

SECTION II – PSYCHIATRIC RESIDENTIAL TREATMENT FACILITY SERVICES FOR UNDER AGE 21

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200.000 PSYCHIATRIC RESIDENTIAL TREATMENT FACILITY SERVICES FOR UNDER AGE 21 GENERAL INFORMATION

201.000 Arkansas Medicaid Participation Requirements for Providers of Psychiatric Residential Treatment Facilities 10-27-25

All enrolled Medicaid providers must follow the guidelines specified in Section I of this manual.

Psychiatric Residential Treatment (PRTF) services for residents under age 21 are facility based. Facilities and treatment services in this program shall be referred to as PRTF providers and PRTF services throughout Section II of this manual.

Reimbursement may be made for PRTF services when provided to eligible Medicaid residents by licensed providers who are enrolled in the Arkansas Medicaid Program.

202.000 Arkansas Participation Requirements for Inpatient Psychiatric Providers 10-27-25

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

- A. An in-state PRTF must be licensed by the Office of Long-term Care as a PRTF. An out-of-state PRTF must be licensed by the appropriate licensing agency within its home state as a PRTF. A copy of the current license must accompany the provider application and Medicaid contract.

DHS or its designated vendor shall require proof of unavailable treatment or extenuating circumstances prior to authorizing services. PASSE Single Case Agreements (SCA) may be utilized on an as needed basis for out of network providers enrolled in Arkansas Medicaid. SCAs must be approved for each individual instance.

203.000 Psychiatric Residential Treatment Facilities 10-27-25

To enroll as a freestanding psychiatric residential treatment facility, the PRTF provider must meet both of the conditions listed below:

- A. The provider must meet the child and adolescent standards of The Joint Commission (TJC) and be accredited by TJC as a PRTF.

- B. Any provider located within Arkansas must be licensed by the Office of Long-term Care, and have a permit issued by the Health Permit Agency as a psychiatric residential treatment facility.

204.000 Documentation

10-27-25

The provider must develop and maintain complete written documentation to support each medical or remedial therapy, service, activity, or session for each receiving treatment. This documentation, at a minimum, must consist of:

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

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

All documentation must be available to representatives of DHS, DHS contractors, and PASSEs at the time of an audit. All documentation must be available at the provider's place of business. If an audit results in sanction or recoupment, no more than thirty (30) days will be allowed after the date on the recoupment notice in which additional documentation will be accepted. Additional documentation will not be accepted after the 30-day period.

210.000 PROGRAM COVERAGE

210.000 Definitions

10-27-25

- A. *Active Treatment* means beneficiaries are to be consistently engaged in active treatment during their waking hours. Active treatment will begin immediately upon admission utilizing information gathered for the certification of need (CON). Moreover, diagnostic assessment conducted by the multidisciplinary team encompassing medical, psychosocial, and behavioral evaluations informs the development of a comprehensive plan of care and discharge criteria. Active Treatment encompasses a variety of therapeutic modalities including family, group, individual, and milieu therapy, accompanied by continual treatment planning. All active treatment shall be designed to achieve the individual's discharge to a lower level of care at the earliest time possible. For beneficiaries attributed to a Provider-Led Arkansas Shared Savings Entity (PASSE), active treatment can be further defined by the respective PASSE
- B. *Psychiatric Residential Treatment Facility* means a non-hospital facility offering intensive inpatient services through Medicaid to individuals who have various mental health diagnoses and resulting functional deficits who required a higher level of service than can be obtained within the community, but do not require hospitalization for their issues. All services must be provided under the direction of a physician.

PRTFs are designed to offer intensive, time-limited (generally less than six (6) months) care for beneficiaries and their families/guardians/caregivers, who require a higher level of support and supervision than what can be provided in a traditional outpatient setting. These facilities are staffed by a multidisciplinary team of professionals, under the supervision of the physician, including psychiatrists, licensed mental health professionals,

nurses, direct care staff, and when necessary, psychologists, speech-language pathologists, occupational therapists, and physical therapists.

The main goal of a PRTF is to provide a structured and therapeutic environment where beneficiaries can receive the necessary treatment and support to stabilize their mental health and develop skills to successfully transition back to their communities in the shortest possible timeframe.

The specific services and treatment approaches may vary between PRTFs, as they are tailored to meet the unique needs of each beneficiary.

PRTFs must provide a trauma-informed response to service delivery with staff trained to recognize how individuals are impacted by traumatic events and have skills to avoid re-traumatization.

- C. *Sexualized Rehabilitation Program* means a specialized program designed to address and treat beneficiaries who have engaged in sexually inappropriate or harmful behaviors. These programs aim to provide comprehensive treatment and support to help individuals understand and change their behaviors, develop healthier attitudes towards sexuality, and promote healthy relationships.

The primary focus of a sexualized rehabilitation program is to ensure the safety and well-being of beneficiaries who have engaged in sexually harmful behaviors, as well as the safety of potential victims or potential future victims. The programs will follow a structured, evidence-based curriculum to address the underlying factors contributing to problematic behaviors and to promote accountability and responsibility. Medical necessity is determined by the beneficiary's PASSE and consideration is given on the beneficiary's progress through the curriculum.

- D. *Required Services* means the treatment provided to individuals admitted to the PRTF used to decrease or ameliorate the symptoms of the diagnosed mental health condition. Coverage includes all medical, psychiatric, and social services required of the admitting facility for licensure, certification and accreditation (Section 202.000). This includes, but is not limited to:

1. **Intake/Initial Comprehensive Assessment and Diagnosis:** Comprehensive evaluation, within 60 hours of admission, of the beneficiary's mental health needs, including, but not limited to psychiatric assessment, health assessment, biopsychosocial, nursing assessment, and when necessary psychological, developmental testing, and psychosexual assessment. Information shall be gathered from the beneficiary's parent or legal guardian, medical records from previous behavioral health service providers, community providers and schools shall also be utilized in the evaluation.
2. **Ongoing Assessment and Diagnosis:** Additional evaluation should be completed throughout the patients stay to measure response to interventions and may include observation or additional testing.
3. **Individualized Treatment Planning:** Development of a personalized treatment plan that addresses the beneficiary's specific needs and goals. Treatment planning must be strengths-based, with measurable and attainable goals, and appropriate for the beneficiary's developmental stage and cognitive ability. The treatment plan shall consider parent or legal guardian input on goals that would contribute to successful transition and stabilization upon discharge.
4. **24/7 Supervision and Support:** Continuous supervision and support from trained staff to ensure the safety and well-being of the beneficiaries. This may include assistance with daily living activities, medication administration, and crisis management.
5. **Psychiatric Services:** Access to psychiatric care, including psychiatric evaluation, medication evaluation, medication management, establishing a written plan of care, coordinating care with treatment team; directing and monitoring the use of restraints.

Medications should be prescribed in line with professional best standards and current guidance (e.g. UpToDate, Epocrates, American Academy of Child & Adolescent Psychiatry).

6. Mental Health Therapy Services: evidenced-based individual and group therapy to address emotional and behavioral issues, develop coping skills, and improve interpersonal relationships.
 7. Milieu Therapy: Aims to enhance the beneficiary's problem-solving abilities, increase capacity for self-control and self-regulation, while minimizing specific behaviors that jeopardize their safety at home and in the community. The program establishes clear rules and behavioral boundaries, emphasizing structure. Every interaction between beneficiaries and staff or other beneficiaries serves as an opportunity for therapeutic intervention. All PRTF staff who have interaction with a beneficiary shall have training in trauma informed care.
 8. Education Services: On-site educational programming, in compliance with curriculum standards approved by the Arkansas Department of Education, to ensure beneficiaries continue their academic progress while receiving treatment.
 9. Recreational and Therapeutic Activities: Engagement in recreational and therapeutic activities, such as art therapy, music therapy, and physical fitness, to promote overall well-being and skill development.
 10. Family Involvement: Inclusion of family members in the treatment process through therapeutic leave days, family therapy sessions, and family support in developing strategies to support the beneficiary's mental health after discharge.
 11. Discharge Planning: planning begins during the intake and continues throughout placement with ongoing discussions with family. Discharge planning includes, but not limited to, referral to appropriate home and community resources, coordination with appropriate education programs, safety planning, beneficiary education that is specific to the diagnosis, and transportation plan including contingencies.
- E. *Elective* means an admission in which the decision to admit can be separated in time from the actual admission and usually requires at least a one-night stay.
- F. A total of forty (40) hours per week of documented treatment services must be provided not to include education/classroom time. Five hours/encounters per week must be provided by a licensed mental health professional (LMHP), with a minimum of one being in an individual rather than group setting. Included in the five LMHP hours/encounters per week there should be a minimum of two family therapy sessions per month, as well as a weekly visit with the psychiatrist or APRN with a behavioral health specialty.

The Facility shall ensure that treatment and support interventions have a strong focus on strategies to address significant trauma, reduce symptomology and increase youth capacity for self-control and self-regulation, with a focus on four (4) major areas that research has found has the most long-term positive impact:

- A. Short-term crisis stabilization
- B. Intensive clinical services
- C. Engagement and work with the family and natural supports
- D. Ensuring comprehensive family and community supports following the residential stay

The Facility shall provide evidence-based programs and practices and shall have policies and procedures in place to ensure fidelity to the evidence-based programs and practices utilized by the Facility. The Facility shall provide training, supervision, and quality assurance and quality improvement strategies to monitor fidelity to evidence-based practices and track related outcomes.

211.000 Sexualized Rehabilitation Program 10-27-25

The Arkansas Medicaid Program designed a Sexualized Rehabilitation Program to specifically treat those patients under age 21 who have engaged in sexually inappropriate or harmful behaviors.

This manual, the Psychiatric Residential Treatment Facility Services for Under Age 21 Provider Manual, shall govern all aspects of services provided in the Sexualized Rehabilitation Program.

All treatment must be evidence based and therapist must be Credentialed Sexually Abusive Youth Clinicians (CSAYC). Evidence based practice models include children with Problematic Sexual Behavior Cognitive Behavior Treatment Program, Multisystemic Therapy (MST), and Trauma-Focused Cognitive Behavioral Therapy (TF-CBT). Treatment protocols are different based on age/developmental level, and thus programs shall demonstrate training and deliver of evidence-based programming that aligns with the individual's developmental and chronological age.

211.100 Human and Sex Trafficking Program 10-27-25

A Human and Sex Trafficking Program shall include specialized services delivered within the PRTF to deliver intensive treatment for youth experiencing symptoms of a mental health condition related to their experience of being trafficked. Trafficking causes complex trauma which often results in complex intense behaviors that require supervision and services delivered by a specially trained staff.

PRTF staff must be trained in trauma informed care, receive yearly training regarding sex and human trafficking and effects on victims. Therapist providing individual and group treatment must be trained in an evidence-based trauma model as well as certified clinical trauma specialist- sex trafficking and exploitation, or similar training.

The treatment team will ensure that patients are provided with weekly trauma therapy services, group services, individualized treatment plans, family therapy, life skills, and other supportive treatment as ordered on their treatment plan. The treatment team shall be staffed by a multidisciplinary team of professionals, under the supervision of the physician, including psychiatrists, licensed mental health professionals, nurses, direct care staff, and when necessary, psychologists, speech-language pathologists, occupational therapists, and physical therapists.

211.200 Other Medical Services 10-27-25

Medical services that are not within the scope of PRTF Services may be provided to the beneficiary while in the facility, but must be billed to the Arkansas Medicaid Program or by their respective PASSE by the performing provider of the services, e.g., physician, hospital etc. The performing provider must be an Arkansas Medicaid provider in order to receive reimbursement from the Arkansas Medicaid Program. These services may not be billed with the beneficiary's psychiatric diagnosis.

If not already enrolled the potential provider may [contact the Provider Enrollment Unit](#) to receive information about the process required to become an Arkansas Medicaid provider.

212.000 Scope 10-27-25

PRTF services covered by the Arkansas Medicaid Program must be provided:

- A. By a PRTF provider enrolled in the Arkansas Medicaid Program;
- B. By an enrolled PRTF provider selected by the beneficiary/guardian;

- C. To eligible Arkansas Medicaid beneficiaries who have a certification of need determined by the independent PASSE team that the beneficiary meets the criteria for PRTF services;
- D. To eligible Arkansas Medicaid beneficiaries who have a prior authorization documenting the need for this level of service;
- E. To eligible Arkansas Medicaid beneficiaries after the beneficiary has reached age 10 and before the beneficiary reaches age 21 or, if the beneficiary was receiving PRTF services at the time he or she reached age 21, services may continue until the beneficiary no longer requires the services or the beneficiary becomes 22 years of age, whichever comes first; and
- F. Under the direction of a psychiatrist or physician with oversight by a psychiatrist (contracted physicians are acceptable).

213.000 Age Considerations

10-27-25

PRTF services should be designed with age and developmental needs in mind recognizing that the needs of youth vary based on their developmental functioning. Youth will not be placed in units with other youth when ages ranges exceed more than three (3) years apart. Considerations will be made for developmental versus chronological age. Size and behaviors of youth may also be considered. Documentation must include clinical justification outlining why a child's developmental age and size justify exceeding the three (3) year requirement.

214.000 General Requirements

10-27-25

Each beneficiary must be evaluated to determine the need for PRTF services by the respective PASSE. The Certification of Need (CON) must be made prior to admission.

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

In compliance with 42 CFR 441.152, the CON must ensure:

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

All elective admissions of current Medicaid beneficiaries must be certified prior to admission.

214.100 Facility-Based CON Team

10-27-25

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

214.110 Facility-Based Team Responsibilities

10-27-25

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

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

214.120 **Composition of the Facility-Based Team (42 CFR 441.156)** **10-27-25**

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

214.200 **Independent Certification of Need (CON) Team** **10-27-25**

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

214.210 **Composition of the Independent CON Team** **10-27-25**

The independent certification team must:

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

214.220 **Information Required for Pre-Certification Review** **10-27-25**

To receive a CON, also often referred to as a Prior Authorization, the admitting facility must initiate a pre-certification review by submitting the required information to the members PASSE. This information must be maintained in the client's record.

215.000 Individual Plan of Care (42 CFR 441.154) 10-27-25

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

215.100 Development of the Individual Plan of Care 10-27-25

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

- A. Developed no later than seven (7) days after admission;
- B. Designed to improve the beneficiary's condition to the extent that inpatient psychiatric services will no longer be necessary and to achieve the beneficiary's discharge from PRTF status at the earliest possible time;
- C. Based on a diagnostic evaluation that includes examination of the medical, social, psychological, behavioral and developmental aspects of the beneficiary's situation and reflects the need for PRTF services; and
- D. Developed:
 1. By the facility-based team and
 2. In consultation with the beneficiary and his or her parent(s), legal guardian(s) or others in whose care he or she will be released after discharge.

215.110 Requirements for the Individual Plan of Care (42 CFR 456.180) 10-27-25

The individual plan of care must:

- A. Include diagnoses, symptoms, complaints and complications indicating the need for admission;
- B. Include a description of the developmental and functional level of the beneficiary;
- C. Include that are measurable treatment objectives;
- D. Include any orders for medications, diet, treatments, restorative and rehabilitative services or special procedures recommended for the health and safety of the beneficiary;
- E. Contain an integrated program of therapies, social services, activities and experiences designed to meet the treatment objectives;
- F. Include plans for continuing care, regular review and modification to the plan of care and
- G. Include discharge plans and, at an appropriate time, post-discharge plans, and include the coordination of PRTF services with partial discharge plans and related community services to ensure continuity of care with the beneficiary's family, school, and community upon discharge.

215.120 Individual Plan of Care Review 10-27-25

The plan of care must be reviewed at least every thirty (30) calendar days by the facility-based team as specified in 42 CFR §441.155(c) with an additional review and staffing note completed fifteen (15) calendar days prior to the plan of care review to:

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

216.000 Therapeutic Leave Days

10-27-25

Therapeutic visits away from the PRTF to home, relatives, or friends are encouraged and authorized if certified by the attending physician as medically necessary in the treatment of the recipient. The Arkansas Medicaid Program and/or the PASSEs cover a maximum of seven (7) consecutive days for therapeutic leave days. Therapeutic leave days must be clearly documented in the beneficiary's record. At a minimum, the beneficiary's record must reflect:

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

216.100 Absent Without Permission Days

10-27-25

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

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

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

or
- B. Keep the beneficiary's case on hold for up to 7 consecutive days without Medicaid reimbursement:
 1. If the beneficiary returns to the PRTF within the seven (7) days, the PRTF provider must conduct a plan of care review within three (3) days of the beneficiary's return and modify the plan of care as necessary.
 2. If the beneficiary does not return to PRTF within the seven (7) days, the provider must formally discharge the beneficiary. If the beneficiary is to be readmitted, the

provider must formally admit the beneficiary by following all policies, including the certification of need and prior authorization policies, as stated in this manual.

216.110 Acute Care Leave Days 10-27-25

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

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

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

or

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

217.000 Survey Activity for Psychiatric Residential Treatment Facilities (PRTFs) 10-27-25

Federal regulations regarding facility reporting and survey activity are located at 42 CFR Part 483, Subpart G §§483.374 – 483.376 and can be found in the Office of Long Term Care PRTF Licensure Manual.

217.100 Utilization Control 10-27-25

217.200 General Information 10-27-25

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

217.300 Utilization Review (UR) Plan 10-27-25

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

217.310 UR Plan Administrative Requirement 10-27-25

217.320 UR Plan Requirements 10-27-25

The UR plan must:

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

217.330 Organization and Composition of UR Committee (§42 CFR 456.206) 10-27-25

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

The UR committee must be constituted as:

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

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

217.340 UR Plan Information Requirement

217.350 Beneficiary Information Required for UR 10-27-25

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

- A. Identification of the beneficiary;
- B. Name of the beneficiary's physician;
- C. Date of admission;
- D. Dates of application and authorization for Medicaid benefits, if application is made after admission;
- E. Individual plan of care;
- F. Initial and subsequent continued stay review dates;
- G. Reasons and plan for continued stay if the attending physician believes continued stay is necessary or
- H. Other supporting material believed appropriate by the committee.

218.000 Records and Reports 10-27-25

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

218.100 Confidentiality 10-27-25

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

218.200 **Review of Need for Continued Stay** **10-27-25**

218.210 **Continued Stay Review Required** **10-27-25**

The UR plan must provide for a review of each beneficiary's continued stay in the PRTF facility to decide whether it is needed. See Sections 218.400 through 218.450.

218.220 **Evaluation Criteria for Continued Stay** **10-27-25**

The UR plan must provide that the UR Committee develops:

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

218.230 **Initial Continued Stay Review Date** **10-27-25**

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

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

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

The committee must use any available appropriate regional medical care appraisal norms, such as those developed by abstracting services or third-party payers, to assign the initial continued stay review date. These norms must be based on current and statistically valid data on duration of stay in PRTFs for beneficiaries whose characteristics, such as age and diagnosis, are similar to those of the beneficiary whose need for continued stay is being reviewed. If the committee uses norms to assign the initial continued stay review day, the number of days between the beneficiary's admission and the initial continued stay review date must not be greater than the 50th percentile of the norms. However, the committee may assign a later review date if it documents that the later date is more appropriate. The initial continued stay review date is not in any case later than thirty (30) calendar days after admission of the beneficiary or notice to the PRTF of the beneficiary's application for Medicaid. The committee must ensure that the initial continued stay review date is recorded in the beneficiary's record.

218.240 **Subsequent Continued Stay Review Dates** **10-27-25**

The UR plan must provide:

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

- C. That the committee ensures that each continued stay review date it assigns is recorded in the beneficiary's record.

218.250 **Description of Methods and Criteria: Continued Stay Review Dates** **10-27-25**

The UR plan must describe:

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

218.260 **Continued Stay Review Process** **10-27-25**

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

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

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

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

218.270 **Continued Stay Approval** **10-27-25**

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

218.280 **Continued Stay Denial** **10-27-25**

The UR plan must provide that, if the committee, subgroup or designee finds that a continued stay case does not meet the criteria, the committee or a subgroup that includes at least one physician must review the case to decide the need for continued stay. If the committee or subgroup making the review finds that a continued stay is not needed, it must notify the beneficiary's attending or staff physician and give him or her an opportunity to present his or her views before it makes a final decision on the need for the continued stay.

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

218.300 **Notification of Adverse Action** **10-27-25**

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

- A. The PRTF administrator;
- B. The attending or staff physician;

- C. The independent CON Team;
- D. The beneficiary and
- E. The next of kin or the sponsor or guardian (if possible).

218.310 Time Limits for Final Decision and Notification 10-27-25

The UR plan must provide that:

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

218.400 UR Plan Medical Care Evaluation Studies 10-27-25

218.410 Purpose and General Description 10-27-25

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

218.420 UR Plan Requirements for Medical Care Evaluation Studies 10-27-25

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

- A. Determine, for each study, the methods to be used in selecting and conducting medical care evaluation studies in the PRTF;
- B. Document, for each study, the results and how the results have been used to make changes to improve the quality of care and promote more effective and efficient use of PRTFs and services;
- C. Analyze the findings for each study and
- D. Act as needed to correct or investigate any further deficiencies or problems in the review process, or to recommend more effective and efficient care procedures.

218.430 Content of Medical Care Evaluation Studies 10-27-25

Each medical care evaluation study must:

- A. Identify and analyze medical or administrative factors related to the PRTF beneficiary care and
- B. Include analysis of at least the following:
 - 1. Admissions;
 - 2. Durations of stay;
 - 3. Ancillary services furnished, including drugs and biologicals;

4. Professional services performed in the PRTF and
5. If indicated, contain recommendations for change beneficial to beneficiaries, staff, the PRTF and the community.

218.440 Data Sources 10-27-25

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

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

218.450 Number of Studies Required 10-27-25

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

219.000 Electronic Signatures 10-27-25

Arkansas Medicaid will accept electronic signatures, in compliance with Arkansas Code § 25-31-103, et seq.

220.000 PRIOR AUTHORIZATION

220.100 Prior Authorization Information 10-27-25

Prior authorization (PA) is required for all PRTF services.

The prior authorization function is the responsibility of the members assigned PASSE utilization management team. All PRTF providers must follow the process outlined by the PASSE in order to receive prior authorization

220.110 Prior Authorization Approvals 10-27-25

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

230.000 REIMBURSEMENT

230.100 Provider Review Information 10-27-25

The Arkansas Medicaid Program, through the PASSE program, reimburses PRTF providers for medically necessary services only. Prior authorization, including Certification of need are prerequisites for reimbursement.

240.000 BILLING PROCEDURES

240.100 Billing

10-27-25

A Medicaid claim may contain only one billing provider's charges for services furnished to only one Medicaid beneficiary.