MEDICAL POLICY STATEMENT
Arkansas PASSE

Policy Name & Number	Date Effective
Rehabilitative Services for Persons with Physical Disabilities-AR PASSE-MM-1188	09/01/2024-05/31/2025
Policy Type	
MEDICAL	

Medical Policy Statement prepared by CareSource and its affiliates are derived from literature based on and supported by clinical guidelines, nationally recognized utilization and technology assessment guidelines, other medical management industry standards, and published MCO clinical policy guidelines. Medically necessary services include, but are not limited to, those health care services or supplies that are proper and necessary for the diagnosis or treatment of disease, illness, or injury and without which the patient can be expected to suffer prolonged, increased or new morbidity, impairment of function, dysfunction of a body organ or part, or significant pain and discomfort. These services meet the standards of good medical practice in the local area, are the lowest cost alternative, and are not provided mainly for the convenience of the member or provider. Medically necessary services also include those services defined in any Evidence of Coverage documents, Medical Policy Statements, Provider Manuals, Member Handbooks, and/or other policies and procedures.

Medical Policy Statements prepared by CareSource and its affiliates do not ensure an authorization or payment of services. Please refer to the plan contract (often referred to as the Evidence of Coverage) for the service(s) referenced in the Medical Policy Statement. If there is a conflict between the Medical Policy Statement and the plan contract (i.e., Evidence of Coverage), then the plan contract (i.e., Evidence of Coverage) will be the controlling document used to make the determination. According to the rules of Mental Health Parity Addiction Equity Act (MHPAEA), coverage for the diagnosis and treatment of a behavioral health disorder will not be subject to any limitations that are less favorable than the limitations that apply to medical conditions as covered under this policy.

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A. Subject

Rehabilitative Services for Persons with Physical Disabilities (RSPD)

B. Background

Under 165-00-04 Ark. Code R. § 2, Arkansas Rehabilitation Services (ARS) receives a federal grant from the Rehabilitation Services Administration (Office of Special Education and Rehabilitation Services, Department of Education) to operate a comprehensive, coordinated, effective, and accountable program designed to assess, plan, develop, and provide vocational rehabilitation services for individuals with disabilities. Service provision is consistent with individual strengths, resources, priorities, concerns, abilities, capabilities, and informed choice to prepare individuals for and engage in gainful employment. These services are provided on an inpatient basis for Medicaid-eligible beneficiaries when prescribed by a licensed physician and deemed medically necessary. Persons needing rehabilitative services on a less intensive basis than those provided in the inpatient setting may receive outpatient rehabilitative services through other appropriate sources (eg, outpatient hospital, physical therapy, occupational therapy, speech language therapy).

This policy is provided as a courtesy only. Arkansas Department of Human Services publishes a provider manual, *Rehabilitative Services for Persons with Physical Disabilities,* in which more information can be located. Any information published by the State supersedes information in this policy.

C. Definitions

- **Absent Days** – Days when a member is absent from an RSPD facility.
- **Covered Services** – A global service covering all rehabilitative, psychological and/or social services required of the admitting facility for licensure, certification and/or accreditation, including evaluations, therapies and visits by a licensed practitioner directly related to the member's rehabilitative adjustment, such as
  - **Restorative Therapies** – Provided in an individual or group setting, including physical, occupational, speech and cognitive therapy.
  - **Behavioral Rehabilitation** – Services to address the needs of members with significant personality changes due to stroke, illness, or serious accident to decrease and control disruptive behaviors and improve coping skills, including diagnosis, evaluation and treatment of aggression, depression, denial and other common behavioral problems.
  - **Life Skills Training** – Activities of daily living that are rehabilitative in nature.
  - **Individual and Group Counseling** – Services for members diagnosed with psychological, adjustment disorders, or substance abuse secondary to injury or illness, including family counseling when directed exclusively to effective treatment of the member and included in the plan of care.
  - **Assessment Services** – Assessment of a member's potential for functional improvement under the direction of a neuropsychologist, physician or team of specialists providing continuous testing during the residential stay as determined medically necessary by the neuropsychologist and/or physician.

  - **Nursing Care** – The availability of registered nursing services 24 hours a day.
- **Facility-Based Interdisciplinary Team** – Medical personnel licensed to practice in the State of Arkansas, including
  - neuropsychologist and/or physician
  - at least one of the following employed or contracted by the facility
    - registered nurse (RN) with at least 1 years' experience or specialized training in a rehabilitation treatment setting
    - occupational therapist
    - physical therapist

  Responsibilities of this team include
  - assessing the member's immediate and long-range therapeutic needs, developmental priorities, personal strengths/liabilities, and potential social resources, including family resources
  - developing the member's plan of care and setting treatment objectives
  - prescribing therapeutic modalities to achieve objectives in the plan of care
- **Places of Service** – The following facilities may be enrolled as RSPD providers:
  - Residential Rehabilitation Centers
  - Extended Rehabilitative Hospitals
  - State-Operated Extended Rehabilitative Hospitals
- **Plan of Care** – An individualized plan designed to improve the member's condition to the extent that RSPD services are no longer necessary.
- **Medically Necessary/Medical Necessity** – A healthcare service that is provided in accordance with generally accepted standards of medical practice, clinically appropriate (ie, type, frequency, extent, site and duration), not primarily for the economic benefit of a health plan or purchaser or for the convenience of the patient, treating physician or other healthcare provider.

D. Policy

I. Specialty services are not included in the RSPD global service coverage. Therefore, Medicaid-enrolled specialists, such as neurologists seeing a member due to an injury, may bill the Medicaid Program for any Medicaid-covered service rendered. Length of stay is determined by CareSource. Members are considered eligible for RSPD services when **all** of the following clinical criteria have been met:

A. Medical necessity criteria include

1. a prescription signed by a licensed physician indicating member need for RSPD services or a physician-signed individualized plan of care (POC) serving as the prescription
2. physician examination of the member within 30 days preceding the date of the written prescription or POC
3. renewal of the prescription or POC every 3 months from the prescription date and before services may continue beyond 3 months

B. Medical profile criteria for members include the following:

1. ability to communicate through spoken, written, gestural/environmental cues
2. absence of acute medical problems
3. adequate nutrition maintained without intravenous (IV) administration

4. does not require drug or alcohol treatment, unless secondary to injury
5. does not require a ventilator
6. free from any communicable disease requiring total isolation
7. mentally and physically able to participate in an intensive rehabilitation program for a minimum of 3 hours daily
8. motivated to live in the community
9. medically stable
10. depends on others for self-care, mobility or safety
11. requires at least 2 rehabilitation services with 1 of which being restorative therapy (see *Section 215.000*)

C. Medical diagnosis criteria includes the following:
   1. Residential Rehabilitation Centers and Extended Rehabilitative Hospitals
      Members must have a diagnosis of post-acute traumatic or acquired brain injury, including one of the following neurological conditions with or without moderate to severe behavioral disorders secondary to a brain injury:
      a. viral encephalitis
      b. meningitis
      c. aneurysms
      d. cerebral vascular accident/stroke
      e. post-operative tumors
      f. anoxia
      g. hypoxias
      h. toxic encephalopathies
      i. refractory seizure disorders
      j. congenital neurological brain disorders
      k. head injuries causing a loss of consciousness, resulting in neurological deficits
   2. State-Operated Extended Rehabilitative Hospitals
      Members eligible for admission must have a diagnosis listed in section I.C.1. above or congenital disorders of the spinal cord.

II. Extensions
When the RSPD provider's neuropsychologist and/or physician determines that a patient aged 1 year or older should not be discharged by the 5th day of residential stay due to the need for continued services, an RSPD medical staff member must contact CareSource and request an extension of the admission. The above criteria must be met. An RSPD medical staff member must submit a request to CareSource with the following required information:
A. principal diagnosis and other diagnoses influencing this stay
B. number of days being requested for continued residential stay
C. available medical information justifying or supporting necessity for continued stay

III. Plan of Care (POC)
A. Initial POC
An individual and supervised POC must be developed and written by the facility-based interdisciplinary team in consultation with the member and parents or legal

guardian to be implemented no later than 4 days after admission. Revisions must be made by the same team and signed and dated by a licensed physician who verifies continued medical necessity. The POC must include

1. a diagnostic evaluation reflecting the need for RSPD services, including an examination of the medical, social, psychological, behavioral and developmental aspects of the member's situation
2. member diagnosis(-es), symptoms, complaints, and complications indicating the need for admission
3. description of the member's functional level
4. signature of a licensed physician
5. member's treatment objectives
6. a prescribed, integrated program of therapies, social services, activities and experiences designed to meet the treatment objectives
7. feasible rehabilitation goals
8. orders for medications, diet, treatments, restorative and rehabilitative services or special procedures recommended for the health and safety of the member
9. projected schedule for service delivery, including the expected frequency and duration of each type of planned therapeutic session, medications or other prescribed special procedure
10. type of personnel furnishing the services
11. plans for continuing care, including review and modifications to the POC
12. discharge plans, including the following:
    a. At least 30 days prior to anticipated discharge, a person-centered discharge planning meeting will occur and include the RSPD provider, Care Coordination, family/guardians, and any other relevant stakeholders.
    b. Planning will support successful integration of members into homes, schools, and medical communities to prevent institutional care.
    c. Person centered support plans (PCSPs) will be updated to include discharge plans, coordination, and referrals.

B. Periodic Review of the POC

The POC must be reviewed every 30 days by the facility-based interdisciplinary team. Detailed documentation must be entered in the member's record, made available, as requested, and determine

1. member progress toward treatment and care objectives
2. appropriateness of the rehabilitative services provided
3. need for continued participation in the RSPD program

IV. Non-Covered Services

The following is a list of services excluded from payment in the RSPD program. The list also includes services included in the RSPD global coverage and, therefore, cannot be billed separately:

A. beauty or barber shop services, clothing, or personal allowances
B. cost for visitors, including meals and/or guest trays
C. dietary or nutritional consultation or plans
D. discharge plans
E. durable medical equipment and prosthetics

F. educational services, including evaluations
G. habilitation
H. inpatient or outpatient hospital services
I. leave days, including leave days for therapeutic or acute care, which are taken with or without permission from the RSPD medical staff
J. occupational therapy tools (eg, scissors, construction paper, pencils)
K. private duty nursing services
L. recreational services or social services
M. room and board costs
N. RSPD services provided in a residential rehabilitation center to Medicaid patients who are 21 years of age and older
O. services found not to be medically necessary, reasonable or necessary for the treatment of an illness or injury
P. take home drugs and supplies
Q. telephones and/or television
R. therapies that are included in the RSPD global service coverage
S. vocational services and/or training

V. Absent Days from the RSPD Facility
CareSource will not cover the days the member is absent from the facility, regardless of the reason for absenteeism.
A. When a member is absent from the facility, the RSPD provider must document when the member left the facility, if possible, why the member left, where the member was going, and, when applicable, the member's expected return date.
B. When a member is absent, the RSPD provider must follow **1** of the following procedures:
1. Formally discharge the member, regardless of the length of absenteeism.
2. Allow the member up to 7 days to return to the facility:
a. If the member returns within 7 days, the provider must conduct a plan of care review within 3 days of the member's return and modify, as necessary.
b. If the member does not return within 7 days, the provider must formally discharge the member. If the member is to be readmitted, the provider must formally admit the member by following the normal procedures.

E. Conditions of Coverage
NA

D. Related Policies/Rules
Medical Necessity Determinations
Nonmedical Community Supports and Services
Person Centered Services Plans

E. Review/Revision History

	DATE	ACTION
Date Issued	01/01/2022	
Date Revised	07/20/2022	Annual review. Clarified Section D. II. Added Medical Necessity Determinations to Section G.
	06/21/2023	Annual review. Added discharge criteria in III. A. I. Added NCSS & PCSP to Related Policies. Approved at Committee.
	05/22/2024	Annual review. Updated references. Approved at Committee.
Date Effective	09/01/2024	
Date Archived	05/31/2025	This Policy is no longer active and has been archived. Please note that there could be other Policies that may have some of the same rules incorporated and CareSource reserves the right to follow CMS/State/NCCI guidelines without a formal documented Policy.

F. References

1. Definitions, ARK. CODE ANN. § 23-99-1103 (2022).
2. Rehabilitation Services Policy and Procedure Manual, 165-00-04 ARK. CODE R. § 2 (2004).
3. *Rehabilitative Services for Persons with Physical Disabilities, Section II*. Arkansas Dept of Human Services. Accessed May 13, 2024. www.mmis.arkansas.gov