

SECTION II – ARCHOICES IN HOMECARE (ARCHOICES) HOME AND COMMUNITY-BASED SERVICES (HCBS) WAIVER

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200.000 ARCHOICES IN HOMECARE (ARCHOICES) HCBS WAIVER PROGRAM GENERAL INFORMATION

201.000 Arkansas Medicaid Certification Requirements for ARChoices HCBS Waiver Program

10-1-22

All ARChoices Home and Community-Based Services (HCBS) Waiver providers must meet the Provider Participation and enrollment requirements contained within Section 140.000 of this manual as well as the following criteria to be eligible to participate in the Arkansas Medicaid Program:

ARChoices HCBS Waiver providers must be licensed and/or certified by the State of Arkansas as having met all Centers for Medicare and Medicaid Services (CMS) approved provider criteria for the service(s) they wish to enroll to provide.

Certification by Division of Provider Services and Quality Assurance does not guarantee enrollment in the Medicaid program.

All providers must maintain their provider files at the Provider Enrollment Unit by submitting current certification, licensure, all DPSQA-issued certification renewals and any other renewals affecting their status as a Medicaid-eligible provider, etc.

201.100 Providers of ARChoices HCBS Waiver Services in Bordering and Non-Bordering States

1-1-19

An ARChoices provider must be physically located in the State of Arkansas or physically located in a bordering state and serving a trade-area city. The trade-area cities are limited to Monroe and Shreveport, Louisiana; Clarksdale and Greenville, Mississippi; Poplar Bluff and Springfield, Missouri; Poteau and Sallisaw, Oklahoma; Memphis, Tennessee; and Texarkana, Texas.

All providers must be licensed and/or certified by their states' appropriate licensing/certifying authorities. Copies of all appropriate licenses and certifications must be submitted to the Division of Provider Services and Quality Assurance (DPSQA) for certification as a potential ARChoices provider.

Arkansas Medicaid does not provide ARChoices Waiver services in non-bordering states.

201.105 Provider Assurances**10-1-22****A. Agency Staffing**

The Provider agrees that he or she will maintain adequate staffing levels to ensure timely and consistent delivery of services to all participants for whom they have accepted a Person-Centered Service Plan (PCSP).

The Provider agrees:

1. Personnel responsible for direct service delivery will be properly trained and in compliance with all applicable licensure requirements. The Provider agrees to require personnel to participate in any appropriate training provided by, or requested by, the Department of Human Services. The Department of Human Services (DHS) requires mandatory training. The provider must attend one of the two provider workshop trainings in the calendar year. "Provider" in this context means at least one provider representative who will be able to inform the rest of the provider staff of what was covered in training. Failure to attend one of these trainings could jeopardize the provider's licensure and/or certification for the waiver. The Provider acknowledges the cost of training courses for certification and/or licensure is not reimbursable through DHS. Direct care workers must be trained prior to providing services to a participant.
2. Each service worker possesses the necessary skills to perform the specific services required to meet the needs of the participant he/she is to serve.
3. Staff is required to attend orientation training prior to allowing the employee to deliver any ARChoices Waiver service(s). This orientation shall include, but not be limited to:
 - a. Description of the purpose and philosophy of the ARChoices Waiver program;
 - b. Discussion and distribution of the provider agency's written code of ethics;
 - c. Discussion of activities which shall and shall not be performed by the employee;
 - d. Discussion, including instructions, regarding ARChoices Waiver program record keeping requirements;
 - e. Discussion of the importance of the PCSP;
 - f. Discussion of the agency's procedure for reporting changes in the participant's condition;
 - g. Discussion, including potential legal ramifications, of the participant's right to confidentiality;
 - h. Discussion of the participant's rights regarding HCBS Settings as discussed in C of this section.

B. Code of Ethics

The Provider agrees to follow and/or enforce for each employee providing services to an ARChoices Waiver participant a written code of ethics that shall include, but not be limited to, the following:

1. No consumption of the participant's food or drink;
2. No use of the participant's telephone for personal calls;
3. No discussion of one's personal problems, religious or political beliefs with the participant;
4. No acceptance of gifts or tips from the participant or their caregiver;

5. No friends or relatives of the employee or unauthorized participant are to accompany the employee to participant's residence;
6. No consumption of alcoholic beverages or use of non-prescribed drugs prior to or during service delivery;
7. No smoking in the participant's residence;
8. No solicitation of money or goods from the participant;
9. No breach of the participant's privacy or confidentiality of records.

C. 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).

Settings that are HCBS must be integrated in and support full access of participants 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:

1. Chosen by the participant 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.
 - a. Choice must be identified and included in the PCSP.
 - b. Choice must be based on the participant's needs, preferences and, for residential settings, resources available for room and board.
2. Ensures a participant's rights of privacy, dignity and respect and freedom from coercion and restraint.
3. Optimizes, but does not regiment, participant initiative, autonomy and independence in making life choices, including but not limited to, daily activities, physical environment and with whom to interact.
4. Facilitates participant choice regarding services and supports and who provides them.
5. The setting is integrated in and supports full access of participants 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.
6. In a provider-owned or controlled residential setting, in addition to the qualities specified above, the following additional conditions must be met:
 - a. The unit or dwelling is a specific physical place that can be owned, rented, or occupied under a legally enforceable agreement by the participant receiving services, and the participant 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.
 - b. Each participant has privacy in their sleeping or living unit:

- i. Units have entrance doors lockable by the participant, with only appropriate staff having keys to doors.
 - ii. Participants sharing units have a choice of roommates in that setting.
 - iii. Participants have the freedom to furnish and decorate their sleeping or living units within the lease or other agreement.
- c. Participants have the freedom and support to control their own schedules and activities and have access to food at any time.
- d. Participants are able to have visitors of their choosing at any time.
- e. The setting is physically accessible to the participant.
- f. Any modification of the additional conditions specified in items 6.a. through 6.e. above must be supported by a specific assessed need and justified in the PCSP. The following requirements must be documented in the PCSP:
 - Identify a specific and individualized assessed need.
 - i. Document the positive interventions and supports used prior to any modifications to the PCSP.
 - ii. Document less intrusive methods of meeting the need that have been tried but did not work.
 - iii. Include a clear description of the condition that is directly proportionate to the specific assessed need.
 - iv. Include regular collection and review of data to measure the ongoing effectiveness of the modification.
 - v. Include established time limits for periodic reviews to determine if the modification is still necessary or can be terminated.
 - vi. Include the informed consent of the participant.
 - vii. Include an assurance that interventions and supports will cause no harm to the participant.

210.000 PROGRAM COVERAGE

211.000 Scope

10-1-22

The Arkansas Medical Assistance (Medicaid) Program offers certain home and community-based outpatient services as an alternative to nursing home placement. These services are available to persons age 21 through 64 who are determined to have a physical disability through the Social Security Administration or the DHS Medical Review Team (MRT) and require an intermediate level of care in a nursing facility, or are 65 years of age or older and require an intermediate level of care in a nursing facility. The community-based services offered through the ARChoices Home and Community-Based Waiver are as follows:

- A. Attendant Care Services
- B. Home-Delivered Meals
- C. Personal Emergency Response System
- D. Adult Day Services
- E. Adult Day Health Services
- F. Prevocational Services
- G. Respite Care
- H. Environmental Accessibility Adaptations/Adaptive Equipment

These services are designed to maintain Medicaid eligible participants at home in order to preclude or postpone institutionalization of the participant.

In accordance with 42 CFR 441.301(b) (1) (ii) ARChoices services may not be provided to individuals inpatient in nursing facilities, hospitals or other inpatient institutions except for inpatient respite services.

Participants who are determined to require skilled level of care as defined by State administrative rule are not eligible for this waiver program. Please see DHS Procedures for Determination of Medical Need for Nursing Home Services as established by the DHS Office of Long Term Care.

212.000 Eligibility for the ARChoices Program

10-1-22

- A. To qualify for the ARChoices Program, a person must meet the targeted population as described in section 211.000 in this manual and must be found to require an intermediate level of care in a nursing facility.

The ARChoices Program processes for participant intake, assessment and service plan development include:

1. Determination of financial eligibility;
2. Determination of medical eligibility;
3. Determination of nursing facility level of care;
4. Determination of a Service Budget Limit;
5. Development of a person-centered service plan (PCSP);
6. Development of an individual services budget (ISB);
7. Notification to the participant of his or her choice between home- and community-based services and institutional services; and,
8. Choice by the participant among certified providers.

- B. Applicants for participation in the program (or their representatives) must make application for services at the Division of County Operations (DCO) office in the county of their residence or on any electronic format provided by DHS for application through an interactive process. Medicaid eligibility is determined by the DCO based on non-medical and medical criteria. The participant must be a participant individual with a functional need.

- C. Each waiver applicant to the ARChoices program will be assessed by the Independent Assessment Contractor. The independent assessment is performed utilizing the approved assessment instrument to assess functional need.

The approved assessment instrument will recommend tiers designed to help further differentiate participants by need. The tiers do not replace the Level of Care criteria, waiver eligibility determinations, or the PCSP process.

1. Tier 0 (zero) and Tier 1 (one) indicate the participant's assessed needs, if any, do not support the need for either ARChoices waiver services or nursing facility services.
2. Tier 2 (two) indicates the participant's assessed needs are consistent with services available through either the ARChoices waiver program or a licensed nursing facility.
3. Tier 3 (three) indicates the participant needs skilled care available through a licensed nursing facility and therefore is not eligible for the ARChoices waiver program.

These indications notwithstanding, the final determination of Level of Care and medical eligibility is made by DCO.

This assessment of functional need is used as part of the process to determine if the person is medically and financially eligible as well in the development of a participant's

PCSP. Medical eligibility is valid for twelve (12) months, unless a shorter period is specified.

Evaluations will continue to be performed at least every twelve (12) months, with the medical eligibility reaffirmed or revised and a written determination issued. In cases where it is reported a participant has experienced a significant change in circumstances (e.g., an inpatient hospital admission, skilled nursing facility admission, or the loss of a primary family caregiver), an evaluation will be performed, and based on the review of the evaluation, a reassessment may be requested.

- D. For more information please see the ARIA Manual.
- E. No participant who is otherwise eligible for waiver services shall have his or her eligibility denied or terminated solely as the result of a disqualifying episodic medical condition that is temporary and expected to last no more than twenty-one (21) days. However, that participant shall not receive waiver services or benefits when subject to a condition or change of condition that would render the participant ineligible if the condition or change in condition is expected to last more than twenty-one (21) days.
- F. Participants diagnosed with a serious mental illness or intellectual disability are not eligible for the ARChoices Waiver program unless they have medical needs unrelated to the diagnosis of mental illness or intellectual disability and meet the other qualifying criteria. A diagnosis of severe mental illness or intellectual disability must not bar eligibility for participants having medical needs unrelated to the diagnosis of serious mental illness or intellectual disability when they meet the other qualifying criteria.
- G. Eligibility for the ARChoices Waiver program begins the date DCO approves the application. (If a waiting list is implemented in order to remain in compliance with the waiver application as approved by CMS, the eligibility date determination will be based on the waiting list process.) If a participant is moving from a Provider-Led Arkansas Shared Saving Entity (PASSE) to the ARChoices waiver program, the eligibility date will be no earlier than the first day following disenrollment from the PASSE.
- H. The ARChoices Waiver program provides for the entrance of all eligible persons on a first-come, first-served basis, once participants meet all medical and financial eligibility requirements.

However, once all the waiver slots are filled, a waiting list will be implemented for this program and the following process will apply. Each ARChoices application will be accepted and eligibility will be determined. If all waiver slots are filled, the applicant will be notified of his or her eligibility for services; that all waiver slots are filled; and that the applicant is number X in line for an available slot. It is not permissible to deny any eligible person based on the unavailability of a slot in the ARChoices Waiver Program.

Entry to the waiver will then be prioritized based on the following criteria and in the following order:

- a. Waiver application determination date for participants inadvertently omitted from the waiver waiting list due to administrative error;
- b. Waiver application determination date for persons residing in a nursing facility and being discharged after a 90-day stay; or waiver application determination date for persons residing in an approved Level II Assisted Living Facility for the past six months or longer;
- c. Waiver application determination date for persons in the custody of DHS Adult Protective Services (APS);
- d. Waiver application determination date for all other persons.

- A. MEDICAL ELIGIBILITY means the level of care needed to receive services through the waiver rather than in an institutional setting considering the participants functional needs. To be determined to meet medical eligibility, an applicant/participant must not require a skilled level of care.
- B. APPROVED ASSESSMENT INSTRUMENT means DHS approved the instrument used by registered nurses employed by the Independent Assessment Contractor to collect information used in determining level of care and developing the person-centered service plan (PCSP).
- C. INDEPENDENT ASSESSMENT CONTRACTOR means the DHS vendor responsible for administering the approved assessment instrument for the purpose of collecting information used in determining level of care and developing the PCSP.
- D. INDEPENDENT ASSESSMENT means the process completed by registered nurses employed by the Independent Assessment Contractor utilizing the approved assessment instrument to assess functional need. This assessment is used by DHS as part of the process to make a final determination of eligibility and, if the person is determined to be eligible, to be used in the development of the PCSP.
- E. EVALUATION means the process completed in conjunction with the participant, at a minimum of every twelve (12) months, to determine continued evidence of established medical eligibility or a change in medical condition that may impact continued medical eligibility. The evaluation may result in a reassessment being requested if there is evidence of a material change in the medical need of the participant.
- F. REASSESSMENT means the process completed by registered nurses employed by the Independent Assessment Contractor utilizing the approved assessment instrument to assess functional need when requested, based on evidence of a material change in medical eligibility documented at the evaluation. This information is used by DHS as part of the process to make a final determination of continued eligibility and, if the person is determined to be eligible, is used in the development of the PCSP.
- G. DHS ELIGIBILITY NURSE means a registered nurse authorized by DMS to perform reviews of all medical information available and, based on available information, to make a medical eligibility determination and then, if determined financially eligible the application will be approved for ARChoices, DHS eligibility nurses are also responsible for reviewing evaluation documentation for material changes to medical need and requesting a reassessment if warranted
- H. DHS Person Centered Service Plan/Care Coordinator (PCSP/CC) NURSE means a registered nurse authorized by DMS to perform evaluations, develop person-centered service plans, and serve as the primary care coordinator and DHS contact for assigned participants.
- I. SERVICE BUDGET LIMIT (SBL) means the limit on the maximum dollar amount of waiver services that may be authorized for and received by each specific participant.
- J. PANEL means a team of three medical professionals comprising DAABHS nurse supervisory staff and a DHS Eligibility Nurse responsible for the determination of eligibility and LOC. Upon referral, the panel completes a review to determine a change in medical condition that may impact continued medical eligibility. The review may result in a temporary increase in the Service Budget Limit (SBL) for a period of 60 days and a reassessment utilizing the ARIA instrument if the panel determines that there is evidence of a material change in the functional or medical need of the participant which may require an increase in the SBL. Final determination of change in SBL is made by the DCO Eligibility Nurse

- K. Temporary LEVEL OF CARE criteria means a temporary increase in SBL approved by the panel. The PCSP, ISB, and SBL shall be adjusted to provide additional services on a temporary basis within and up to the participant's new SBL. The temporary PCSP, ISB, and SBL will remain in effect for up to 60 calendar days. Before the end of this 60 calendar days period, a reassessment must be completed using the approved assessment instrument and a new SBL determination must be made.
- L. LICENSED MEDICAL PROFESSIONAL means a licensed nurse, physician, physical therapist, or occupational therapist.

212.100 Service Budget Limit (SBL)**10-1-22**

Definition:

SERVICE BUDGET LIMIT (SBL) means the limit on the maximum dollar amount of waiver services that may be authorized for and received by each specific participant.

Methodology for Determining the SBL:

- A. An Independent Assessment Contractor will perform independent assessments that gather functional information about each applicant using the approved instrument. This assessment is used as part of the process to make a final determination of eligibility and, if the applicant is determined to be eligible, to be used to determine the SBL.
- B. For participants, an evaluation is initiated at least every twelve (12) months. Based on the review of the evaluation, should a change of medical condition be present, a referral is made to the Independent Assessment Contractor to complete a reassessment using the approved instrument. This information is used as part of the process to make a final determination of continued eligibility and, if the participant is determined to be eligible, to be used to determine the SBL.
- C. The three SBLs are:
 - 1. Intensive: The participant requires total dependence or extensive assistance from another person in all three (3) areas of mobility, feeding and toileting. The maximum SBL for services is \$34,000 annually.
 - 2. Intermediate: The participant requires total dependence or extensive assistance from another person in two (2) of the areas of mobility, feeding and toileting. The maximum SBL for services is \$23,000 annually.
 - 3. Preventative: The participant meets the functional need eligibility requirements for ARChoices but does not meet the criteria for the ISB Levels of Intensive or Intermediate. The maximum SBL for services is \$6,000 annually.

If the projected cost of services identified in the PCSP is less than the applicable SBL amount, this shall not be construed to permit, suggest, or justify approval, coverage, or reimbursement of different or additional waiver services (including changes in amount, frequency, or duration); coverage and reimbursement of any medically unnecessary Medicaid State Plan or waiver services; or other actions to increase spending to use the remaining "unused" portion of the SBL amount.

DHS will monitor and take steps necessary to update these SBL amounts when waiver rates change.

212.200 Individual Services Budget (ISB)**10-1-22**

Individual Service Budget Limit (ISB):

- A. Each PCSP shall include an Individual Service Budget (ISB) based upon the determination of Service Budget Limit (SBL) described above. The projected total cost of all authorized

services in any PCSP shall not exceed the participant's SBL applicable to the time period covered by the PCSP.

- B. For purposes of determining the projected cost of all waiver services in a PCSP, DAABHS shall assume that:
 - 1. The participant will receive or otherwise use all services identified in the PCSP and in their respective maximum authorized amounts, frequencies, and durations; and
 - 2. There are no interruptions in the provision of waiver services due to possible future events such as an inpatient admission, nursing facility admission, or short-term admission to another facility setting.
- C. Each participant's ISB and PCSP shall be discussed with the participant.
- D. Each participant shall also receive written notice of their ISB that includes notice of the right to request a Fair Hearing if they are denied waiver services as a result of a dollar limit.
- E. The Individual Services Budget shall not apply to environmental accessibility adaptations/adaptive equipment.
- F. Adjustments and Considerations Regarding Individual Services Budgets:
 - 1. Process for a Change of Condition within the SBL Level with an increase in ISB: If a waiver participant, physician, family member, Targeted Case Manager, or PCSP/CC Nurse reports a change in the participant's medical condition that may affect his or her functional ability or their natural supports, steps shall be taken to determine if the participant's PCSP, ISB, or SBL require adjustment based on the change of condition. A face-to-face visit and the task and hours guide shall be completed. If it is determined that the participant may require additional services within the current SBL, the results shall be reviewed with the program supervisor and the supervisor may approve the adjustment of the participant's PCSP and ISB to provide additional services up to the participant's current SBL. If the supervisor approves the additional services, the PCSP and ISB will remain in effect until the participant's next evaluation and determination of eligibility.
 - 2. Process for a Change of Condition with an Increase of SBL Level: If a waiver participant, physician, family member, Targeted Case Manager, or PCSP/CC Nurse reports a change in the participant's medical condition that may affect his or her functional ability or their natural supports, steps shall be taken to determine if the participant's PCSP, ISB, or SBL require adjustment based on the change of condition. An evaluation and task and hours guide is completed. If it is determined that the participant may be in need of additional services that may require an increase in the participant's SBL, the participant's case will be submitted to the panel for review and approval of temporary increase in SBL. The PCSP, ISB, and SBL will be adjusted to provide additional services on a temporary basis within and up to the participant's new SBL. The temporary PCSP, ISB, and SBL will remain in effect no longer than 60 calendar days. Before the end of this 60 calendar days period, a reassessment must be completed using the ARIA instrument and a new SBL determination must be made.
 - 3. Process for a Change in Condition with a Decrease in SBL, ISB or Change in Eligibility: If a waiver participant, physician, family member, Targeted Case Manager, or PCSP/CC Nurse reports a change in the participant's medical condition that may affect his or her functional ability or their natural supports, and which may result in a decrease in the participant's SBL, ISB, or change in eligibility. An evaluation is initiated and provided for review. Based on the review, should a change of medical condition be present, a referral is made to the Independent Assessment Contractor to complete a reassessment utilizing the ARIA Instrument. This information is used as part of the process to make a final determination of continued eligibility and, if the participant is determined to be eligible, to be used to determine the

4. Process for Granting an Exception to the \$34,000 Maximum SBL: If a waiver participant, physician, family member, Targeted Case manager, or PCSP/CC Nurse requests an exception to the \$34,000 maximum SBL due to additional medical or behavioral needs, without which the individual is likely to be institutionalized, steps will be taken to determine if the exception is to be granted. A participant will be granted an exception to the \$34,000.00 maximum Service Budget Limit (SBL) if the participant, due to additional medical or behavioral needs, is likely to be institutionalized but for additional waiver services and the cost of the needed additional waiver services exceeds the \$34,000 maximum SBL.
 - a. The DHS PCSP/CC Nurse will exercise professional medical judgment to make an initial determination of whether the participant may qualify for an exception to the maximum SBL based on:
 - i. The participant's evaluation utilizing the DHS-703 Form;
 - ii. Other medical records or information pertinent to the participant's needs and documented in the participant's record;
 - iii. The participant's physical, mental, or environmental needs observed by the DHS PCSP/CC Nurse and documented in the DHS-703 Form; and
 - iv. The participant's preferences, risks, dangers, and supports as documented in the DHS-703 Form.
 - b. If the DHS PCSP/CC Nurse makes an initial determination that the beneficiary may qualify for an exception, the DHS PCSP/CC Nurse will calculate the SBL as the sum of the SBL maximum above, plus the cost of the additional waiver services needed to prevent institutionalization. The participant's case will be submitted to the panel for review and approval of temporary increase in SBL. The PCSP, ISB, and SBL will be adjusted to provide additional services on a temporary basis for 60 calendar days. During the 60-calendar day temporary increase time period, a reassessment must be completed utilizing the ARIA Instrument and a final determination must be made by the panel based on all information available whether to grant the exception.
 - c. The panel shall ensure that:
 - i. Any temporary increase granted under this section meets the above criteria; and
 - ii. Both temporary increase and exception amounts are determined in an equitable manner across the program, so that participants with comparable needs receive comparable exception amounts
 - d. In no case may an exception increase the SBL above the cost of institutionalization as set forth in Column 5 of Appendix J-1 Factor G of the CMS-approved ARChoices Waiver.

212.300 Person-Centered Service Plan (PCSP)**10-1-22**

- A. Each participant in the ARChoices Program must have an individualized PCSP. The authority to develop a PCPS is given to the Medicaid State agency's designee, the DHS PCPS/CC Nurse). At the discretion of the participant, the PCSP is developed with the participant, representative, the participant's family or anyone requested by the participant, including the provider, if requested by the participant. At the request of the participant or their representative, the PCSP/CC Nurse can assist in coordinating and inviting any requested parties.
- B. When developing the waiver PCSP, the participant may freely choose a family member or individual to appoint as a representative. The participant and representative may participate in all decisions regarding the types, amount and frequency of services included in the PCSP. The representative may participate in choosing the provider(s) for the participant. If anyone other than the participant chooses the provider, the PCSP/CC Nurse

will identify that individual on the PCSP. Should the self-directed service delivery model be selected by an individual other than the participant, that individual may not be the paid employee.

- C. The PCSP developed by the DHS PCSP/CC Nurse includes, but is not limited to:
1. Participant identification and contact information, including full name and address, phone number, date of birth, and Medicaid number;
 2. Contact person;
 3. Physician's name and address;
 4. The amount, frequency and duration of authorized waiver services to be provided and the name of the service provider chosen by the participant or representative to provide the services.
 5. Other services outside the waiver services, regardless of payment source, identified and/or ordered to meet the participant's needs including the option for the self-directed service delivery model;
 6. The election of community services by the waiver participant or representative;
 7. The name and title of the DHS PCSP/CC Nurse responsible for the development of the participant's PCSP; and
 8. The individual services budget for the participant within the Service Budget Limit.
- D. Task and Hour Standards (THS):

1. Background on THS

The Arkansas Medicaid Task and Hour Standards (THS) is the written methodology used by DHS PCSP/CC Nurses as the basis for calculating the number of Attendant Care, Respite Care and State Plan Personal Care hours that are reasonable and medically necessary to perform needed ADL and IADL tasks. The THS provides a standardized process for calculating the amount of reasonable, medically necessary Attendant Care, Respite Care, and State Plan Personal Care services hours, with the minute ranges and frequencies providing DHS nurses with the ability to adjust PCSPs based on unique factors related to a given participant's needs, preferences, and risks.

The current Division of Aging, Adult and Behavioral Health Services (DAABHS)-approved [THS](#) is located on the web.

The number of Attendant Care, Respite Care, and State Plan Personal Care hours/minutes that are authorized for each necessary task by week/month are calculated by the PCSP/CC Nurse consistent with the THS grid and based on:

- a. Responses by the participant and their representatives to certain relevant questions in the approved assessment instrument or the annual evaluation conducted by the PCSP/CC Nurse, and
- b. As appropriate, information obtained by the PCSP/CC Nurse during their PCSP meeting with the participant and participant's representatives or from participant's physician.

The Arkansas THS methodology has been reviewed and approved by DHS nurse leadership and is based on Texas Form 2060 Task/Hour Guide, which has been used to determine personal attendant service hours in Texas Medicaid home and community-based services programs for over 20 years.

The Arkansas THS is also used to calculate the reasonable quantity of hours to perform medically necessary tasks covered under Independent Choices self-directed personal assistance or State Plan personal care services for adults aged 21 or older.

DAABHS will periodically review the THS grid and may revise it based on, for example, experience; information from the independent assessments; annual DHS nurse evaluations; electronic visit verification system; DMS audits of providers; and participant and provider feedback. These revisions could result in different, broader, or narrower minute ranges, frequencies per task type, and Needs Intensity Scores.

2. The THS includes the following four components, described in a grid format:

a. The participant's Needs Intensity Score (0, 1, 2, or 3) for each task:

For each task, the DHS nurse will assign a Needs Intensity Score to the participant. The four Impairment Scores are defined as follows:

1. Needs Intensity Score 0 – The participant has no functional impairment with regard to the task and can perform it without assistance.
2. Needs Intensity Score 1 – (Mild): Minimal/mild functional impairment. The participant is able to conduct activities with minimal difficulty and need minimal assistance.
3. Needs Intensity Score 2 – (Severe): Extensive/severe functional impairment. The participant has extensive difficulty carrying out activities and needs extensive assistance.
4. Needs Intensity Score 3 – (Total): The participant is completely unable to carry out any part of the activity.

A Needs Intensity Score is separate and distinct from a Tier Level under the approved system.

b. The number of minutes within the minute range for the Needs Intensity Score that are reasonable to perform the particular task at the respective Needs Intensity Score:

The THS grid specifies a minute range for each Needs Intensity Score for each task. For example, for the bathing task, at Needs Intensity Score 2 the minute range is 15-20 minutes, and the minute range for the grooming task at Needs Intensity Score 1 is 10-20 minutes. The PCSP/CC Nurse preparing the PCSP will determine the number of minutes within the range that are appropriate for the participant based on conditions specific to the participant. For example, if a participant has cognitive or behavioral issues, the PCSP/CC Nurse may find that the maximum number of minutes in the range for bathing is warranted. On the other hand, assigning the maximum number of minutes for grooming might not be appropriate for a participant who is bald.

If the participant has extenuating circumstances and requires time outside the range (either more or less) for the task, the PCSP/CC Nurse must obtain supervisory approval. For supervisory approval, the PCSP/CC Nurse must document the participant's extenuating circumstances and justify the need for minutes outside the range. The justification of need must be based solely on the participant's assessed or observed medical needs and may not be for the convenience of a service provider or attendant. The request must be in writing (written or email) and the supervisor's approval or disapproval must be in writing. If the extenuating circumstances are expected to be temporary, the PCSP must identify a date by which the deviation from the minute range will cease. Documentation of the request and the approval/disapproval must be filed with the PCSP.

c. The frequency with which a task is necessary and reasonably performed:

The THS methodology considers the frequency with which each ADL and IADL is performed and reasonably necessary.

d. The amount of assistance with ADLs and IADLs provided by other sources, such as (A) informal caregivers (e.g., relatives, neighbors, and friends), (B) community-based agencies such as Meals on Wheels, and (C) Medicare or a Medicare Advantage health plan.

ARChoices does not cover assistance that is needed but provided by other sources. Therefore, the THS grid includes fields, by task, for the number of minutes of support provided by other sources.

If instances of a needed assistance with an ADL or IADL are generally provided through another source, then attendant care is not necessary and no time for that task is included in the PCSP. When another source is available to provide assistance with a needed ADL or IADL task, the time associated with the assistance from that other source is deducted from the total minutes per week.

Other sources include informal caregivers (e.g., daughter or neighbor), community-based services such as Meals on Wheels, and services available through Medicare (e.g., Medicare home health aide services) or a Medicare Advantage health plan (e.g., supplemental services). Other support is calculated for each task based on how much support is provided with the task. For example, the participant's daughter may bathe her mother once a week and prepare all meals on weekends, eliminating the need for an attendant care aide to perform those tasks. For this participant, the total minutes per week for the tasks of bathing and meal preparation would be adjusted by the minutes associated with an aide assisting with one bath and six meals per week.

3. Calculation of total hours of attendant care per month

The final step in the methodology is to add up the total minutes per week for each task. That total is converted to hours per week by dividing the number of minutes by 60. Monthly total hours can be calculated by multiplying the total weekly hour amount by 4.334. This monthly hourly value is the maximum number of attendant care hours approved for the participant for a month. The projected total cost of attendant care plus all other authorized services in the PCSP shall not exceed the participant's Individual Services Budget applicable to the time period covered by the PCSP.

- E. If waiver eligibility is approved by DCO after a review of financial documentation and either the independent assessment performed by the contractor or the annual evaluation as performed by the PCSP/CC Nurse, a copy of the PCSP signed by the DHS PCSP/CC Nurse and the waiver participant or representative, will be forwarded to the participant or representative and the Medicaid enrolled service provider(s) included in the PCSP. The service provider and the participant must review and follow the signed authorized PCSP. Services cannot begin until the Medicaid provider receives the authorized PCSP from the PCSP/CC Nurse. The original PCSP will be maintained by the DHS PCSP/CC Nurse.

The implementation of the PCSP by a provider must ensure that services are:

1. Individualized to the participant's unique circumstances;
2. Provided in the least restrictive environment possible;
3. Developed within a process ensuring participation of those concerned with the participant's welfare;
4. Monitored and adjusted as needed, based on changes authorized and reported by the DHS PCSP/CC Nurse regarding the waiver PCSP;
5. Provided within a system that safeguards the participant's rights to quality services as authorized on the waiver PCSP; and
6. Documented carefully, with assurance that required information is recorded and maintained.

NOTE: Each service included on the ARChoices PCSP must be justified by the PCSP/CC Nurse. This justification is based on medical necessity, the participant's physical, cognitive and functional status, other support services available to the participant and other factors deemed appropriate by the PCSP/CC Nurse.

Each individual service must be provided according to the participant's PCSP. For services included in the waiver PCSP, Medicaid reimbursement is limited to the amount and frequency that is authorized in the PCSP, subject to the participant's individual services budget. As detailed in the Medicaid Program provider agreement, providers may bill only after services are provided. Service are not compensable unless there is a valid and current PCSP in effect on the date of service.

212.305 Targeted Case Management Services (Non-Waiver Service) 10-1-22

Each PCSP will include Targeted Case Management, unless refused by the waiver participant. The Targeted Case Manager is responsible for monitoring the participant's status on a regular basis for changes in their service need, referring the participant for reassessment, if necessary, and reporting any participant complaints and changes in status to the PCSP/CC Nurse or DAABHS supervisory staff immediately upon learning of the change.

212.312 Comprehensive Person-Centered Service Plan (PCSP) 10-1-22

The comprehensive PCSP will be sent the waiver participant to and all providers included on the PCSP after completion thereof.

The comprehensive PCSP expiration date will be twelve (12) months from the earliest date of approval by DCO of medical and/or financial eligibility.

Prior to the expiration of the twelve (12) months, financial and medical eligibility will be reviewed.

The DHS-703 form (Evaluation of Medical Need Criteria) is used at a minimum of every 12 months, or more frequently based on reported changes in medical condition, by registered nurses employed by the Division of Aging, Adult and Behavioral Health Services to determine continued evidence of established medical eligibility or a change in medical condition that may impact continued medical eligibility.

If there is evidence of a change in medical condition that may impact continued medical eligibility, based on the evaluation completed using the DHS-703 form, a referral may be made for an independent assessment utilizing the ARIA instrument. The information collected through the reassessment process, utilizing the ARIA instrument along with the tier determination, and any additional information are utilized by registered nurses within the Division of County Operations to evaluate whether the individual continues to meet the states level of care criteria and to determine any changes to the level of care. No change in level of care will occur without the use of the approved assessment instrument.

212.313 ARChoices Applicants Leaving an Institution 10-1-22

No waiver eligibility date may be established prior to an applicant's discharge date from an institution. Therefore, if eligibility is determined and the PCSP is developed while an applicant is a resident of a nursing home or an inpatient in an institution, the earliest waiver eligibility date will be the day the applicant is discharged from the facility.

This policy applies to applicants leaving hospitals or nursing facilities.

212.320 Authorization of the Person-Centered Service Plan (PCSP) with Personal Care Services 10-1-22

The following applies to participants receiving both personal care services and waiver services.

- A. The DHS PCSP/CC Nurse is responsible for developing a PCSP that includes both waiver and non-waiver services. Once developed, the PCSP is signed by the DHS PCSP/CC Nurse authorizing the services.

- B. PCSP developed on or after the effective date of this Provider Manual may not include attendant care services unless the PCSP provides for at least 64 hours per month of personal care services. Attendant care services are intended to supplement personal care services available under the Medicaid state plan.
- C. The PCSP signed by the DHS PCSP/CC Nurse will suffice as the "Personal Care Authorization" for services required in the Personal Care Program.

The responsibility of developing a personal care service plan is not placed with the PCSP/CC Nurse. The personal care provider is still required to complete a service plan, as described in the Arkansas Medicaid Personal Care Provider Manual.

- D. For ARChoices participants who have chosen to receive their personal care services through the IndependentChoices Program, the PCSP, signed by a PCSP/CC Nurse will serve as the authorization for personal care services for up to one year from the date of the PCSP/CC Nurse signature.

212.323 Medicaid Audit Requirements

10-1-22

When the Medicaid Program, as authorized by the PCSP, reimburses for personal care services, all Medicaid audits will be performed based on that authorization. Therefore, all documentation by the personal care provider must tie services rendered to authorized services as reflected on the PCSP.

212.400 Temporary Absences from the Home

10-1-22

Once an ARChoices eligibility application has been approved, waiver services must be provided in a home and community-based services setting for eligibility to continue. Unless stated otherwise below, the DCO must be notified immediately by the DHS PCSP/CC Nurse when waiver services are discontinued and action will be initiated by DCO to close the waiver case. Providers will be notified by the PCSP/CC Nurse.

A. Absence from the Home due to Institutionalization

A participant cannot receive waiver services while in an institution. The following policy applies to any inpatient stay where Medicaid pays the facility for the date of admission, i.e., hospitals, nursing homes, rehab facilities, etc., for active waiver cases when the participant is hospitalized or enters a nursing facility for an expected stay of short duration.

1. When a waiver participant is admitted to a hospital, DCO will not take action to close the waiver case unless the participant does not return home within 30 days from the date of admission. If, after 30 days, the participant has not returned home, the PCSP/CC Nurse will notify DCO and action will be initiated to close the waiver case.
2. If DCO becomes aware that a participant has been admitted to a nursing facility and it is anticipated that the stay will be short (30 days or less), the waiver case will be closed effective the date of the admission, but the Medicaid case will be left open. When the participant returns home, the waiver case may be reopened effective the date the participant returns home. A new assessment and medical eligibility determination will not be required unless a change of condition is determined requiring a change in SBL.

Nursing facility admissions, when referenced in this section, do not include ARChoices participants admitted to a nursing facility to receive facility-based respite services.

B. Absence due to Reasons Other than Institutionalization

When a waiver participant is absent from the home for reasons other than institutionalization, DCO will not be notified unless the participant does not return home within 30 days. If, after 30 days, the participant has not returned home and the providers

can no longer deliver services as authorized on the PCSP (e.g., the participant has left the state and the return date is unknown), the PCSP/CC Nurse will notify DCO. Action will be taken by the DHS Division of County Operations to close the waiver case.

NOTE: It is the responsibility of the provider to notify the PCSP/CC Nurse immediately via form AAS-9511 upon learning of a change in the participant's status.

212.500 Reporting Changes in Participant's Status

10-1-22

Because the provider has more frequent contact with the participant, many times the provider becomes aware of changes in the participant's status sooner than PCSP/CC Nurse or Targeted Case Manager. It is the provider's responsibility to report these changes immediately so proper action may be taken. Providers must complete the Waiver Provider Communication – Change of Participant Status Form (AAS-9511) and send it to the PCSP/CC Nurse. A copy must be retained in the provider's participant case record. Regardless of whether the change may result in action by DCO, providers must immediately report all changes in the participant's status to the PCSP/CC Nurse.

The Targeted Case Manager is responsible for monitoring the participant's status on a regular basis for changes in service need, referring the participant for evaluation of any participant complaints or change of condition to the PCSP/CC Nurse, or DHS Nurse Supervisor immediately upon learning of the change. The PCSP/CC nurse will take steps to determine if the participant's PCSP, ISB, or SBL require adjustment based on the change of condition.

212.600 Relatives Providing ARChoices Services

10-1-22

ARChoices services may be provided by a participant's relative, unless stated otherwise in this manual.

For the purposes of this section, a relative or family member shall be defined as all persons related to the participant by virtue of blood, marriage, or adoption.

The following is applicable for all waiver services:

- A. Under no circumstances may Medicaid payment be made for any waiver service rendered by the waiver participant's:
 - 1. Spouse
 - 2. Legal guardian of the person
 - 3. Attorney-in-fact granted authority to direct the participant's care
- B. All providers, including relatives, are required to meet all ARChoices provider licensure and/or certification requirements, Arkansas Medicaid enrollment requirements and provide services according to the participant's PCSP and any established benefit limits for that specific service.

213.210 Attendant Care Services

10-1-22

Procedure Code	Modifier	Description
S5125	U2	Attendant Care Services
S5125		Attendant Care Self-Directed Model

Attendant Care services are designed to reduce or prevent inappropriate institutionalization by maintaining, strengthening or restoring an eligible participant's functioning in his or her own

home or elsewhere in the community where the participant engages in activities, including work-related activities. Attendant Care services may be provided in a participant's home or while accompanying the participant to other locations, including without limitation for medical appointments or community activities, subject to the restrictions on travel time in section 213.220.

Attendant Care services consists of assistance with activities of daily living (ADLs), instrumental activities of daily living (IADLs) and health-related tasks through hands-on assistance, supervision and/ or cueing.

Hands-on assistance, supervision and/or cueing are defined as:

- A. "Hands-on assistance" means a provider physically performs all or part of an activity because the participant is unable to do so.
- B. "Set-up", a form of hands on assistance, means getting personal effects, supplies, or equipment ready so that an participant can perform an activity.
- C. "Supervision" means a provider must be near the participant to observe how the participant is completing a task.
- D. "Cueing and/or reassurance" means giving verbal or visual clues and encouragement during the activity to help the participant complete activities without hands-on assistance.
- E. "Monitoring", a form of supervision, means a provider must observe the participant to determine if intervention is needed.
- F. "Stand-by", a form of supervision, means a provider must be at the side of a participant ready to step in and take over the task should the participant be unable to complete the task independently.
- G. "Support", a form of supervision, means to enhance the environment to enable the participant to be as independent as possible.
- H. The following forms of assistance combine elements of Hands-on assistance, supervision and/or cueing:
- I. "Redirection", a form of supervision or cueing, means to divert the participant to another more appropriate activity.
- J. "Memory care support", a blend of supervision, cueing and hands-on assistance. Includes services related to observing behaviors, supervision and intervening as appropriate in order to safeguard the service participant against injury, hazard or accident. These specific supports are designed to support participants with cognitive impairments.

Activities of daily living include:

- A. Eating
- B. Bathing
- C. Dressing
- D. Personal hygiene (grooming, shampooing, shaving, skin care, oral care, brushing or combing of hair, menstrual hygiene, etc.)
- E. Toileting
- F. Mobility/ambulating, including functional mobility (moving from seated to standing, getting in and out of bed) and mastering the use of adaptive aids and equipment

Instrumental activities of daily living include:

- A. Meal planning and preparation consumed only by the participant
- B. Laundry for the participant or incidental to the participant's care
- C. Shopping for food, clothing and other essential items required specifically for the health and maintenance of the participants
- D. Housekeeping (cleaning of furniture, floors and areas directly used by the participant)
- E. Assistance with medications (to the extent permitted by nursing scope of practice laws)

Health-related tasks are limited to the following activities:

- A. Performing and recording simple measurements of body weight, blood glucose, heart pulse, blood pressure, temperature (forehead, tympanic or oral), respiratory rate and blood oxygen saturation, if in physician's order or medical plan of care. Attendant must use and appropriate weight scale and FDA approved, handheld personal health monitoring device(s);
- B. Additional assistance with self-administration of prescribed medications, and/or
- C. Emptying and replacing colostomy and ostomy bags.

Health-related tasks must be:

- A. Consistent with all applicable State scope of practice laws and regulations;
- B. Within the documented skills, training, experience, and other relevant competencies of the attendant performing the task;
- C. For the care and safety of the participant, do not require monitoring or supervision of the attendant by a licensed physician, nurse, or therapist;
- D. Necessary to meet specific needs of the participant consistent with a written plan of care by a physician or registered nurse; and
- E. Tasks that the participant is unable to perform for themselves without hands-on assistance, direct supervision, and/or active cueing of the attendant.

The provision of assistance with ADLs, IADLs or health-related tasks does not entail nursing care.

Attendant care services tasks must be:

- A. Reasonable and medically necessary, supported by the participant's latest independent assessment, and consistent with the participant's Level of Care;
- B. Not available from another source (including without limitation family members, a member of the participant's household, or other unpaid caregivers; a Medicaid State Plan covered service; the Medicare program; the participant's Medicare Advantage plan or Medicare prescription drug plan; or private long-term care, disability, or supplemental insurance coverage);
- C. Expressly authorized in the participant's person-centered service plan;
- D. Not in excess of or otherwise inconsistent with limits on the amount, frequency, or duration of services;
- E. Provided by qualified, Medicaid-certified providers and in compliance with all applicable Arkansas Medicaid program regulations and provider manuals; and

- F. Provided in compliance with all applicable Arkansas scope of practice laws and regulations pertaining to nurses, physicians, skilled therapists, and other professionals.

Attendant care services exclude all of the following:

- A. Medical, skilled nursing, pharmacy, skilled therapy services, medical social services, or medical technician services of any kind, including without limitation: aseptic or sterile procedures; application of dressings; medication administration; injections, observation and assessment of health conditions, other than as permitted for health-related tasks above; insertion, removal, or irrigation of catheters; tube or other enteral feedings; tracheostomy care; oxygen administration; ventilator care; drawing blood; and care and maintenance of any medical equipment;
- B. Services within the scopes of practice of licensed cosmetologists, manicurists, electrologists, or aestheticians, except for necessary assistance with personal hygiene and basic grooming;
- C. Services provided for any person other than the participant, including without limitation a provider, family member, household resident, or neighbor;
- D. Companion, socialization, entertainment, or recreational services or activities of any kind (including without limitation game playing, television watching, arts and crafts, hobbies, and other activities pursued for pleasure, relaxation, or fellowship);
- E. Cleaning of any spaces of a home or place of residence (including without limitation kitchen, bathroom, living room, dining room, family room, and utility or storage rooms, and the floors, furnishings, and appliances therein) shared by the participant with one or more adults who are, together or separately, physically able to perform housekeeping of these areas; and
- F. Habilitation services, including assistance in acquiring, retaining, or improving self-help, socialization, and/or adaptive skills.

Participants may choose to receive authorized attendant care services through any of the following:

- A. Home health agency licensed as Class A by the Arkansas State Board of Health, certified by DPSQA, and enrolled as a Medicaid provider;
- B. Home health agency licensed as Class B by the Arkansas State Board of Health, certified by DPSQA, and enrolled as a Medicaid provider;
- C. Private care agency licensed by the Arkansas State Board of Health, certified by DPSQA, and enrolled as a Medicaid provider; or
- D. Consumer-directed attendant care through Independent Choices, the Arkansas self-directed personal assistance benefit under section 1915(j) of the Social Security Act, provided the participant is capable of self-directing the assistance and subject to the requirements of the Independent Choices provider manual and applicable provider qualifications and certification.

The aggregate amount, frequency, and duration of attendant care services must be consistent with the aggregate amounts, frequencies, and durations calculated by DHS for the participant in accordance with the Arkansas Medicaid Task and Hour Standards ("THS"), as issued by DAABHS and posted publicly on the DHS website with the ARChoices waiver provider manual. DAABHS will publish and periodically update the THS as necessary, following a public notice and comment process. The THS specifies limits on each ADL, IADL, and health-related task at the intensity of human assistance needed for the task, including maximum frequency (by day or week or month), maximum minutes per task allowable, and maximum hours by day, week, month, and year. Any aggregate

amounts, frequencies, or durations in excess of the weekly or monthly limits calculated by DHS for the participant in accordance with the THS specifications are not covered.

Attendant care services are not available (not covered and not reimbursable) through the ARChoices program when and to the extent any of the following may apply:

- A. When reasonably comparable or substitute services are available to the participant through an Arkansas Medicaid State Plan benefit including without limitation personal care services, home health services, and private duty nursing services;
- B. When assistance with the equivalent ADL, IADL, or health-related task(s) is covered under an Arkansas Medicaid State Plan benefit but determined as medically unnecessary for the participant during adjudication of a prior authorization request or utilization review;
- C. When assistance with the comparable ADL, IADL, or health-related task(s) is available through targeted or supplemental benefits offered by the participant's Medicare Advantage plan;
- D. When attendant care services delivered through a home health agency or private care agency are provided by the waiver participant's (i) spouse, (ii) legal guardian of the person; or (iii) attorney-in-fact granted authority to direct the participant's care;
- E. On dates of service when the participant:
 - 1. Receives Medicare home health aide services, whether through traditional Medicare fee-for-service or a Medicare Advantage plan of any kind for the same tasks;
 - 2. Receives targeted or other supplemental benefits from a Medicare Advantage plan of any kind, where such supplemental services are reasonably comparable to or duplicative of attendant care services, personal care services, or self-directed personal assistance;
 - 3. Spends more than five hours at an adult day services or adult day health services facility, unless prior approved in writing by the PCSP/CC Nurse;
 - 4. Receives long-term or short-term facility-based respite care; and/or
 - 5. Receives services from an inpatient hospital, nursing facility, assisted living facility, hospice facility, or residential care facility, unless approved in writing by a PCSP/CC Nurse as reasonable and necessary given the time of day of the facility admission or discharge, the need for transition assistance, or an inpatient hospital admission incident to an emergency department visit or direct inpatient admission by the attending physician.
- F. When a duplicate claim for the same performance of the same task is paid or submitted for personal care services, self-directed personal assistance, or home health aide services under the Medicaid State Plan; and/or
- G. For a task that was not actually performed.

Participants may choose to self-direct this service through Arkansas's IndependentChoices program under 1915(j) authority; or may receive services through an agency. The IndependentChoices Medicaid Provider Manual describes the self-directed service delivery model.

Attendant Care services must be provided according to the participant's written PCSP.

A brief description of the service(s) provided, including the signature and title of the individual rendering the service, must be documented in the participant's case record. See Section 214.000 for additional documentation requirements.

Benefit limits will be determined on a participant basis based on application of the Arkansas Medicaid Task and Hour Standards (THS) and the service limitations described in this manual.

DAABHS will update the Person-Centered Service Plan to take into the account any changes in the participant's condition and/or living arrangements that would affect the number of hours of attendant care that could be approved under the Task and Hour Standards.

Fifteen (15) minutes of service equals one (1) unit.

An ARChoices participant who spends more than five (5) hours (20 units) at an adult day services or adult day health services facility or who is receiving short-term, facility-based respite care will not be eligible for Attendant Care services on the same date of service unless authorized by the PCSP/CC Nurse.

An ARChoices participant receiving long-term, facility-based respite care is not eligible for Attendant Care services on the same date of service.

213.220 Travel Time of Attendant Accompanying Participant

10-1-22

- A. The Attendant Care benefit only covers attendant travel time when all of the following applies:
1. The attendant accompanies the participant in the same vehicle as the participant travels to and returns from a community location for medical appointment or community activity;
 2. The travel time billed is solely for necessary time in transit from the participant's home to the community location and the return travel from the community location to the participant's home;
 3. The participant's participation in the local community activity is for the benefit of the participant and to meet the participant's goals for independent living in the community, and the travel, including stops, is not for the benefit or convenience of any other person (including the attendant, a family member, the driver, or other passengers);
 4. The traveling activity itself is for practical transit within the community and not for diversional or recreational purposes of any kind;
 5. The participant's approved patient-centered service plan includes Attendant Care service hours for one or both of the following activities of daily living (ADLs): toileting and mobility / ambulating;
 6. While in transit to and from the community location, the participant requires, or is likely to need given assessed functional limitations, hands-on assistance with the ADL task of toileting or the ADL task of mobility / ambulating; and,
 7. The travel time is reasonable given driving distances, traffic conditions and weather with time and location documented.
- B. Travel time is not reimbursable if any other adult person accompanying (or driving) the participant is a family member and is reasonably able to assist the participant in transit if needed.
- C. Travel time accompanying a participant will count against the total number of Attendant Care hours per month authorized in the participant's person-centered service plan.
- D. Requesting Hours for Travel Time of Attendant Accompanying Participant:

Participants vary in their medical appointments, participation in community activities, the availability of family or other assistance they may need while traveling, and the time involved when traveling to medical appointments and local community activities. When covered, travel time of an attendant accompanying a participant is incident to but itself not

the ADL task of toileting or the ADL task of mobility / ambulating. Therefore, the Task and Hour Standards are not currently used to help determine the number of Attendant Care hours, if any, associated solely with travel time of an attendant accompanying a participant to a medical visit or community activity. During the home visit to discuss the person-centered service plan, the participant (or their legal representative) should inform the DHS nurse of the participant's community activities, need for an attendant to accompany them, and the distances and roundtrip travel times typically involved. Based on this information, consistent with the above requirements, and within the person's applicable Individual Services Budget, the DHS nurse may increase the number of Attendant Care hours per month covered in the PCSP to reasonably accommodate the travel time of an attendant accompanying the participant.

213.230 Attendant Care Services Certification Requirements**10-1-22**

The following requirements must be met prior to certification by the Division of Provider Services and Quality Assurance (DPSQA) by providers of attendant care services. The provider must:

- A. Hold a current Arkansas State Board of Health Class A and/or Class B license, Or Private Care Agency license.
- B. All owners, principals, employees, and contract staff of an attendant care services provider must have national and state criminal background checks and central registry checks. Criminal background and central registry checks must comply with Arkansas Code Annotated §§20-33-213 and 20-38-101 *et seq.* Criminal background checks shall be repeated at least once every five (5) years. Central registry checks shall include the Child Maltreatment Central Registry; the Adult and Long-Term Care Facility Resident Maltreatment Central Registry; and the Certified Nursing Assistant/Employment Clearance Registry.
- C. Employ and supervise direct care staff who:
 - 1. Prior to providing an ARChoices service, have received instruction regarding the general needs of the elderly and adults with physical disabilities;
 - 2. Possess the necessary skills to perform the specific services required to meet the needs of the participant the direct care staff member is to serve; and
 - 3. Are placed under bond by the provider or are covered by the professional medical liability insurance of the provider.

Each provider must maintain adequate documentation to support that direct care staff meets the training and, as applicable, testing requirements according to licensure, agency policy and DPSQA certification.

Attendant Care service providers who hold a current Arkansas State Board of Health Class A and/or Class B license or Private Care Agency license must recertify with DPSQA annually.

Providers are required to submit copy of renewed license to DPSQA.

213.240 Environmental Accessibility Adaptations/Adaptive Equipment**10-1-22**

Environmental Accessibility Adaptations/Adaptive Equipment services enable the participant to increase, maintain and/or improve his or her functional capacity to perform daily life tasks that would not be possible otherwise. Environmental Accessibility Adaptations/Adaptive Equipment are physical adaptations to the home that are necessary to ensure the health, welfare and safety of the participant, to function with greater independence in the home and preclude or postpone institutionalization. Adaptive equipment also enables the participant to increase, maintain and/or improve his/her functional capacity to perform daily life tasks that would not be possible otherwise and perceive, control or communicate with the environment in which he or she lives.

Excluded are adaptations or improvements to the home which are of general utility and are not of direct medical or remedial benefit to the participant, such as carpeting, roof repair, air conditioning and others. Adaptations which add to the total square footage of the home are excluded from this benefit. All services must be in accordance with applicable state or local building codes. All dwellings that receive adaptations must be in good repair and have the appearance of sound structure.

Permanent fixtures are not allowed on rented or leased properties.

Reimbursement is not permitted for Environmental Accessibility Adaptations/Adaptive Equipment services provided by a waiver participant's:

- A. Spouse;
- B. Legal guardian of the person; or,
- C. Attorney-in-fact granted authority to direct the participant's care.

213.250 **Benefit Limit - Environmental Accessibility Adaptations/Adaptive Equipment** **10-1-22**

The overall cap for Environmental Accessibility Adaptations/Adaptive Equipment is \$7,500 per the lifetime of the eligible waiver participant, including this service if received under the Alternatives for Adults with Physical Disabilities (AAPD) waiver. If a waiver participant is receiving Environmental Accessibility Adaptations and Adaptive Equipment, the combined cost cannot exceed the \$7,500 overall cap. A waiver participant may access through the waiver several occurrences of Environmental Accessibility Adaptations or for several items of Adaptive Equipment over a span of years, or he/she may access the whole \$7,500 at one time. Once the \$7,500 per eligible participant is reached, no further Environmental Accessibility Adaptations/Adaptive Equipment can be accessed through the waiver by the eligible waiver participant during his/her remaining lifetime.

213.260 **Examples of Acceptable Environmental Accessibility Adaptations/Adaptive Equipment** **10-1-22**

Acceptable environmental accessibility adaptations/adaptive equipment must be necessary for the welfare of the participant and may include, but are not limited to:

- A. Installing and/or repairing ramps and grab-bars
- B. Widening doorways
- C. Modifying bathroom facilities
- D. Installing specialized electronic and plumbing systems
- E. Installing an electrical entry door to the home – if based on need and accessibility
- F. Installing overhead tracks for transferring
- G. Durable Medical Equipment not payable by Medicare/Medicaid
- H. Generators for ventilator-dependent beneficiaries

213.270 **Examples of Unacceptable Environmental Accessibility Adaptations/Adaptive Equipment** **10-1-20**

Unacceptable environmental accessibility adaptations/adaptive equipment to the home include, but are not limited to:

- A. Those that are of general utility

- B. Those not of direct medical or remedial benefit to the participant, such as carpeting, roof repair, central air conditioning, etc.
- C. Those that add to the total square footage of the home
- D. Purchase of any vehicle, such as automobile/van, regardless of previously installed modifications or adaptations
- E. Vehicle modifications or purchase of a vehicle
- F. Replacement of all carpeting when door widening is completed
- G. Repairs or updates necessary in order to complete the environment accessibility adaptations/adaptive equipment

Examples:

- 1. In order to install a ramp, repairs to the porch or deck must be made to support the ramp. The ramp could be approved; the repairs to the existing porch or deck could not be approved.
- 2. Bathroom needs adaptation to install a new commode for disabled participant. In order to replace the commode, the flooring must be replaced due to dry rot or decay. The new commode could be approved. The sub-flooring, etc., could not be approved.
- H. Permanent fixtures to leased or rented homes.

213.280 Provider Qualifications Environmental Accessibility Adaptations/Adaptive Equipment

1-1-19

Individuals or businesses seeking certification by the Division of Provider Services and Quality Assurance (DPSQA) and enrollment as Medicaid providers of environmental accessibility adaptations/adaptive equipment services must meet the following criteria:

- A. The provider of services must be a builder, tradesman or contractor.
- B. The provider must be licensed (where applicable) as appropriate for home improvement contracting or adaptation and equipment provided.
- C. The provider must certify that his or her work meets state and local building codes.
- D. The provider must obtain all applicable permits.
- E. The provider must be knowledgeable of and comply with the Americans with Disabilities Act Accessibility Guidelines.
- F. Contractors are required to adhere to the Uniform Federal Accessibility Standards.

NOTE: All environmental modifications requiring electrical or plumbing work must be completed by an appropriately licensed professional. If the proposed work requires a plumbing or electrical license, the contractor must submit a copy of the contractor's plumbing or electrical license with the claim form. If a contractor subcontracts with an electrician or plumber, the contractor must submit a copy of the subcontractor's license with the claim form.

213.290 Environmental Modifications/Adaptive Equipment

10-1-22

Prior to payment for this service, the waiver participant is required to secure 3 separate itemized bids for the same service. Each bid must itemize the work to be done and must specifically identify any work that requires a plumbing or electrical license. The bids are reviewed by the PCSP/CC Nurse or designee prior to submission for Medicaid payment. If only two bids can be

secured due to a shortage of qualified providers in the service area, documentation attesting to the attempt to secure bids and the shortage of providers must be provided. All modification funds must be verified by the DAABHS prior to receiving services.

Each claim must be signed by the provider, the waiver participant and PCSP/CC Nurse, or designee. A statement of satisfaction form must be signed by the waiver participant prior to any claim being submitted. All claim forms, bids and participant satisfaction statement forms must be submitted to the DAABHS Unit prior to submission for payment.

NOTE: The Environmental Modification provider's Alternatives for Adults with Physical Disabilities (AAPD) certification will be valid as an ARChoices Environmental Modification provider under the ARChoices Waiver program. The provider will not be required to recertify until the expiration of the previous certification under AAPD.

213.310 Hot Home-Delivered Meals

10-1-22

Hot Home-Delivered Meals provide one meal per day with a nutritional content equal to 33 1/3 percent of the Dietary Reference Intakes established by the Food and Nutrition Board of the National Academy of Sciences. The meals must comply with the Dietary Guidelines for Americans and with the Division of Aging, Adult and Behavioral Health Services (DAABHS) Nutrition Services Program Policy Number 206.

Hot Home-Delivered Meal services provide one daily nutritious meal to eligible participants who are homebound. Homebound is defined as a person with normal inability to leave home without assistance (physical or mental) from another person; a person who is frail, homebound by reason of illness or incapacitating disability or otherwise isolated; or for whom leaving home requires considerable and taxing effort by the participant and absences from the home are infrequent, relatively short in duration or are attributable to the need to receive medical treatment.

Additionally, the participant must:

- A. Be unable to prepare some or all of his or her own meals;
- B. Have no other individual to prepare his or her own meals; and
- C. Have the provision of the Home-Delivered Meals included on his or her PCSP

The provision of a Home-Delivered Meal is the most cost-effective method of ensuring a nutritiously adequate meal.

The Home-Delivered Meals provider must maintain a log sheet signed by the participant that includes date and time of delivery each time a meal is delivered to document receipt of the meal.

Hot Home-Delivered Meals must be provided according to the participant's written ARChoices PCSP.

Procedure Code	Required Modifier	Description
S5170	U2	Hot Home-Delivered Meal
S5170	—	Frozen Home-Delivered Meal
S5170	U1	Emergency Home-Delivered Meal

213.311 Hot Home-Delivered Meal Provider Certification Requirements

10-1-22

To be certified by the Division of Provider Services and Quality Assurance (DPSQA) as a provider of Hot Home-Delivered Meal services, a provider must:

- A. Be a nutrition services provider whose kitchen is approved by the Arkansas Department of Health and whose meals are approved by a Registered Dietitian who has verified by nutrient analysis that meals provide 33 1/3 percent of the Dietary Reference Intakes established by the Food and Nutrition Board of the National Academy of Sciences and comply with the Dietary Guidelines for Americans and Division of Aging, Adult and Behavioral Health Services (DAABHS) Nutrition Services Program Policy Number 206.*
- B. Comply with all federal, state, county and local laws and regulations concerning the safe and sanitary handling of food, equipment and supplies used in the storage, preparation, handling, service, delivery and transportation of meals;*
- C. If applicable, assure that the provider's intermediate source of delivery meets or exceeds federal, state and local laws regarding food transportation and delivery;*
- D. Procure and have available all necessary licenses, permits and food handlers' cards as required by law;*

***NOTE: For providers located in Arkansas, all requirements must meet applicable Arkansas laws and regulations. For Home-Delivered Meal providers located in bordering states, all requirements must meet their states' applicable laws and regulations.**

- E. All owners, principals, employees, and contract staff of a hot, home-delivered meal services provider must have national and state criminal background checks and central registry checks. Criminal background checks and central registry checks must comply with Arkansas Code Annotated §§ 20-33-213 and 20-38-101 et seq. Criminal background shall be repeated at least once every five years. Central registry checks shall include the Child Maltreatment Central Registry, the Adult and Long-Term Care Facility Resident Maltreatment Central Registry and the Certified Nursing Assistant/Employment Clearance Registry.
- F. Notify the DHS PCSP/CC Nurse immediately if:
 - 1. There is a problem with delivery of service
 - 2. The participant is not consuming the meals
 - 3. A change in the participant's condition is noted

NOTE: Changes in service delivery must receive prior approval by the PCSP/CC Nurse who is responsible for the participant's Person-Centered Service Plan (PCSP). Requests must be submitted in writing to the PCSP/CC Nurse. Any changes in the participant's circumstances must be reported to the PCSP/CC Nurse via form AAS-9511.

Home-Delivered Meals, hot or frozen, shall be included in the participant's PCSP only when they are necessary to prevent the institutionalization of a participant. Hot Home-Delivered Meals providers must recertify with DPSQA annually and the provider shall attach a copy of the agency's current Food Establishment Permit to the annual recertification.

213.320 Frozen Home-Delivered Meals

10-1-22

Frozen Home-Delivered Meals service provides one meal per day with a nutritional content equal to 33 1/3 percent of the Dietary Reference Intakes established by the Food and Nutrition Board of the National Academy of Sciences. The meals must comply with the Dietary Guidelines for Americans and with DAAS Nutrition Services Program Policy Number 206.

The goal of the Frozen Home-Delivered Meals service is to supplement, not replace, the Hot Home-Delivered Meal service by providing one daily nutritious meal to homebound persons at risk of being institutionalized who:

- A. Reside in remote areas where daily hot meals are not available;
- B. Choose to receive a frozen meal rather than a hot meal; or
- C. Are at nutritional risk and are certified to receive a meal for use on weekends or holidays when the hot meal provider is not in operation.

NOTE: While the participant has freedom of choice regarding this service, it is the responsibility of the DAAS RN developing the PCSP to ensure the appropriateness of the service. A hot meal delivered daily remains the food service of choice, when available. Therefore, a frozen meal must be approved by the DAAS RN. The service must be included on the PCSP. If the individual responsible for developing the PCSP does not think the frozen meals are appropriate for the participant, other options will be considered. Those options include removing the Home-Delivered Meal service rather than authorizing a frozen meal.

It is the certified provider's responsibility to deliver the meals regardless if they are hot or frozen. Meals may not be left on the doorstep. The meals cannot be mailed to the participant via United States Postal Service or delivered by paid carrier such as Fed Ex or UPS.

213.321 Participant Requirements for Frozen Home-Delivered Meals

10-1-22

The participant must:

- A. Be homebound, which is defined by the following requirements:
 - 1. The person is normally unable to leave home without assistance (physical or mental) from another person;
 - 2. The person is frail, homebound by reason of illness or incapacitating disability or otherwise isolated;
 - 3. Leaving home requires considerable and taxing effort by the participant; and
 - 4. Absences of the participant from home are infrequent, of relatively short duration or attributable to the need to receive medical treatment.
- B. Be unable to prepare some or all of his or her meals or require a special diet and be unable to prepare it.
- C. Have no other individual available to prepare his or her meals and the provision of a Frozen Home-Delivered Meal is the most cost-effective method of ensuring a nutritionally adequate meal.
- D. Have adequate and appropriate storage and be able to perform the simple tasks associated with storing and heating a Frozen Home-Delivered Meal or have made other appropriate arrangements approved by DAABHS.
- E. Have the provision of frozen meals included on his or her PCSP as developed by the appropriate PCSP/CC Nurse.

Frozen Home-Delivered Meals must be documented on the PCSP by the PCSP/CC Nurse and must be provided in accordance with the participant's written PCSP.

213.322 Reserved

1-1-16

213.323

Frozen Home-Delivered Meal Provider Certification Requirements

10-1-22

In order to become approved providers of frozen meals, providers must meet all applicable requirements of the Division of Aging, Adult and Behavioral Health Services (DAABHS) Nutrition Services Program Policy Number 206.

To be certified by Division of Provider Services and Quality Assurance (DPSQA) as a provider of Home-Delivered Meal services, a meal provider must:

- A. Be a nutrition services provider whose kitchen is approved by the Arkansas Department of Health and whose meals are approved by a Registered Dietitian who has verified by nutrient analysis that meals provide 33 1/3 percent of the Dietary Reference Intakes established by the Food and Nutrition Board of the National Academy of Sciences and comply with the Dietary Guidelines for Americans and DAABHS Nutrition Services Program Policy Number 206.*
- B. Comply with all federal, state, county and local laws and regulations concerning the safe and sanitary handling of food, equipment and supplies used in the storage, preparation, handling, service, delivery and transportation of meals;*
- C. If applicable, ensure that intermediate sources of delivery meet or exceed federal, state and local laws regarding food transportation and delivery*
- D. Procure and have available all necessary licenses, permits and food handlers' cards as required by law*

*NOTE: For providers located in Arkansas, all requirements must meet applicable Arkansas laws and regulations. For Home-Delivered Meal providers located in bordering states, all requirements must meet their states' applicable laws and regulations.

- E. All owners, principals, employees, and contract staff of a home-delivered meal services provider must have national and state criminal background checks and central registry checks. Criminal background checks and central registry checks must comply with Arkansas Code Annotated §§ 20-33-213 and 20-38-101 *et seq.* Criminal background shall be repeated at least once every five years. Central registry checks shall include the Child Maltreatment Central Registry; the Adult and Long-Term Care Facility Resident Maltreatment Central Registry; and the Certified Nursing Assistant/Employment Clearance Registry.
- F. Provide frozen meals that:
 - 1. Were prepared or purchased according to the Department of Health and DAABHS Nutrition Services Program Policy guidelines in freezer-safe containers that can be reheated in the oven or microwave.
 - 2. Are kept frozen from the time of preparation through placement in the participant's freezer.
 - 3. Have a remaining freezer life of at least three months from the date of delivery to the home.
 - 4. Are part of a meal cycle of at least four weeks (i.e., four weeks of menus that differ).
 - 5. Are properly labeled, listing food items included and non-frozen items that are delivered with the frozen components to complete the meal (which must include powdered or fluid milk, whichever is preferred by the participant), menu analysis as required by DAABHS Nutrition Services Program Policy if other than DAABHS menus are used and both packaging and expiration dates.

NOTE: The milk must be delivered to the participant at least seven (7) days prior to its expiration date.

- G. Instruct each participant, both verbally and in writing, in the handling and preparation required for frozen meals and provide written re-heating instructions with each meal, preferably in large print.
- H. Ensure that meals that are not commercially prepared but produced on-site in the production kitchen:
 - 1. Are prepared and packaged only in a central kitchen or on-site preparation kitchen;
 - 2. Are prepared specifically to be frozen;
 - 3. Are frozen as quickly as possible;
 - 4. Are cooled to a temperature of below 40 degrees Fahrenheit within four hours;
 - 5. Have food temperatures taken and recorded at the end of food production, at the time of packaging and throughout the freezing process, with temperatures recorded and kept on file for audit;
 - 6. Are packaged in individual trays, properly sealed and labeled with the date, contents and instructions for storage and reheating;
 - 7. Are frozen in a manner that allows air circulation around each individual tray;
 - 8. Are kept frozen throughout storage, transport and delivery to the participant; and
 - 9. Are discarded after 30 days.
- I. Verify quarterly that all participants receiving Frozen Home-Delivered Meals continue to have the capacity to store and heat meals and are physically and mentally capable of performing simple associated tasks unless other appropriate arrangements have been made and approved by DAABHS. Any changes in the participant's circumstances must be reported to the PCSP/CC Nurse via form AAS-9511.
- J. Notify the appropriate PCSP/CC Nurse immediately if:
 - 1. There is a problem with delivery of service
 - 2. The participant is not consuming the meals
 - 3. A change in a participant's condition is noted

NOTE: Changes in service delivery must receive prior approval by the PCSP/CC Nurse who is responsible for the participant's Person-Centered Services Plan (PCSP). Requests must be submitted in writing to the PCSP/CC Nurse. Any changes in the participant's circumstances must be reported to the PCSP/CC Nurse via form AAS-9511.

- K. Contact each participant daily Monday through Friday, either in person or by the phone, to ensure the participant's safety and well-being. This is not required for:
 - 1. Participants receiving Frozen Home-Delivered Meals only for weekends; or,
 - 2. Participants who receive Attendant Care services or Personal Care services at least three (3) times per week.

Home-Delivered Meals, hot or frozen, shall be included in the participant's PCSP only when they are necessary to prevent the institutionalization of a participant. Frozen Home-Delivered Meals providers must recertify with DPSQA annually; however, DPSQA must maintain a copy of the agency's current Food Establishment Permit at all times.

One unit of service equals one meal. The maximum number of HDMs eligible for Medicaid reimbursement per month equals 31 meals. This includes hot, frozen or a combination of the two. There is no separate benefit limit for frozen meals.

The maximum number of emergency meals per State Fiscal Year is four (4).

Frozen HDMs may be provided daily to eligible beneficiaries. A maximum of seven (7) meals may be delivered at one time.

HDM providers may deliver more than seven meals at one time, if:

- A. The waiver participant receives Attendant Care services or Personal Care services at least three (3) times per week,
- B. Frozen HDMs are ordered on the Person-Centered Services Plan (PCSP),
- C. The waiver participant has the means of storing 14 frozen meals (as verified by the PCSP/CC Nurse).

HDM providers delivering frozen meals may deliver 14 at one time if PCSP/CC Nurse enters 14 meals delivery approved in the comments section of the HDM entry on the PCSP. If this statement is not on the PCSP, or if any of the other factors above are not in place, the meal providers cannot deliver more than seven (7) meals at one time.

A participant may not be provided with a Hot or Frozen HDM on any day during which the participant receives more than five (5) hours of in-home or facility-based Respite care or more than five (5) hours of Adult Day Services or Adult Day Health Services. (Licensure mandates that providers of these services provide a meal or meals; therefore, a HDM on these dates is a duplicative service and prohibited under waiver guidelines.)

NOTE: Medicaid reimbursement for HDMs is not allowed on the same day to participants who are also attending Adult Day Services, Adult Day Health Services, or facility-based Respite care for more than five (5) hours. When applying this policy, the time of day the participant receives day services or respite services are also a factor. Whether there is duplication of services will be determined by comparing the time of day during which services occur.

When considering whether a HDM is billable for a participant receiving Adult Day Services, Adult Day Health Services or facility-based Respite services, on a specific date of service, the following must be applied:

If a participant is receiving Adult Day Services, Adult Day Health Services or facility-based Respite at any time between the hours of 11:00 a.m. and 1:30 p.m. **and** the noon meal is routinely served to others at the facility during this timeframe, the noon meal must also be served to this participant. A HDM is not allowable on the same date of service. This is true **regardless of the total number of Adult Day Services, Adult Day Health Services or Respite hours provided.**

213.340 Combination of Hot and Frozen Home-Delivered Meals

10-1-22

In instances where the participant wishes to receive a combination of hot and frozen meals, the PCSP/CC Nurse shall evaluate the participant's situation based on the criteria set forth in Section 213.320, Frozen Home-Delivered Meals. If the criteria are met, the PCSP/CC Nurse may prescribe on the PCSP a combination of hot and frozen meals to be delivered.

213.350 Emergency Meals

10-1-22

Participants may receive up to four (4) emergency meals per state fiscal year. The meals must:

- A. Contain 33 1/3 percent of the Dietary Reference intakes established by the Food and Nutrition Board of the National Academy of Sciences and comply with the Dietary Guidelines for Americans and Division of Aging, Adult and Behavioral Health Services (DAABHS) Nutrition Services Program Policy Number 206.
- B. Be labeled “Emergency Meal” in large print, with instruction on use of the meal.
- C. Be used within the limits of their shelf life, usually within six months.

213.400 Personal Emergency Response System**10-1-22**

Procedure Code	Required Modifier	Description
S5161	UA	PERS Unit
S5160	—	PERS Installation

The Personal Emergency Response System (PERS) is an in-home, 24-hour electric support system with two-way verbal and electronic communication with an emergency control center. PERS enables an elderly, infirm or homebound participant to secure immediate help in the event of a physical, emotional or environmental emergency.

PERS is specifically designed for high-risk participants whose needs have been carefully determined based on their level of medical vulnerability, functional impairment and social isolation. PERS is not intended to be a universal benefit. The PCSP/CC Nurse must verify that the participant is capable, both physically and mentally, of operating the PERS unit.

PERS must be included in the participant's written PCSP.

PERS providers must contact each participant at least once per month to test the system's operation. The provider shall maintain a log of test calls that includes the date and time of the test, specific test results, corrective actions and outcomes.

A log of all participant calls received must be maintained by the emergency response center. The log must reflect the date, time and nature of the call and the response initiated by the center. All calls must be documented in the participant's record. See Section 214.000 for other documentation requirements.

One (1) unit of service equals one (1) month. PERS is limited to a maximum of twelve (12) units per year.

The installation of PERS will be allowed once per lifetime or period of eligibility. Claims submitted for the installation of PERS should use procedure code **S5160**. Procedure code **S5160** may be billed for participants who are accessing PERS services for their first time or for the current period of re-eligibility for ARChoices Waiver Services. In the event of extenuating circumstances that result in the need for reinstallation, the provider may contact the Division of Aging, Adult and Behavioral Health Services for extension of the benefit.

213.410 Personal Emergency Response System (PERS) Certification Requirements**10-1-22**

To be certified by the Division of Provider Services and Quality Assurance (DPSQA) as a provider of personal emergency response services, a provider must:

- A. Provide, install and maintain Federal Communications Commission (FCC) approved equipment which meets all Underwriter Laboratories Safety Standards;
- B. Designate or operate an emergency response center to receive signals and respond according to specified operating protocol;

- C. Establish a response system for each participant and ensure responders receive necessary instruction and training; and
- D. Ensure that equipment is installed by qualified providers who also provide instruction and training to participants. PERS providers must recertify annually with DPSQA.

213.500

Adult Day Services

10-1-22

Procedure Code	Required Modifier	Description
S5100	U1	Adult Day Services, 8-20 Units Per Date of Service
S5100	—	Adult Day Services, 21-40 Units Per Date of Service

Adult day services facilities are licensed by the Division of Provider Services and Quality Assurance (DPSQA) to provide care and supervision to meet the needs of four (4) or more functionally impaired adults for periods of less than 24 hours but more than two (2) hours per day, in a place other than the participants' own homes.

When provided according to the participant's written PCSP, participants may receive adult day services for 8 or more units (2 or more hours) per day, not to exceed 40 units (10 hours) per day, according to the participant's written PCSP. Adult day services of less than 8 units (2 hours) per day are not reimbursable by Medicaid. Adult day services may be utilized up to 200 units (50 hours) per week, not to exceed 920 units (230 hours) per month. One (1) unit of service equals 15 minutes.

As required, participants who are present in the facility for more than 20 units (5 hours) a day (procedure code **S5100**) must be served a nutritious meal that equals one-third of the Recommended Daily Allowance. Therefore, participants are not eligible to receive a home-delivered meal on the same day they receive more than 20 units (5 hours) of adult day services. Additionally, participants who attend an adult day service for more than 20 units (5 hours) are not eligible to receive Attendant Care services on the same date of service unless authorized by the DHS PCPS/CC Nurse.

NOTE: As stated in this manual, home-delivered meals may not be provided on the same day for a participant who attends adult day services, adult day health services, or facility-based respite care for more than 20 units (5 hours). The time of day the participant is receiving day services, day health services or respite services is also a factor in the application of this policy. The time of day services are received will be reviewed by the PCSP/CC Nurse and/or Department of Human Services (DHS) audit staff and considered when determining any duplication in services for participants participating in the ARChoices Waiver program.

Providers must consider the following to determine whether a home-delivered meal is billable for a participant receiving day services, day health services or facility-based respite services on a specific date of service.

If a participant is receiving day services, day health services or facility-based respite between the hours of 11:00 a.m. and 1:30 p.m. and the noon meal is routinely served to others at the facility during this time frame, the noon meal must also be served to this participant. A home-delivered meal is not allowable on the same date of service. This is true regardless of the total number of day services or respite units provided.

Adult day services and day health services providers are required to maintain a daily attendance log of participants. Section 214.000 contains information regarding additional documentation requirements.

213.510 Adult Day Services Certification Requirements**1-1-19**

To be certified by the Division of Provider Services and Quality Assurance (DPSQA) as a provider of adult day services in Arkansas, a provider must be a person, corporation, partnership, association or organization licensed by the Arkansas Department of Human Services, DPSQA as a long-term adult day care facility. Providers in the designated trade area cities in states that border Arkansas must be licensed and/or certified by the appropriate state agency as an Adult Day Care Facility.

In order to be certified by DPSQA, Adult Day Services providers must meet the Home and Community-Based Services (HCBS) Settings rules found in section C of 201.105.

Adult Day Services providers must recertify with DPSQA annually; however, DPSQA must maintain a copy of the agency's current Adult Day Care license at all times.

In order to be recertified by DPSQA, Adult Day Services providers must meet the HCBS Settings rules found in section C of 201.105.

Providers are required to submit copy of renewed license to DPSQA.

213.600 Adult Day Health Services (ADHS)**10-1-22**

Procedure Code	Required Modifier	Description
S5100	TD, U1	Adult Day Health Services, 8-20 Units Per Date of Service
S5100	TD	Adult Day Health Services, 21-40 Units Per Date of Service

Adult day health services facilities are licensed to provide a continuing, organized program of rehabilitative, therapeutic and supportive health services, social services and activities to participants who are functionally impaired and who, due to the severity of their functional impairment, are not capable of fully independent living.

Adult day health services programs provide rehabilitative and health services directed toward meeting the health restoration and maintenance needs of the participant that cannot be provided by adult day care programs. Adult day health services are appropriate only for participants whose facility-developed care plans specify one or more of the following health services:

- A. Rehabilitative therapies (e.g., physical therapy, occupational therapy),
- B. Pharmaceutical supervision,
- C. Diagnostic evaluation or
- D. Health monitoring

Participants may receive adult day health services for 8 or more units (2 or more hours) per day, not to exceed 40 units (10 hours) per day when the service is provided according to the participant's written PCSP. Adult day health services of less than 8 units (2 hours) per day are not reimbursable by Medicaid. Adult day health services may be utilized up to 200 units (50 hours) per week, not to exceed 920 units (230 hours) per month.

Participants who are present in the facility for more than 20 units (5 hours) a day (procedure code **S5100**, modifier **TD**) must be served a nutritious meal that equals one-third of the Recommended Daily Dietary Allowances. Therefore, participants are not eligible to receive a home-delivered meal on the same day they receive more than five (5) hours of adult day health services. Additionally, participants who attend an adult day health services for more than 20 units

(5 hours) are not eligible to receive Attendant Care services on the same date of service unless authorized by the PCSP/CC Nurse.

Adult day health services providers are required by licensure to maintain a daily attendance log of participants. See Section 214.000 for additional documentation requirements.

NOTE: As stated in this manual, home-delivered meals may not be provided on the same day for a participant who attends adult day services, adult day health services, or facility-based respite care for more than 20 units (5 hours). The time of day the participant is receiving day services or respite services is also a factor in the application of this policy. The time of day services are received will be reviewed by the PCSP/CC Nurse and/or DHS audit staff and considered when determining any duplication in services for participants participating in the ARChoices Waiver program.

Providers must consider the following to determine whether a home-delivered meal is billable for a participant receiving day services or facility-based respite services on a specific date of service.

If an ARChoices participant is receiving day services or facility-based respite between the hours of 11:00 a.m. and 1:30 p.m. and the noon meal is routinely served to others at the facility during this time frame, the noon meal must also be served to the participant. A home-delivered meal is not allowable on the same date of service. This is true regardless of the total number of day services or respite units provided.

213.610 Adult Day Health Services (ADHS) Provider Certification Requirements

1-1-19

To be certified by the Division of Provider Services and Quality Assurance (DPSQA) as a provider of adult day health services in Arkansas, a provider must be a person, corporation, partnership, association or organization licensed by Arkansas Department of Human Services, DPSQA as an adult day health care facility. Providers in the designated trade area cities in states that border Arkansas must be licensed and/or certified by the appropriate state agency as an Adult Day Health Care Facility.

In order to be certified by DPSQA, Adult Day Health Services providers must meet the Home and Community-Based Services (HCBS) Settings rules found in section C of 201.105.

Adult Day Health Services providers must recertify with DPSQA annually; however, DPSQA must maintain a copy of the agency's current Adult Day Health Care license at all times. In order to be recertified, Adult Day Health Services providers must meet the HCBS Settings rules found in section C of 201.105.

Providers are required to submit copy of renewed license to DAABHS.

NOTE: Adult day services and adult day health services are not allowed on the same date of service.

213.620 Prevocational Services

10-1-22

Procedure Code	Modifier	Description
T2015		Prevocational Services Skills Development
T2015	U3	Prevocational Services Career Exploration

Prevocational services are available to ARChoices waiver participants with physical disabilities who wish to join the general workforce. Prevocational Services comprise a range of learning and experiential type activities that prepare a participant for paid employment or self-employment in the community.

Prevocational services are as follows:

- A. Development and teaching of general employability skills (non-job-task-specific strengths and skills) directly relevant to the participant's pre-employment needs and successful participation in individual paid employment. These skills are: ability to communicate effectively with supervisors, coworkers, and customers; an understanding of generally accepted community workplace conduct and dress; the ability to follow directions; the ability to attend to tasks; workplace problem-solving skills and strategies; general workplace safety and mobility training; the ability to navigate local transportation options; and skills related to obtaining paid employment. Excluded are services involving development or training of job-specific or job-task oriented skills.
- B. Career exploration activities designed to develop an individual career plan and facilitate the participant's experientially-based informed choice regarding the goal of individual paid employment. These may include business tours, informational interviews, job shadows, benefits education and financial literacy, assistive technology assessment, and local job exploration events. The expected outcome of career exploration activities is a written, actionable, person-centered career plan designed to lead to community employment or self-employment for the participant.

The expected outcome of prevocational services is individual employment in the general workforce, or self-employment, in a setting typically found in the community, where the participant interacts with individuals without disabilities, other than those providing services to the participant or other individuals with disabilities, to the same extent that individuals without disabilities in comparable positions interact with other persons; and for which the participant is compensated at or above the minimum wage, but not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities.

Prevocational services may be provided one-to-one or in a small group format and may be provided as a site-based service or in a community setting, consistent with requirements of the ARChoices provider manual.

All prevocational services must be prior approved in the participant's person-centered service plan, provided through a DPSQA-certified prevocational services provider, and delivered and documented consistent with requirements of the ARChoices provider manual.

Prevocational services exclude any services otherwise available to the participant under a program funded under section 110 of the Rehabilitation Act of 1973 (Rehab Act), the Individuals with Disabilities Education Act (IDEA), or any other federally funded (non-Medicaid) source. Proper documentation shall be maintained in the file of each participant receiving prevocational services under the waiver.

The amount of all prevocational services provided to any participant shall not exceed \$2,500 per lifetime.

The amount of career exploration activities provided per participant shall not exceed 30 hours.

The duration of prevocational services provided to any given participant shall be limited to 180 days (six months). Services not completed within this timeframe are not covered.

Fifteen (15) minutes of services equals one (1) unit.

Providers of Prevocational Services under the ARChoices Waiver program must be certified by the Division of Provider Services and Quality Assurance and must recertify annually.

Reimbursement is not permitted for prevocational services provided by a waiver participant's:

- A. Spouse;
- B. Legal guardian of the person; or,
- C. Attorney-in-fact granted authority to direct the participant's care.

213.700 Respite Care

10-1-22

Procedure Code	Description
T1005	Long-Term Facility-Based Respite Care
S5135	Short-Term Facility-Based Respite Care
S5150	In-Home Respite Care

Respite Care is provided to waiver participants unable to care for themselves and is furnished on a limited or short-term basis because of the absence of, or need for relief of, those persons normally providing the care.

Specifically, Respite Care consists of temporary care provided for short term relief for the primary caregiver, subject to the following:

- A. The participant lives at home and is cared for, without compensation, by their families or other informal support systems;
- B. As determined by the independent assessment, the participant has a severe physical, mental, or cognitive impairment(s) that prevents him or her from being left alone safely in the absence or unavailability of the primary caregiver;
- C. The primary caregiver to be relieved is identified and with sufficient documentation that he or she furnishes substantial care of the participant comparable to or in excess of services described under the Attendant Care service;
- D. No other alternative caregiver (e.g., other member of household, other family member) is available to provide a respite for the primary caregiver(s);
- E. Respite Care services are limited to (a) direct human assistance with specific Activities of Daily Living (ADLs), Instrumental Activities of Daily Living (IADLs), and health-related tasks as described under Attendant Care services and (b) supervision necessary to maintain the health and safety of the participant, as supported by the independent assessment and determined medically necessary by the PCSP/CC Nurse; and
- F. Respite Care solely serves to supplement (not replace) and otherwise facilitate the continued availability of care provided to waiver participants by families and other informal support systems.

Respite Care is available on a short-term basis (8 hours or less per date of service) or a long-term basis (a full 24 hours per date of service) because of the absence or need for relief of those persons who normally provide care for the participant. Respite Care is available to meet an emergency need or to schedule relief periods in accordance with the regular caregiver's need for temporary relief from continuous care giving.

Respite Care is available in the following locations:

- A. The Participant's home or place of residence;
- B. Medicaid-certified hospital;

- C. Medicaid-certified nursing facility;
- D. Medicaid-certified adult day health facility; and
- E. Medicaid-certified assisted living facility with a level II state license.

To allow the person who normally provides care for the waiver participant some time away from his or her caregiving of the participant, Respite Care may be provided in or outside the participant's home as follows:

- A. In-home respite may be provided for up to 24 hours per date of service.
- B. Facility-based respite care may be provided outside the participant's home on:
 - 1. A short-term basis (eight (8) hours or less per date of service), or
 - 2. A long-term (maximum of 24 hours per date of service and used most often when respite needed exceeds the short-term respite amount).

Reimbursement is only permitted for direct care rendered according to the participant's person-centered service plan by trained respite care workers employed and supervised by certified in-home respite providers.

Respite care is subject to the following limitations:

- C. The purpose of Respite Care is to provide respite for unpaid caregivers. The amount, frequency, and duration of Respite Care must be entirely consistent with the amounts, frequencies, and durations of assistance from unpaid caregivers identified and calculated for the participant in the completed form of the Arkansas Task and Hour Standards (THS). Any amounts, frequencies, or durations in excess of the unpaid caregiver assistance amounts identified for the participant in the THS are not covered.
- D. Respite Care excludes:
 - 1. Skilled health professional services, including physician, nursing, therapist, and pharmacist services.
 - 2. Services within the scopes of practice of licensed cosmetologists, manicurists, electrologists, or aestheticians, except for necessary assistance with personal hygiene and basic grooming;
 - 3. Services provided for any other person other than the participant;
 - 4. Companion, socialization, entertainment, or recreational services or activities of any kind, including, but not limited to, game playing, television watching, arts and crafts, hobbies, and other activities pursued for pleasure, relaxation, or fellowship; and
 - 5. Habilitation services, including but not limited to, assistance in acquiring, retaining, or improving self-help, socialization, and/or adaptive skills; and,
 - 6. Services provided for any tasks not included in a participant's service plans.
- E. Participants are limited to no more than 1,200 hours (4,800 quarter-hour units) per year of in-home respite care, facility-based respite care, or a combination thereof. Respite Care is not subject to a monthly or weekly limit but is limited to the annual amount of time identified and calculated for the participant in the completed form of the Arkansas Medicaid Task and Hour Standards.
- F. Respite Care services are not covered to provide continuous or substitute care while the primary caregiver(s) is working or attending school.
- G. Reimbursement is not permitted for Respite Care services provided by a waiver participant's:

1. Spouse;
2. Legal guardian of the person; or,
3. Attorney-in-fact granted authority to direct the participant's care.

In the event the in-home functional assessments performed by the Independent Assessment Contractor and the PCSP/CC Nurse substantiates a need for respite care services, the service will be authorized as needed, via the participant's PCSP, not to exceed an hourly maximum. The PCSP/CC Nurse will establish the service limitation based on the participant's medical need, other services included on the PCSP and support services available to the participant. Respite care services must be provided according to the participant's written PCSP subject to the participant's Individual Services Budget.

An individual living in the home with the participant is prohibited from serving as a Respite Services provider for the participant.

213.710 In-Home Respite Care

10-1-22

In-home respite care may be provided by licensed personal care or home health agencies. Reimbursement will be made for direct care rendered according to the participant's PCSP by trained respite workers employed and supervised by certified in-home respite providers.

Providers rendering respite care services in the participant's home must bill procedure code **S5150**. One (1) unit of service for procedure code **S5150** equals 15 minutes.

Eligible participants may receive up to 96 units of in-home respite care per date of service. For the state fiscal year (SFY), July 1 through June 30 each year, eligible participants may receive up to 4800 units (1200 hours) of In-Home Respite Care, or Facility-Based Respite Care or a combination of the two services.

When respite care is provided, the provision of or payment for other duplicate services under the waiver is prohibited. When a respite care provider is in the home to provide respite care services, the provider is responsible for all other in-home ARChoices services included on the participant's PCSP. For example, if attendant care services and/or home-delivered meals are included on the PCSP, the respite provider must provide these services while in the home. No other ARChoices service, other than PERS, may be reimbursed for the same time period.

213.711 Facility-Based Respite Care

10-1-22

Facility-based respite care may be provided outside the participant's home on a short- or long-term basis by residential care facilities, nursing facilities, adult day care facilities, adult day health care facilities, Level I and Level II Assisted Living Facilities and hospitals.

Facility-based providers rendering services for eight (8) hours or less per date of service must bill **S5135** for short-term, facility-based respite care. One (1) unit of service for procedure code **S5135** equals 15 minutes. Eligible participants may receive up to 32 units (8 hours) of short-term, facility-based respite care per date of service.

Facility-based providers rendering services for more than 32 units (8 hours) per day must bill **T1005** for long-term, facility-based respite care. One (1) unit of service for procedure code **T1005** equals 15 minutes. A participant may receive up to 96 units (24 hours) of service per date of service if the provider bills procedure code **T1005**.

Facility-based respite care services include short-term and long-term respite care services and can include any combination of billing codes **S5135** or **T1005**. A single provider may provide both long-term and short-term facility-based respite care services for a particular participant, but not on the same date of service.

Eligible participants may receive up to 4800 units (1200 hours) per State Fiscal Year of Facility-Based Respite Care- or In-Home Respite Care, or a combination of the two. Participants

receiving long-term, facility-based respite care services may receive only ARChoices Personal Emergency Response System (PERS) services concurrently.

Please refer to the NOTE found in Section 213.500 regarding Home-Delivered Meals and facility-based respite services.

213.712 In-Home Respite Care Certification Requirements

1-1-19

To be certified by the Division of Provider Services and Quality Assurance (DPSQA) as a provider of in-home respite care services, a provider must:

- A. Hold a current Class A and/or Class B Home Health Agency license or a Private Care Agency license to provide personal care and/or home health services as issued by the state licensing authority;
- B. Employ and supervise direct care staff trained and qualified to provide respite care services; and
- C. Agree to the minimum Assurances of Providers of ARChoices Waiver Services.

In-Home Respite Care providers as described in A. above must recertify with DPSQA annually; however, DPSQA must maintain a copy of the agency's current license at all times.

Providers are required to submit copy of renewed license to DPSQA.

213.713 Facility-Based Respite Care Certification Requirements

1-1-19

To be certified by the Division of Provider Services and Quality Assurance (DPSQA) as a provider of facility-based respite care services, a provider must be licensed in their state as one or more of the following:

- A. A licensed adult day care facility
- B. A licensed adult day health care facility
- C. A licensed nursing facility
- D. A licensed residential care facility
- E. A licensed Level I or Level II Assisted Living Facility
- F. A licensed hospital

Facility-Based Respite Care providers as listed above, must recertify with DPSQA annually; however, DPSQA must maintain a current copy of the facility's current license at all times.

214.000 Documentation

10-1-22

In addition to the service-specific documentation requirements previously listed, ARChoices 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 participant's PCSP
- B. A brief description of the specific service(s) provided
- C. The signature and title of the individual rendering the service(s)
 - 1. For records created through an electronic data system such as telephony, computer or other electronic devices, a unique identifier such as a PIN number assigned to and

entered by the employee at the time of data input may suffice as an electronic signature and title, and

- D. The date and actual time the service(s) was rendered. For Attendant Care or In-Home Respite Care, it is not necessary to itemize the time spent on each individual ADL or IADL task.

A provider's failure to maintain sufficient documentation to support his or her billing practices may result in recoupment of Medicaid payment.

No documentation for ARChoices services, as with all Medicaid services, may be made in pencil.

215.000 ARChoices Forms

10-1-22

ARChoices providers are required to utilize all program forms as appropriate and as instructed by the Division of Medical Services and the Division of Aging, Adult and Behavioral Health Services. These forms include but are not limited to:

- A. Person Centered Service Plan — AAS-9503
- B. Start Services — AAS-9510
- C. Participant Change of Status — AAS-9511

Providers may request form AAS-9511 by writing to the Division of Aging, Adult and Behavioral Health Services.

Forms AAS-9503 and AAS-9510 will be mailed to the provider by the PCSP/CC Nurse.

Instructions for completion and retention are included with each form. If there are questions regarding any ARChoices form, providers may contact the PCSP/CC Nurse in your area.

216.000 Retention of Records

1-1-16

See Section 142.300 for additional record keeping requirements.

217.000 Electronic Signatures

1-1-16

Medicaid will accept electronic signatures provided the electronic signatures comply with Arkansas Code 25-31-103.

240.000 PRIOR AUTHORIZATION

10-1-22

Attendant care, personal care and prevocational services provided under an authorized PCSP require prior authorization. Other services provided under the ARChoices Waiver program under an authorized PCSP do not require prior authorization. The PCSP signed by the DHS PCSP/CC Nurse serves as the authorization for ARChoices waiver services and Personal Care services.

250.000 REIMBURSEMENT

251.000 Method of Reimbursement

1-1-16

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

251.010 Fee Schedules

1-1-19

Arkansas Medicaid provides fee schedules on the Arkansas Medicaid website. The fee schedule link is located at <https://medicaid.mmis.arkansas.gov> under the provider manual section. The fees represent the fee-for-service reimbursement methodology.

Fee schedules do not address coverage limitations or special instructions applied by Arkansas Medicaid before final payment is determined.

Procedure codes and/or fee schedules do not guarantee payment, coverage or amount allowed. Information may be changed or updated at any time to correct a discrepancy and/or error. Arkansas Medicaid always reimburses the lesser of the amount billed or the Medicaid maximum.

252.000 Rate Appeal Process

1-1-16

A provider may request reconsideration of a program decision by writing to the Assistant Director, Division of Medical Services. This request must be received within 20 calendar days following the application of policy and/or procedure or the notification of the provider of its rate. Upon receipt of the request for review, the Assistant Director will determine the need for a Program/Provider conference and will contact the provider to arrange a conference if needed. Regardless of the Program decision, the provider will be afforded the opportunity for a conference, if he or she so wishes, for a full explanation of the factors involved and the Program decision. Following review of the matter, the Assistant Director will notify the provider of the action to be taken by the Division within 20 calendar days of receipt of the request for review or the date of the Program/Provider conference.

If the decision of the Assistant Director, Division of Medical Services is unsatisfactory, the provider may then appeal the question to a standing Rate Review Panel established by the Director of the Division of Medical Services which will include one member of the Division of Medical Services, a representative of the provider association and a member of the Department of Human Services (DHS) Management Staff who will serve as chairman.

The request for review by the Rate Review Panel must be postmarked within 15 calendar days following the notification of the initial decision by the Assistant Director, Division of Medical Services. The Rate Review Panel will meet to consider the question(s) within 15 calendar days after receipt of a request for such appeal. The question(s) will be heard by the panel and a recommendation will be submitted to the Director of the Division of Medical Services.

260.000 BILLING PROCEDURES

1-1-16

261.000 Introduction to Billing

10-1-22

ARChoices providers use the CMS-1500 form to bill the Arkansas Medicaid Program on paper for services provided to eligible Medicaid participants. Each claim may contain charges for only one (1) participant.

Section III of this manual contains information about available options for electronic claim submission.

261.100 Electronic Visit Verification (EVV)

1-1-24

Refer to Provider Manual Section 1, General Policy, subsection 145.000 for EVV requirements regarding attendant care and respite care services.

262.000 CMS-1500 Billing Procedures

262.100 HCPCS Procedure Codes

7-1-20

The following procedure codes must be billed for ARChoices Services.

Electronic and paper claims now require the same National Place of Service code.

Procedure Code	Modifiers	Description	Unit of Service	National POS for Claims
S5125	U2	Agency Attendant Care Traditional	15 minutes	12, 99
S5170	U2	Home-Delivered Meals	1 meal	12
S5170		Frozen Home-Delivered Meal	1 meal	12
S5170	U1	Emergency Home Delivered Meals	1 meal	12
S5161	UA	Personal Emergency Response System	1 day	12
S5160		Personal Emergency Response System – Installation	One install	12
S5100	U1	Adult Day Services, 8 to 20 units per date of service	15 minutes	99
S5100		Adult Day Services, 21 to 40 units per date of service	15 minutes	99
S5100	TD, U1	Adult Day Health Services, 8 to 20 units per date of service	15 minutes	99
S5100	TD	Adult Day Health Services, 21 to 40 units per date of service	15 minutes	99
S5150		Respite Care – In-Home	15 minutes	12
S5135		Respite Care – Short-Term Facility-Based	15 minutes	99, 21, 32
T1005		Respite Care – Long-Term Facility-Based	15 minutes	21, 32, 99
T2015		Prevocational Services Skills Development	15 minutes	11, 12, 99
T2015	U3	Prevocational Services Career Exploration	15 minutes	11, 12, 99

262.210 Place of Service Codes**10-1-22**

The national place of service (POS) code is used for both electronic and paper billing.

Place of Service	POS Codes
Inpatient Hospital	21
Participant's Home	12
Day Care Facility	99
Nursing Facility	32
Provider's Office	11
Other Locations	99

262.220 Rounding**7-1-20**

When a quotient contains decimals, look at the numbers after the decimal point.

- A. If the number after the decimal point is 500 (e.g., 3.500) or less (e.g., 3.495) round downward to the whole number displayed before the decimal point (three (3), in this example)
- B. If the number after the decimal is 501 (e.g., 3.501) or greater (e.g., 3.576) round upward to the whole number one (1) greater than the whole number displayed before the decimal point (four (4) in this example, because it is a whole number one greater than three (3)).

262.300 Billing Instructions – Paper Only**10-1-22**

Bill Medicaid for ARChoices services with form CMS-1500. The numbered items in the following instructions correspond to the numbered fields on the claim form. [View a sample form CMS-1500.](#)

Carefully follow these instructions to help the Arkansas Medicaid fiscal agent efficiently process claims. Accuracy, completeness and clarity are essential. Claims cannot be processed if necessary information is omitted.

Forward completed claim forms to the Claims Department. [View or print the Claims Department contact information.](#)

NOTE: A provider delivering services without verifying participant eligibility for each date of service does so at the risk of not being reimbursed for the services.

The Arkansas Medicaid Program considers a participant an inpatient of a facility beginning with the date of admission. Therefore, payment to the inpatient facility begins on the date of admission. Payment to the inpatient facility does not include the date of discharge.

Payment for ARChoices services may be allowed for the date of a participant's admission to an inpatient facility if the provider can provide verification that services were provided before the participant was admitted. In order for payment to be allowed, providers are responsible for obtaining the following:

- Copies of claim forms or timesheets listing the times that services were provided
- A statement from the inpatient facility showing the time that the participant was admitted

- This information must be submitted to DAABHS within 10 working days of receiving a request for verification.

If providers are unable to provide proof that ARChoices services were provided before the participant was admitted to the inpatient facility, then payments will be subject to recoupment. ARChoices services provided on the same day the participant is discharged from the inpatient facility are billable when provided according to policy and after the participant was discharged.

262.310 Completion of CMS-1500 Claim Form**10-1-22**

Field Name and Number		Instructions for Completion
1.	(type of coverage)	Not required.
1a.	INSURED'S I.D. NUMBER (For Program in Item 1)	Participant's 10-digit Medicaid or ARKids First-A or ARKids First-B identification number.
2.	PATIENT'S NAME (Last Name, First Name, Middle Initial)	Participant's last name and first name.
3.	PATIENT'S BIRTH DATE	Participant's date of birth as given on the participant's Medicaid or ARKids First-A or ARKids First-B identification card. Format: MM/DD/YY.
	SEX	Check M for male or F for female.
4.	INSURED'S NAME (Last Name, First Name, Middle Initial)	Required if insurance affects this claim. Insured's last name, first name and middle initial.
5.	PATIENT'S ADDRESS (No., Street)	Optional. Participant's complete mailing address (street address or post office box).
	CITY	Name of the city in which the participant resides.
	STATE	Two-letter postal code for the state in which the participant resides.
	ZIP CODE	Five-digit zip code; nine digits for post office box.
	TELEPHONE (Include Area Code)	The participant's telephone number or the number of a reliable message/contact/ emergency telephone.
6.	PATIENT RELATIONSHIP TO INSURED	If insurance affects this claim, check the box indicating the patient's relationship to the insured.
7.	INSURED'S ADDRESS (No., Street)	Required if insured's address is different from the patient's address.
	CITY	
	STATE	
	ZIP CODE	
	TELEPHONE (Include Area Code)	
8.	RESERVED	Reserved for NUCC use.
9.	OTHER INSURED'S NAME (Last name, First Name, Middle Initial)	If patient has other insurance coverage as indicated in Field 11d, the other insured's last name, first name and middle initial.

Field Name and Number	Instructions for Completion
a. OTHER INSURED'S POLICY OR GROUP NUMBER	Policy and/or group number of the insured participant.
b. RESERVED	Reserved for NUCC use.
SEX	Not required.
c. RESERVED	Reserved for NUCC use.
d. INSURANCE PLAN NAME OR PROGRAM NAME	Name of the insurance company.
<hr/>	
10. IS PATIENT'S CONDITION RELATED TO:	
a. EMPLOYMENT? (Current or Previous)	Check YES or NO.
b. AUTO ACCIDENT?	Required when an auto accident is related to the services. Check YES or NO.
PLACE (State)	If 10b is YES, the two-letter postal abbreviation for the state in which the automobile accident took place.
c. OTHER ACCIDENT?	Required when an accident other than automobile is related to the services. Check YES or NO.
d. CLAIM CODES	The "Claim Codes" identify additional information about the participant's condition or the claim. When applicable, use the Claim Code to report appropriate claim codes as designated by the NUCC. When required to provide the subset of Condition Codes, enter the condition code in this field. The subset of approved Condition Codes is found at www.nucc.org under Code Sets.
<hr/>	
11. INSURED'S POLICY GROUP OR FECA NUMBER	Not required when Medicaid is the only payer.
a. INSURED'S DATE OF BIRTH	Not required.
SEX	Not required.
b. OTHER CLAIM ID NUMBER	Not required.
c. INSURANCE PLAN NAME OR PROGRAM NAME	Not required.
d. IS THERE ANOTHER HEALTH BENEFIT PLAN?	When private or other insurance may or will cover any of the services, check YES and complete items 9, 9a and 9d. Only one box can be marked.
<hr/>	
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE	Enter "Signature on File," "SOF" or legal signature.

Field Name and Number	Instructions for Completion
13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE	Enter "Signature on File," "SOF" or legal signature.
14. DATE OF CURRENT: ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)	<p>Required when services furnished are related to an accident, whether the accident is recent or in the past. Date of the accident.</p> <p>Enter the qualifier to the right of the vertical dotted line. Use Qualifier 431 Onset of Current Symptoms or Illness; 484 Last Menstrual Period.</p>
15. OTHER DATE	<p>Enter another date related to the participant's condition or treatment. Enter the qualifier between the left-hand set of vertical, dotted lines.</p> <p>The "Other Date" identifies additional date information about the participant's condition or treatment. Use qualifiers:</p> <p>454 Initial Treatment</p> <p>304 Latest Visit or Consultation</p> <p>453 Acute Manifestation of a Chronic Condition</p> <p>439 Accident</p> <p>455 Last X-Ray</p> <p>471 Prescription</p> <p>090 Report Start (Assumed Care Date)</p> <p>091 Report End (Relinquished Care Date)</p> <p>444 First Visit or Consultation</p>
16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION	Not required.
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	Primary Care Physician (PCP) referral is not required for ARChoices services. If services are the result of a Child Health Services (EPSDT) screening/referral, enter the referral source, including name and title.
17a. (blank)	Not required.
17b. NPI	Enter NPI of the referring physician.
18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES	When the serving/billing provider's services charged on this claim are related to a participant's or inpatient's hospitalization, enter the participant's admission and discharge dates. Format: MM/DD/YY.
19. ADDITIONAL CLAIM INFORMATION	Identifies additional information about the participant's claim. Enter the appropriate qualifiers describing the identifier. See www.nucc.org for qualifiers.
20. OUTSIDE LAB?	Not required.
\$ CHARGES	Not required.

Field Name and Number	Instructions for Completion
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY	<p>Enter the applicable ICD indicator to identify which version of ICD codes is being reported.</p> <p>Use "9" for ICD-9-CM.</p> <p>Use "0" for ICD-10-CM.</p> <p>Enter the indicator between the vertical, dotted lines in the upper right-hand portion of the field.</p> <p>Diagnosis code for the primary medical condition for which services are being billed. Use the appropriate International Classification of Diseases (ICD). List no more than 12 diagnosis codes. Relate lines A-L to the lines of service in 24E by the letter of the line. Use the highest level of specificity.</p>
22. RESUBMISSION CODE ORIGINAL REF. NO.	<p>Reserved for future use.</p> <p>Any data or other information listed in this field does not/will not adjust, void or otherwise modify any previous payment or denial of a claim. Claim payment adjustments, voids and refunds must follow previously established processes in policy.</p>
23. PRIOR AUTHORIZATION NUMBER	<p>The prior authorization or benefit extension control number if applicable.</p>
24A. DATE(S) OF SERVICE	<p>The "from" and "to" dates of service for each billed service. Format: MM/DD/YY.</p> <ol style="list-style-type: none"> 1. On a single claim detail (one charge on one line), bill only for services provided within a single calendar month. 2. Some providers may bill on the same claim detail for two or more sequential dates of service within the same calendar month when the provider furnished equal amounts of the service on each day of the date sequence.
B. PLACE OF SERVICE	<p>Enter the appropriate place of service code. See Section 262.200 for codes.</p>
C. EMG	<p>Enter "Y" for "Yes" or leave blank if "No." EMG identifies if the service was an emergency.</p>
D. PROCEDURES, SERVICES, OR SUPPLIES CPT/HCPCS MODIFIER	<p>One CPT or HCPCS procedure code for each detail.</p> <p>Modifier(s) if applicable.</p>

Field Name and Number		Instructions for Completion
E.	DIAGNOSIS POINTER	Enter the diagnosis code reference letter (pointer) as shown in Item Number 21 to relate to the date of service and the procedures performed to the primary diagnosis. When multiple services are performed, the primary reference letter for each service should be listed first; other applicable services should follow. The reference letter(s) should be A-L or multiple letters as applicable. The "Diagnosis Pointer" is the line letter from Item Number 21 that relates to the reason the service(s) was performed.
F.	\$ CHARGES	The full charge for the service(s) totaled in the detail. This charge must be the usual charge to any participant, patient, or other participant of the provider's services.
G.	DAYS OR UNITS	The units (in whole numbers) of service(s) provided during the period indicated in Field 24A of the detail.
H.	EPSDT/Family Plan	Not required for ARChoices.
I.	ID QUAL	Not required.
J.	RENDERING PROVIDER ID #	Enter the 9-digit Arkansas Medicaid provider ID number of the individual who furnished the services billed for in the detail or
	NPI	Enter NPI of the individual who furnished the services billed for in the detail.
25.	FEDERAL TAX I.D. NUMBER	Not required. This information is carried in the provider's Medicaid file. If it changes, please contact Provider Enrollment.
26.	PATIENT'S ACCOUNT N O.	Optional entry that may be used for accounting purposes; use up to 16 numeric or alphabetic characters. This number appears on the Remittance Advice as "MRN."
27.	ACCEPT ASSIGNMENT?	Not required. Assignment is automatically accepted by the provider when billing Medicaid.
28.	TOTAL CHARGE	Total of Column 24F—the sum all charges on the claim.
29.	AMOUNT PAID	Enter the total of payments previously received on this claim. Do not include amounts previously paid by Medicaid. Do not include in this total the automatically deducted Medicaid co-payments.
30.	RESERVED	Reserved for NUCC use.
31.	SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS	The provider or designated authorized individual must sign and date the claim certifying that the services were personally rendered by the provider or under the provider's direction. "Provider's signature" is defined as the provider's actual signature, a rubber stamp of the provider's signature, an automated signature, a typewritten signature, or the signature of an individual authorized by the provider rendering the service. The name of a clinic or group is not acceptable.

Field Name and Number	Instructions for Completion
32. SERVICE FACILITY LOCATION INFORMATION	If other than home or office, enter the name and street, city, state and zip code of the facility where services were performed.
a. (blank)	Not required.
b. (blank)	Not required.
33. BILLING PROVIDER INFO & PH #	Billing provider's name and complete address. Telephone number is requested but not required.
a. (blank)	Enter NPI of the billing provider or
b. (blank)	Enter the 9-digit Arkansas Medicaid provider ID number of the billing provider.

262.400 Special Billing Procedures – Environmental Modifications/Adaptive Equipment

10-1-22

Prior to payment for this service, the participant is required to secure three separate itemized bids for the same service. The bids are reviewed by the PCSP/CC Nurse or designee prior to submission for Medicaid payment. If only two bids can be secured due to a shortage of qualified providers in the service area, documentation attesting to the attempt to secure bids and the shortage of providers must be provided.

Each claim must be signed by the provider, the participant, and PCSP/CC Nurse, or designee. A statement of satisfaction form must be signed by the participant prior to any claim being submitted. Please refer to 213.290 for additional information.