

# MEDICAL POLICY STATEMENT

## Arkansas PASSE

| Policy Name & Number                                 | Date Effective |
|--|----------------|
| Residential Community Reintegration-AR PASSE-MM-1855 | 01/01/2026     |
| 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.

### Table of Contents

|                                  |   |
|----------------------------------|---|
| A. Subject .....                 | 2 |
| B. Background .....              | 2 |
| C. Definitions.....              | 2 |
| D. Policy .....                  | 2 |
| E. Conditions of Coverage .....  | 4 |
| F. Related Policies/Rules .....  | 4 |
| G. Review/Revision History ..... | 4 |
| H. References .....              | 4 |

## A. Subject

**Residential Community Reintegration**

## B. Background

The Residential Community Reintegration (RCR) program is designed to serve as an intermediate level of care between psychiatric facilities and home and community-based behavioral health services. The program provides 24-hour per day intensive therapeutic care in a small group home setting for children and youth diagnosed with emotional and/or behavior problems unremedied by less intensive treatment. Prevention of acute or sub-acute hospitalization of youth, including incarceration, is a main goal for treatment. The program is also offered as a step-down or transitional level of care to prepare a youth for less intensive treatment.

RCRs will be appropriately certified by the Arkansas Dept of Human Services (DHS) to ensure quality of care and safety of clients and staff. RCRs must ensure the provision of educational services to all members in the program, which can include education occurring on RCR campuses or school attendance off-campus, if deemed appropriate in accordance with the Arkansas Department of Education.

CareSource follows DHS guidance and state law regarding the provision of RCR services. Any information provided by the State supersedes information in this policy.

## C. Definitions

N/A

## D. Policy

## I. General Guidance

- A. Providers must follow all certification, inspection and accreditation standards set forth by the State of Arkansas.
- B. Programs must adhere to all treatment planning and records requirements located in the *RCR Program Certification Manual* or other state resources. CareSource reserves the right to request documentation.
- C. RCR programs must adhere to the State's policies and requirements regarding incident reporting, staff training, and facility environments.

## II. Program Admission Criteria

CareSource will review requests for medical necessity on a case-by-case basis. Initial authorizations are typically approved for 60-90 days with an expected length of stay of 6-9 months. Continuous assessment of medical necessity is essential, and authorization periods may be adjusted as needed. If there is no demonstrated progress after 3 months and the treatment plan remains unchanged or the family is unwilling to engage, the criteria for medical necessity may no longer be satisfied. Members must meet **ALL** of the following criteria for program admission:

- A. Child or youth must be ages 4-20 with a confirmed diagnosis of a mental health disorder, substance use disorder (SUD), and/or an intellectual or developmental disability (IDD) diagnosis.
  - B. A completed mental health evaluation determines the program is appropriate.
  - C. Services are necessary to reduce a risk of readmission to higher levels of care or assist in maintaining current living situation.
  - D. The presence of moderate to severe psychiatric, behavioral problems result in difficulties with daily living.
  - E. Conditions, barriers, or environmental factors interfere with stability of underlying psychiatric disorder, as indicated by 1 or more of the following:
    - 1. Current environment (eg, home, school) prevents stabilization of underlying psychiatric or SUD (eg, inability to cope with stressors).
    - 2. Member lacks social supports to assist in care, **or** supports are not capable of assisting in care management without therapeutic intervention.
  - F. Member will or has not benefit(-ted) from lower levels of care (ie, multiple outpatient treatment episodes without long-term success).
  - G. Current or recent involvement with systems (eg, child welfare, juvenile justice) and documented difficulties in engaging with previous treatments is noted.
  - H. An individual treatment plan from the provider and Person-Centered Support Plan (PCSP) documenting service needs is completed.
- III. Continuation of Benefits Criteria
- Continuous assessment of medical necessity is essential, and authorization periods may be adjusted as needed. Continuation will be considered for members meeting the following criteria:
- A. meets requirements in D.II.A-H above, which includes submission of
    - 1. the most recent treatment plan
    - 2. progress notes from the last 30 days, including all therapy notes
    - 3. psychotherapy (ie, family or individual therapy) notes conducted quarterly at a minimum unless higher standards are promulgated within provider manuals
  - B. meets 1 of the following progress/revision requirements:
    - 1. The member/family is making satisfactory progress towards meeting goals, and there is documentation supporting that the continuation of services will be effective in addressing goals outlined in the treatment plan.
    - 2. The member/family is making some progress, but the specific interventions in the treatment plan need to be modified to yield more success.
    - 3. The member/family has yet to make progress or has demonstrated regression in meeting goals through the interventions outlined in the treatment plan. The member's diagnosis will be reassessed and interventions in the treatment plan revised. Alternative or additional services will also be considered and documented in the member's record.
- IV. Discharge Criteria:
- The member meets criteria for discharge if the support systems for member have been put in place, and any **1** of the following applies:
- A. Member has achieved goals.

The MEDICAL Policy Statement detailed above has received due consideration as defined in the MEDICAL Policy Statement Policy and is approved.

- B. The member's level of functioning has improved with respect to goals in treatment plan, and the member is ready to step down to a lower level of care.  
**Note:** Any child transitioning to a permanent family setting should be considered for Family Centered Treatment.
- C. If there is no demonstrated progress and the treatment plan remains unchanged or the member is unwilling to engage, the criteria for medical necessity may no longer be satisfied.

E. Conditions of Coverage

Members must be eligible for Intensive Level Services as determined by the Arkansas Independent Assessment (ARIA).

F. Related Policies/Rules

Medical Necessity Determinations  
Nonmedical Community Supports and Services  
Person-Centered Service Plans  
Self-Harm in a Residential Setting

G. Review/Revision History

| DATE           |            | ACTION                             |
|----------------|------------|------------------------------------|
| Date Issued    | 10/08/2025 | New policy. Approved by Committee. |
| Date Revised   |            |                                    |
| Date Effective | 01/01/2026 |                                    |
| Date Archived  |            |                                    |

H. References

1. *Home and Community-Based Services for Clients with Intellectual Disabilities and Behavioral Health Needs Provider Manual, Section II.* Arkansas Dept of Human Services. Accessed September 30, 2025. [www.humanservices.arkansas.gov](http://www.humanservices.arkansas.gov)
2. Outpatient Behavioral Health Service Update 1-17, Inpatient Psychiatric Services for Persons under Age 21 Update1-17 and Residential Community Reintegration Program Certification. 016.06.17 ARK. CODE R. § 015 (2025).
3. Residential Community Reintegration Program. ARK. ADMIN. CODE § 016.06.17-015 (2025).
4. *Residential Community Reintegration Program Certification Manual.* Arkansas Dept of Human Services. Accessed September 30, 2025. [www.humanservices.arkansas.gov](http://www.humanservices.arkansas.gov)
5. *Rules for the Division of Medical Services Licensure Manual for Community Support System Providers.* Arkansas Dept of Human Services. Accessed September 30, 2025. [www.humanservices.arkansas.gov](http://www.humanservices.arkansas.gov)
6. Therapeutic Behavioral On-Site Services B-815-T. MCG 29th ed. Accessed September 30, 2025. [www.careweb.careguidelines.com](http://www.careweb.careguidelines.com)

The MEDICAL Policy Statement detailed above has received due consideration as defined in the MEDICAL Policy Statement Policy and is approved.