tiers of support.

421.000 Therapeutic Communities Services

Therapeutic Communities are highly structured residential environments or continuums of care in which the primary goals are the treatment of behavioral health needs and the fostering of personal growth leading to personal accountability. Services address the broad range of needs identified by the person served. Therapeutic Communities employs community-imposed consequences and earned privileges as part of the recovery and growth process. In addition to daily seminars, group counseling, and individual activities, the persons served are assigned responsibilities within the therapeutic community setting. Participants and staff members act as facilitators, emphasizing personal responsibility for one's own life and self-improvement. The service emphasizes the integration of an individual within his or her community, and progress is measured within the context of that community's expectation.

- Therapeutic Communities Level will be determined by the following:
- Functionality based upon the Independent Assessment Score
- Outpatient Treatment History and Response
- Medication
- Compliance with Medication/Treatment

Eligibility for this service is determined by the Intensive Level Services standardized Independent Assessment. Prior to reimbursement for Therapeutic Communities in Intensive Level Services, a member must be eligible for Rehabilitative Level Services as determined by the standardized Independent Assessment. The member must then also be determined by an Intensive Level Services Independent Assessment to be eligible for Therapeutic Communities.

Therapeutic Communities must be provided in a facility that is certified by the Division of Behavioral Health Services as a Therapeutic Communities provider.

421.100 Therapeutic Communities Exclusions

This service is intended for adults and to be delivered face-to-face. Providers cannot bill any other services on the same date of service. All other provider standards and requirements in accordance with the 1915(b) requirements as defined in the currently approved 1915(b) waiver program.

421.200 Documentation Requirement for Therapeutic Communities Services Requests

The minimum documentation requirements are as listed:

- Date of Service
- Names and relationship to the member of all persons involved.
- Place of service

- Document how interventions used to address goals and objectives from the master treatment plan.
- Information gained from contact and how it relates to master treatment plan objectives.
- Impact of information received/given on the member's treatment.
- Staff signature/credentials/date of signature

422.000 Residential Community Reintegration Services

The Residential Community Reintegration Program is designed to serve as an intermediate level of care between Inpatient Psychiatric Facilities and Outpatient Behavioral Health Services. The program provides twenty-four hour per day intensive therapeutic care provided in a small group home setting for children and youth with emotional and/or behavior problems which cannot be remedied by less intensive treatment. The program is intended to prevent acute or sub-acute hospitalization of youth, or incarceration. The program is also offered as a step-down or transitional level of care to prepare a youth for less intensive treatment. Services include all allowable Outpatient Behavioral Health Services (OBHS) based upon the age of the member as well as any additional interventions to address the member's behavioral health needs.

A Residential Community Reintegration Program shall be appropriately certified by the Department of Human Services to ensure quality of care and the safety of beneficiaries and staff.

A Residential Community Reintegration Program shall have, at a minimum, 2 direct service staff available at all times. Direct service staff may include any allowable performing provider in the Outpatient Behavioral Health Services (OBHS) manual, teachers, or other ancillary educational staff.

A Residential Community Reintegration Program shall ensure the provision of educational services to all beneficiaries in the program. This may include education occurring on campus of the Residential Community Reintegration Program or the option to attend a school off campus if deemed appropriate in according with the Arkansas Department of Education.

Eligibility for this service is determined by the standardized Independent Assessment.

Prior to reimbursement for the Residential Community Reintegration Program in Intensive Level Services, a member must be eligible for Intensive Level Services as determined by the standardized Independent Assessment.

The Residential Community Reintegration program must be provided in a facility that is certified by the Department of Human Services as a Residential Community Reintegration Program provider.

422.100 Residential Community Reintegration Exclusions

This service is intended to be provided face-to-face to children and youth. All other provider standards and requirements in accordance with the 1915(b) requirements as defined in the currently approved 1915(b) waiver program.

422.200 Documentation Requirement for Residential Community Reintegration Services Requests

The minimum documentation requirements are as listed:

- Date of service
- Place of service
- Diagnosis and pertinent interval history
- Daily description of activities and interventions that coincide with master treatment plan and meet or exceed minimum service requirements
- Mental status and observations
- Rationale and description of the treatment used that must coincide with objectives on the master treatment plan.
- Staff signature/credentials/date of signature

422.300 Benefit Limits for Residential Community Reintegration Services

The daily maximum of units that may be billed is 1. The yearly maximum of units that can be billed before an extension of benefits request is required is 90. See Section 260.000 for billing information.

423.000 Respite Services

Planned Respite provides temporary direct care and supervision for a member in the member's community that is not facility-based. The primary purpose is relief to the principal caregiver of an individual with a behavioral health need. Respite services de-escalate stressful situations and provide a therapeutic outlet. Services should be scheduled and reflected in the wraparound or treatment plan.

Planned Respite can only be provided by a provider who is certified by the Division of Behavioral Health Services as a Planned Respite provider.

423.100 Respite Services Exclusions

This service is intended to be provided face-to-face to children and youth. All other provider standards and requirements in accordance with the 1915(b) requirements as defined in the currently approved 1915(b) waiver program.

423.200 Documentation Requirement for Respite Services Requests

A. Updated budget sheet reflecting the most current proposed hours.

B. Documentation as to why natural supports cannot support this request.
C. Any additional information that could be used in a favorable determination.
D. Documentation as to what Respite activities will be performed during the time services are rendered

Specific Documentation Required
a. Service is documented in the Personalized Care Service Plan (PCSP)
b. A recommendation letter from the therapist

423.300 Benefit Limits for Respite Services

The respite services are based upon the tier of support identified in the beneficiary's person-centered service plan after completion of the independent assessment. This includes provider-indirect costs for each component of service. ARTC must prior authorize for all tiers of support.

424.000 Mobile Crisis Intervention Services

A face-to-face therapeutic response to a member experiencing a behavioral health crisis for the purpose of identifying, assessing, treating and stabilizing the situation and reducing immediate risk of danger to the member or others consistent with the member's risk management/safety plan, if available. This service is available 24 hours per day, seven days per week, and 365 days per year; and is available after hours and on weekends when access to immediate response is not available through appropriate agencies.

The service includes a crisis assessment, engagement in a crisis planning process, which may result in the development /update of one or more Crisis Planning Tools (Safety Plan, Advanced Psychiatric Directive, etc.) that contain information relevant to and chosen by the member and family, crisis intervention and/or stabilization services including on-site face-to-face therapeutic response, psychiatric consultation, and urgent psychopharmacology intervention, as needed; and referrals and linkages to all medically necessary behavioral health services and supports, including access to appropriate services and supports, including access to appropriate services along the behavioral health continuum of care.

This service can be provided to beneficiaries that have not been previously assessed or have not previously received behavioral health services. The duration of the service is short in nature and should not be any longer than needed to complete the activities listed above.

The provider of this service MUST complete a Mental Health Diagnosis (90791) within 7 days of provision of this service if provided to a member who is not currently A patient

Allowable performing providers include:

- Independently Licensed Clinicians – Master's/Doctoral (must be employed by Behavioral Health Agency)
- Non-independently Licensed Clinicians – Master's/Doctoral (must be employed by Behavioral Health Agency)

- Advanced Practice Nurse (must be employed by Behavioral Health Agency)

Physician (must be employed by Behavioral Health Agency

424.100 Mobile Crisis Intervention Exclusions

This service is intended to be provided face-to-face to children, youth and adults. All other provider standards and requirements in accordance with the 1915(b) requirements as defined in the currently approved 1915(b) waiver program.

424.200 Documentation Requirement for Mobile Crisis Intervention Services Requests

The minimum documentation requirements are as listed:

- Date of service
- Start and stop time of actual encounter with member and possible collateral contacts with caregivers or informed persons
- Place of service
- Specific persons providing pertinent information in relationship to member
- Diagnosis and synopsis of events leading up to crisis situation
- Brief mental status and observations
- Utilization of previously established psychiatric advance directive or crisis plan as pertinent to current situation OR rationale for crisis intervention activities utilized
- Member's response to the intervention that includes current progress or regression and prognosis
- Clear resolution of the current crisis and/or plans for further services
- Development of a clearly defined crisis plan or revision to existing plan
- Staff signature/credentials/date of signature(s)

424.300 Benefit Limits for Mobile Crisis Intervention Services

The mobile crisis intervention services are based upon the tier of support identified in the beneficiary's person-centered service plan after completion of the independent assessment. This includes provider-indirect costs for each component of service. ARTC must prior authorize for all tiers of support.

425.000 Therapeutic Host Homes Services

A home or family setting that that consists of high intensive, individualized treatment for the member whose behavioral health or developmental disability needs are severe enough that they would be at risk of placement in a restrictive residential setting.

A therapeutic host parent is trained to implement the key elements of the member's PCSP in the context of family and community life, while promoting the PCSP's overall objectives and goals.

The host parent should be present at the PCSP development meetings and should act as an advocate for the member.

425.100 Therapeutic Host Homes Exclusions

This service is intended to be provided face-to-face to children and youth.

425.200 Documentation Requirements for Therapeutic Host Homes Services

The minimum documentation requirements are as listed:

- Date of service
- Place of service
- Diagnosis and pertinent interval history
- Daily description of activities and interventions that coincide with master treatment plan and meet or exceed minimum service requirements
- Mental status and observations
- Rationale and description of the treatment used that must coincide with objectives on the master treatment plan.

Specific Documentation Required

a. Service is documented in the PCSP
b. A recommendation letter from the therapist
c. Weekly group therapy note for a total of up to 18 group therapy notes
d. Monthly individual note for a total of up to 6 therapy notes
e. Monthly MD note for a total of up to 6 MD notes

425.300 Benefit Limits for Therapeutic Host Homes Services Requests

The therapeutic host home services are based upon the tier of support identified in the beneficiary's person-centered service plan after completion of the independent assessment. This includes provider-indirect costs for each component of service. ARTC must prior authorize for all tiers of support.

426.000 Recovery Support Partners Services

A continuum of care provided to recovering members living in the community. Recovery Support partners may educate and assist the individual with accessing supports and needed services, including linkages to housing and employment services. Additionally, the Recovery Support Partner assists the recovering member with directing their resources and building support systems. The goal of the Recovery Support Partner is to help the member integrate into the community and remain there.

426.100 Recovery Support Partners Exclusions

This service is intended to be provided face-to-face. All other provider standards and requirements in accordance with the 1915(b) requirements as defined in the currently approved 1915(b) waiver program.

426.200 Documentation Requirement for Recovery Support Partners Services Requests

The minimum documentation requirements are as listed:

- Date of Service
- Names and relationship to the member of all persons involved
- Start and stop times of actual encounter
- Place of Service (When 99 is used, specific location and rationale for location must be included)
- Member diagnosis necessitating service
- Document how services used address goals and objectives from the master treatment plan
- Information gained from contact and how it relates to master treatment plan objectives
- Impact of information received/given on the member's treatment
- Any changes indicated for the master treatment plan which must be documented and communicated to the supervising MHP for consideration
- Plan for next contact, if any
- Staff signature/credentials/date of signature

426.300 Benefit Limits for Recovery Support Partners Services

The recovery support partners services are based upon the tier of support identified in the beneficiary's person-centered service plan after completion of the independent assessment. This includes provider-indirect costs for each component of service. ARTC must prior authorize for all tiers of support.

427.000 Substance Abuse Detoxification Services

Substance Abuse Detoxification is a set of interventions aimed at managing acute intoxication and withdrawal from alcohol or other drugs. Services help stabilize beneficiaries by clearing toxins from the member's body. Services are short-term and may be provided in a crisis unit, inpatient, or outpatient setting, and may include evaluation, observation, medical monitoring, and addiction treatment. Detoxification seeks to minimize the physical harm caused by the abuse of substances and prepares the member for ongoing treatment.

Typically, detox services are provided for less than five (5) days.

427.100 Substance Abuse Detoxification Exclusions

This service is intended to be provided face-to-face for youth and adults. All other provider standards and requirements in accordance with the 1915(b) requirements as defined in the currently approved 1915(b) waiver program.

427.200 Documentation Requirement for Substance Abuse Detoxification Services Requests

- Start and stop times of actual program participation by member
- Place of service
- Diagnosis and pertinent interval history
- Brief mental status and observations
- Rationale for and treatment used that must coincide with the master treatment plan
- Member's response to the treatment must include current progress or lack of progress toward symptom reduction and attainment of goals
- Rationale for continued acute day service, including necessary changes to diagnosis, master treatment plan or medication(s) and plans to transition to less restrictive services
- All services provided must be clearly documented in the medical record
- Staff signature/credentials

427.300 Benefit Limits for Substance Abuse Detoxification Services

The substance abuse detoxification services are based upon the tier of support identified in the beneficiary's person-centered service plan after completion of the independent assessment. This includes provider-indirect costs for each component of service. ARTC must prior authorize for all tiers of support.

428.000 Partial Hospitalization Services

Partial Hospitalization is an intensive nonresidential, therapeutic treatment program. It can be used as an alternative to and/or a step-down service from inpatient residential treatment or to stabilize a deteriorating condition and avert hospitalization. The program provides clinical treatment services in a stable environment on a level equal to an inpatient program, but on a less than 24-hour basis. The environment at this level of treatment is highly structured and should maintain a staff-to-patient ratio of 1:5 to ensure necessary therapeutic services and professional monitoring, control, and protection. This service shall include at a minimum intake, individual therapy, group therapy, and psychoeducation. Partial Hospitalization shall be at a minimum (5) five hours per day, of which 90 minutes must be a documented service provided by a Mental Health Professional. If a member receives other services during the week but also receives Partial Hospitalization, the member must receive, at a minimum, 20 documented hours of services on no less than (4) four days in that week.

Partial hospitalization may include drug testing, medical care other than detoxification and other appropriate services depending on the needs of the individual.

The medical record must indicate the services provided during Partial Hospitalization.

Partial Hospitalization must be provided in a facility that is certified by the Division of Behavioral Health Services as a Partial Hospitalization provider

428.100 Documentation Requirement for Partial Hospitalization Services Requests

The minimum documentation requirements are as listed:

- Start and stop times of actual program participation by member
- Place of service
- Diagnosis and pertinent interval history
- Brief mental status and observations
- Rationale for and treatment used that must coincide with the master treatment plan
- Member's response to the treatment must include current progress or lack of progress toward symptom reduction and attainment of goals
- Rationale for continued acute day service, including necessary changes to diagnosis, master treatment plan or medication(s) and plans to transition to less restrictive services
- All services provided must be clearly documented in the medical record
- Staff signature/credentials

428.200 Benefit Limits for Partial Hospitalization Services

The partial hospitalization services are based upon the tier of support identified in the beneficiary's person-centered service plan after completion of the independent assessment. This includes provider-indirect costs for each component of service. ARTC must prior authorize for all tiers of support.

429.000 Supportive Housing Services

Supportive Housing is designed to ensure that beneficiaries have a choice of permanent, safe, and affordable housing. An emphasis is placed on the development and strengthening of natural supports in the community. This service assists beneficiaries in locating, selecting, and sustaining housing, including transitional housing and chemical free living; provides opportunities for involvement in community life; and facilitates the individual's recovery journey.

Service settings may vary depending on individual need and level of community integration, and may include the member's home. Services delivered in the home are intended to foster independence in the community setting and may include training in menu planning, food preparation, housekeeping and laundry, money management, budgeting, following a medication regimen, and interacting with the criminal justice system.

Guidelines/Requirements

1. A written recommendation from a therapist.
2. Member is engaged in and attending necessary outpatient behavioral health services.

a. Individual Therapy – Minimum of 1-2 visits per month
b. For non-adults services: Family Therapy – Minimum of 1 visit quarterly
c. Documentation must be sent in with specific encounters per each service code
d. There is adequate documentation from the provider that the service rendered is addressing member's identified needs and meets specific service description.

429.100 Supportive Housing Exclusions

This service is intended for adults and to be provided face-to-face. Providers cannot bill any H2017 or H2015 code on the same date of service. All other provider standards and requirements in accordance with the 1915(b) requirements as defined in the currently approved 1915(b) waiver program.

429.200 Documentation Requirement for Supportive Housing Services Requests

The minimum documentation requirements are as listed:

- Date of Service
- Names and relationship to the member of all persons involved
- Start and stop times of actual encounter with collateral contact
- Place of Service (If 99 is used, specific location and rationale for location must be included)
- Member diagnosis necessitating intervention
- Document how interventions used address goals and objectives from the master treatment plan
- Information gained from collateral contact and how it relates to master treatment plan objectives
- Impact of information received/given on the member's treatment
- Any changes indicated for the master treatment plan which must be documented and communicated to the supervising MHP for consideration
- Plan for next contact, if any
- Staff signature/credentials/date of signature

<u>On Initial Review:</u>
1. Intake Assessment
2. Current PCSP identifying services – As outlined by the PASSE
3. Three most recent outpatient notes for therapy
4. Treatment Plan

<u>Continuation of Services:</u>
1. Psych Assessment (CPT Codes 90791 or 90792)
2. Current PCSP review/ planning – As outlined by the PASSE
3. If applicable, most recent medication note
4. Two most recent notes for each therapy service member is attending
5. Treatment plan containing SMART goals that are within the scope of the service being provided and addresses the member needs and skill sets.
    a. Minimum of every 6 months.

b. Progress or lack of progress toward goals within the last 30 days if the treatment plan was created more than 30 days prior to request.

429.300 Benefit Limits for Supportive Housing Services

The supportive housing services are based upon the tier of support identified in the beneficiary's person-centered service plan after completion of the independent assessment. This includes provider-indirect costs for each component of service. ARTC must prior authorize for all tiers of support

430.000 PRIOR AUTHORIZATION

1915(i) waiver services require prior authorization by Arkansas Total Care. **In the absence of prior authorization, reimbursement will be denied and may not be approved retroactively.**

See the Arkansas Total Care Provider Manual for instructions on how to submit authorization for service request to ARTC. This manual can be found at www.arkansastotalcare.com.

440.000 REIMBURSEMENT

441.000 Method of Reimbursement

The reimbursement rates for 1915(i) waiver services will be according to the lesser of the billed amount or the Title XIX (Medicaid) maximum for each procedure.

450.000 BILLING PROCEDURES

451.000 Introduction to Billing

1915(i) waiver providers use the CMS-1500 claim form to bill ARTC. See the Arkansas Total Care Provider Manual for instructions on how to submit claims for services rendered to ARTC. This manual can be found at www.arkansastotalcare.com.