UNIQUE REQUIREMENTS ATTACHMENT

STATE: Arkansas	**PLAN NAME:** Arkansas Total Care
EFFECTIVE DATE: 01/01/14	**POLICY NAME & NUMBER ATTACHMENT TO:** CC.BH.UM.28 Behavioral Health Covered Benefits and Services
REVIEWED/REVISED DATE: 10/5/20	**ATTACHMENT NUMBER:** F
RETIRED DATE: N/A	

SCOPE:

These unique requirements apply to Arkansas Total Care (ARTC).

PURPOSE:

To provide contractually required information that varies from the CBH policy/procedure.

UNIQUE REQUIREMENTS: *These unique requirements apply to Arkansas Total Care (ARTC) Non-Medical Support Services.*

ARTC Frequency Guidelines							
General Frequency Guidelines (Based on previous Outpatient Behavioral Health Services (OBHS) quick reference) Extension of benefits may be approved with proper documentation based on member need. Internal Use Only							
Name of Service	**Service Code**	**Modifier**	**Visits or Units**	**PA Required**	**3 months (13 weeks)**	**6 months (26 weeks)**	**12 months (52 weeks)**
Peer Support (adult only)	H0038	UC U4, U4 telephonic	Units; 1 Unit=15mins	Yes	30 units (7.5 hours)	60 units (15 hours)	120 units (30 hours)
Supportive Housing	H0043	U4	Units; 1 Unit=60mins	Yes	60 units (60 hours)	120 units (120 hours)	240 units (240 hours)
Family Support Partners	H2014	UC U4, U4 telephonic	Units; 1 Unit=15mins	Yes	30 units (7.5 hours)	60 units (15 hours)	120 units (30 hours)
Child & Youth Support Services	H2015	UC U4 (degreed); U1 U4 (non-degreed)	Units; 1 Unit=60mins	Yes	15 units (15 hours)	30 units (30 hours)	60 units (60 hours)
Individual/ Group Life Skills	H2017 Life Skills (Adolescent, ages 16-21)	UA U4 or U4 U6 (non-degreed); UC U4 (degreed); HQ UC U4 Group (degreed); HQ U4 U6 Group (non-degreed)	Units; 1 Unit=15mins	Yes	73 units (18.25 hours)	146 units (36.5 hours)	292 units (73 hours)

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ARTC Frequency Guidelines

General Frequency Guidelines (Based on previous Outpatient Behavioral Health Services (OBHS) quick reference)
Extension of benefits may be approved with proper documentation based on member need.
Internal Use Only

Adult Life Skills	H2017 (Adult)	U3 U4 (degreed); U4 U5 (non-degreed)	Units; 1 Unit=15mins	Yes	73 units (18.25 hours)	146 units (36.5 hours)	292 units (73 hours)
Adult Rehabilitative Day Service	H2017 Rehab Day	UB U4 (degreed); UA U4 (non-degreed)	Units; 1 Unit=60mins	Yes	90 units (90 hours)	180 units (180 hours)	360 units (360 hours)
Behavioral Assistance	H2019	U4 UC (degreed), U4 (non-degreed)	Units; 1 Unit=15mins	Yes	73 units (18.25 hours)	146 units (36.5 hours)	292 units (73 hours)
Supportive Employment	H2023	U4	Units; 1 Unit=60mins	Yes	60 units (60 hours)	120 units (120 hours)	240 units (240 hours)
Respite	H0045	U4	Unit; 1 = Day	Yes - (providers can request an extension)	8 units (8 days, yearly)	8 units (8 days, yearly)	8 units (8 days, yearly)
Therapeutic Communities	H0019	HQ UC U4 (Level 1); HQ U4 (Level 2)	Units; 1 = Day	Yes - up to 180 (providers can request an extension)	90 units (90 days)	180 units (180 days, yearly)	180 units (180 days, yearly)
Residential Community Reintegration	H2020	U4	Unit; 1 = Day	Yes - up to 90 (providers can request an extension)	90 units (90 days, yearly)	90 units (90 days, yearly)	90 units (90 days, yearly)

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Outpatient (OP) Codes			
Service: All Authorized in Three (3) Month Increments	**Code**	**Guidelines/Requirements**	**Specific Documentation Required to Support Services**
Peer Support	H0038	*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.	<u>On Initial Review:</u> 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 <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.

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Outpatient (OP) Codes			
Service: All Authorized in Three (3) Month Increments	**Code**	**Guidelines/Requirements**	**Specific Documentation Required to Support Services**
Supportive Housing	H0043	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.	<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.

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Service: All Authorized in Three (3) Month Increments	**Code**	**Guidelines/Requirements**	**Specific Documentation Required to Support Services**
Family Support Partners	H2014	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.	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.

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Service: All Authorized in Three (3) Month Increments	**Code**	**Guidelines/Requirements**	**Specific Documentation Required to Support Services**
Child and Youth Support Services	H2015	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.	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.

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Individual/ Group Life Skills	H2017 Life Skills (Adult and Adolescent)	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.	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.

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Adult Rehabilitative Day Service	H2017 Day Rehab (1 unit=60minutes)	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.	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.

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Outpatient (OP) Codes

Service: All Authorized in Three (3) Month Increments	Code	Guidelines/Requirements	Specific Documentation Required to Support Services
Behavioral Assistance	H2019	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.	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.

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Supportive Employment	H2023	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.	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.

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Inpatient Codes			
Service	**Code**	**Guidelines/Requirements**	**Specific Documentation Required to Support Services**
Respite Limited to 8 days per 12 months Limited to 8 units per year	H0045	Yes - Prior authorization required.	We request the following: a. Service is documented in the Personalized Care Service Plan (PCSP) b. A recommendation letter from the therapist
Therapeutic Communities	H0019	Yes - Prior authorization required. Can authorize up to 180 days.	We request the following: 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
Residential Community Reintegration	H2020	Yes - Prior authorization required. Can authorize up to 90 days.	We request the following: a. Service is documented in the PCSP b. A recommendation letter from the therapist c. Treatment notes from first 90 days to show if there were circumstances that prevented a safe integration.

REVISION LOG

REVISION:	**DATE:**
Attachment created to include Arkansas Total Care (ARTC) Non-Medical Support Services.	10/5/20

POLICY AND PROCEDURE ATTACHMENT APPROVAL

The electronic approval retained in Centene's P&P management software is considered equivalent to a signature.