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Division of Medical Services
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TO: **Health Care Provider—Personal Care**

DATE: **January 1, 2003**

SUBJECT: **Update Transmittal No. 50**

REMOVE		INSERT	
Page	**Date**	**Page**	**Date**
Table of Contents	Dates vary	Table of Contents	1-1-03
I-26	8-1-01	I-26	1-1-03
II-1 through II-43	Dates vary	II-1 through II-43	1-1-03
II-55 through II-59	1-1-01	II-55 through II-57	1-1-03
III-29	8-1-02	III-29	1-1-03
III-35 through III-38	8-1-02	III-35 through III-38	1-1-03

Explanation of Updates

Page I-26: A new specialty has been added.

Section II section numbers throughout this update transmittal, except section 221, have been converted to six digits to conform with a new numbering system being implemented by the Division of Medical Services.

Pages II-1 through II-2A, sections 201.100 through 201.150: Clarification has been added to the effect that the "application" and "contract" referred to in these sections are the provider application, which is form DMS-652, and the Medicaid contract, which is form DMS-653.

Page II-2A, section 201.160: This is a new section explaining that school districts and education service cooperatives may enroll as personal care providers, effective for dates of service on and after January 1, 2003. Section 201.200 on this page was previously numbered 201.210. Its text is unchanged. Section 201.210 was previously numbered 201.200. A reference to other sections has been updated.

Page II-2B, sections 201.211 and 201.300: An error in expressing the time of day has been corrected in section 201.211. This section was previously on page II-2A. Section 201.300 has been renumbered. It has been updated to include the prudent layperson standard for an emergency medical condition. Part C provides additional details regarding personal care for clients temporarily in another state. The address of the Utilization Review Section has been updated.

Explanation of Updates (Continued)

Page II-2C, sections 201.310 and 202.000: Section 201.310 was previously numbered 201.300 and was on another page. Its text is unchanged. Obsolete text has been deleted from section 202.000. Additional text in part B is for clarification. Form numbers of the provider application and Medicaid contract have been added to subpart 1 of part C. A section reference in part D has been updated. Other revisions are to enhance readability.

Page II-3, sections 210.000 through 213.000: In sections 210.000 and 211.000, obsolete and unnecessary text has been deleted. Sections 212.000 and 213.000 were previously 212 and 213 and were on page II-4. They have been reformatted only; there are no policy revisions. Heading numbers and cross-referencing have been updated.

Page II-4, sections 213.100 through 213.120: In section 213.100 and 213.110 redundant information has been deleted. References have been updated. In subpart 3, part B of section 213.110, aid category names have been added. Section 213.120 previously was numbered 213.02 and it began on page II-5.

Page II-5, section 213.200: Section 213.200 was previously numbered 213.03. Part D of former section 213.03 has become part A of section 213.200. References have been updated.

Page II-6, sections 213.300 and 213.310: Section 213.300 was formerly 213.10. Section 213.310 was previously 211.10 and was on another page. Revisions to the text are to condense and clarify information.

Page II-7, sections 213.500 and 213.510: Section 213.500 combines the former sections 213.50 and 213.60. The word "law" in part A has been changed to "regulations". Parts D and E have been moved from elsewhere and only references have been revised. Section 213.510 was formerly 213.70 and was on another page. References have been updated.

Page II-8: sections 213.511 and 213.512: Section 213.511 was previously numbered 213.71. It includes a minor text revision for clarity. Section 213.512 was previously 213.72. It has been revised to include a comprehensive definition of the public school place of service.

Page II-9, section 213.600: This section was previously numbered 213.80. Part A contains minor revisions.

Page II-10, sections 213.610 and 214.000: Section 213.610 is a new section, added to correct an oversight in previous updates. Section 214.000 was previously numbered 213.20.

Pages II-11 and II-12, section 214.100: This section was formerly section 213.21. The few text revisions are for clarity and readability and do not represent new policy. In subpart 2 of part I, the word "assessment" has been changed to "evaluation" for consistency.

Page II-12, sections 214.110 and 214.200: Section 214.110 was formerly 213.220. Much of the content has been moved to other sections, leaving only the parts directly related to the physician's notification of service plan authorization. Section 214.200 was formerly 213.230.

Page II-13, sections 215.000 through 215.200: Section 215.000 contains a new heading. Section 215.100 was formerly numbered 213.320. Section 215.200 was formerly 213.300.

Explanation of Updates (Continued)

Page II-14, sections 215.200 and 215.210: Part G of section 215.200 was added for consistency with requirements found at sections 220.110 through 220.112. ***It does not require providers to revise assessments or service plans that are in force on January 1, 2003. Providers must ensure that they follow the guidelines in part G, section 215.200 when assessing individuals whose service plans go into effect on and after January 1, 2003***. Section 215.210 was previously section 213.310. A new part A has been added to state that using alternative resources of assistance is not required when other rules or laws inhibit or prevent doing so. Other revisions to this section are for reformatting and clarity.

Pages II-15 through II-16A, section 215.300: This section was previously 213.400. An error was corrected in subpart c of part 1 of part G by changing the words “service plan” to “registered nurse”. A new part H has been added for consistency with requirements found at sections 220.110 through 220.112. Other revisions in this section are the result of reformatting and minor grammatical corrections.

Pages II-16B and II-17, sections 215.310 through 215.330: Section 215.310 was formerly numbered 213.410 and contains only reformatting revisions and minor wording changes for clarity. Sections 215.320 and 215.330 were formerly numbered 213.44 and 213.430.

Page II-18, sections 215.340 and 215.350: Section 215.340 was formerly numbered 213.45. Section 215.350 was formerly numbered 213.421.

Pages II-19 and II-20, sections 215.360 through 216.140: Section 215.360 was formerly numbered 213.422. All general coverage information is now in section 216.000. The content of sections 216.000 through 216.140 has not been changed. These sections have only been edited for clarity and renumbered. In section 216.140 the word "reimbursable" has been replaced with the word "covered".

Page II-20A, section 216.201: Section 216.201 is a new section regarding simultaneous services and congregate settings. It has been inserted here to ensure continuity with requirements at section 216.211, sections 220.110 through 220.112 and section 220.200.

Pages II-20A through II-21, section 216.211: The word "billed" has been replaced with the word "logged". Three references to "subpart E" have been changed to "part E". A reference in part 1 of part E to “reimbursement” has been changed to use the word “covered”. Cross-references in part F have been updated.

Page II-22, section 216.212: Cross-references have been updated.

Page II-22A, section 216.220: Parts 1, 2 and 3 of part B have been combined into two parts, 1 and 2, and reworded for clarity. In part D, cross-references have been updated.

Page II-23, sections 216.230, 216.240, and 216.250: In part D of each section, cross-references have been updated.

Page II-24, section 216.260: Cross-references have been updated. Section 216.270 is a new section, added to correct an oversight. Assistance with ambulation and mobility is a covered personal care service.

Page II-24A is a new page, added because of printing adjustments. Cross-references have been updated in section 216.300.

Explanation of Updates (Continued)

Pages II-25 and II-26, sections 216.310 through 216.320: Cross-references have been updated.

Page II-26, section 216.330: This section has been reorganized for readability and cross-references have been updated.

Page II-27, section 216.330: A wording change was made in part D to emphasize coverage rather than reimbursement. A similar change was made in section 216.400, part 2 of part B.

Page II-28, section 217.000: Part B was previously part C. The former part C has been deleted. Utilization Review's slot number has been updated.

Page II-29, section 217.100: Subpart 1 of part A contains new instructions regarding the use of the form DMS-618. Parts 2 and 3 of part A include updated cross-references. Section 217.110 was formerly numbered 217.21.

Page II-30, section 217.120 and section 218.000: Section 217.120 was formerly section 217.22. Section 218.000 was formerly 219.000 and was on page II-38. The slot number for Appeals and Hearings Section has been updated.

Pages II-31 through II-37, form DMS-618: This is the most recent revision of this form.

Page II-38, sections 220.000 and 220.100: These sections were previously on page II-39. A grammatical correction has been made in part 2 of part A of section 220.100. Section 220.100 was previously numbered 220.00.

Page II-39, section 220.100: Grammar and punctuation have been corrected on this page.

Page II-40, section 220.110: An introductory paragraph has been added. Parts A, B and C were previously parts A, B and C of section 220.210. Parts D, E and F were parts A, B and C of former section 220.10. Part F of 220.10 was merged with former part A of 220.10 to create part D. Some revisions have been made to emphasize service coverage rather than reimbursement.

Page II-41, section 220.110: In part 4 of part E, the word "tasks" has been changed to "activities". The same change was made in part F.

Page II-41, section 220.111: This section was formerly part D of section 220.10.

Page II-42, sections 220.112 through 220.210: Section 202.112 was formerly part E of section 220.10. It has been revised to replace the word "task" with the words "routine or activity of daily living". Section 220.200 was previously part D of section 220.210. Section 220.210 was formerly section 220.220 and was on page II-43.

Page II-43, sections 220.211 and 220.212: Section 220.211 was formerly section 220.221. Section 220.212 was formerly section 220.222.

Page II-55, sections 240.000 through 242.000: A new part C in section 240.000 includes the disclaimer that prior authorization of a service does not guarantee payment. Part A of section 242.000 has been revised to reflect current requirements.

Page II-56, sections 243.000 and 244.000: These sections have been renumbered and/or reformatted.

Explanation of Updates (Continued)

Page II-57, sections 245.000 and 246.000: These sections were formerly 245 and 246 respectively, and have been renumbered. They previously appeared on page II-59. The new slot number for Appeals and Hearings Section has been added to section 246.000.

Page III-29: This page has been included to update cross-references to billing information.

Page III-35, sections 312.000 through 312.210: In sections 312.000 and 312.100 private care agency billing instructions have been reformatted only. A new heading has been added for reference purposes in section 312.200 and section 312.210. The section formerly numbered 313.02 has been renumbered 312.210 and moved to this page from page II-36A.

Page III-36, sections 312.220 and 312.230: The information in section 312.220 was previously in section 313.03. Obsolete information has been deleted and the section renumbered. Section 312.230 is a new section of billing instructions for personal care in a public school for dates of service on and after January 1, 2003.

Pages III-37 and III-38 are now reserved pages.

A change bar in the left margin denotes a revision.

Attached are updated pages to file in your provider manual.

If you need this material in an alternative format, such as large print, please contact our Americans with Disabilities Act Coordinator at (501) 682-6789 and 1-877-708-8191. Both telephone numbers are voice and TDD.

If you have questions regarding this transmittal, please contact the EDS Provider Assistance Center at 1-800-457-4454 (Toll-Free) within Arkansas or locally and Out-of-State at (501) 376-2211.

Thank you for your participation in the Arkansas Medicaid Program.

Kurt Knickrehm, Director
Department of Human Services

Arkansas Medicaid provider manuals (including update transmittals), official notices and remittance advice (RA) messages are available for downloading from the Arkansas Medicaid website: **www.medicaid.state.ar.us.**

9) Provider Category (Continued)

Code	Category Description
W7	Hospital - Outpatient
CH	Hospital – Critical Access
P7	Hospital - Pediatric Inpatient
R7	Hospital - Rural Inpatient
H4	Hyperalimentation
V8	Immunization (Health Dept. Only)
69	Independent Lab
55	Infectious Diseases
W3	Inpatient Psychiatric - under 21
WA	Inpatient Psychiatric - Residential Treatment Unit within Inpatient Psychiatric Hospital
WB	Inpatient Psychiatric - Residential Treatment Center
WC	Inpatient Psychiatric - Sexual Offenders Program
W4	Intermediate Care Facility
W5	Intermediate Care Facility - Mentally Retarded
11	Internal Medicine
L1	Larynology
M1	Maternity Clinic (Health Dept. Only)
M4	Medicare/Medicaid Crossover Only
WI	Mental Health Practitioner – Licensed Certified Social Worker
W2	Mental Health Practitioner – Licensed Professional Counselor
R5	Mental Health Practitioner – Licensed Marriage and Family Therapist
62	Mental Health Practitioner - Psychologist
N1	Neonatology
39	Nephrology
13	Neurology
N2	Nurse Midwife
N3	Nurse Practitioner
N4	Nurse Practitioner - OB/GYN
RK	Offsite Intervention Service - Outpatient Mental and Behavioral Health (ARKids ONLY)
X1	Oncology
18	Ophthalmology
X4	Optometrist
X6	Orthopedic
12	Osteopathy - Manipulative Therapy
X7	Osteopathy - Radiation Therapy
X8	Otology
X9	Otorhinolaryngology
22	Pathology
37	Pediatrics
P1	Personal Care Services
PA	Personal Care Services / Area Agency on Aging
PD	Personal Care Services / Developmental Disability Services
PE	Personal Care Services / Week-end
R3	Personal Care Services / Residential Care Facility
PS	Personal Care Services: Public School or Education Service Cooperative
P2	Pharmacy
P3	Physical Medicine
48	Podiatrist
63	Portable X-ray Equipment
P6	Private Duty Nursing
28	Proctology
P4	Prosthetic Devices
V4	Prosthetic - Durable Medical Equipment/Oxygen
Z1	Prosthetic - Orthotic Appliances
26	Psychiatry
P5	Psychiatry - Child

(9) Provider Category (Continued)

Code	Category Description
29	Pulmonary Diseases
R9	Radiation Therapy - Complete
RA	Radiation Therapy - Technical
30	Radiology - Diagnostic
31	Radiology - Therapeutic
R6	Rehabilitative Services for Persons with Mental Illness
RC	Rehabilitative Services for Persons with Physical Disabilities
R1	Rehabilitative Hospital
RH	Rehabilitative Hospital-extended Services
R4	Rheumatology
R2	Rural Health Clinic - Provider Based
R8	Rural Health Clinic - Independent Freestanding
S7	School Based Health Clinic - Child Health Services
S8	School Based Health Clinic - Hearing Screener
S9	School Based Health Clinic - Vision Screener
SA	School Based Health clinic - Vision & Hearing Screener
VV	School Based Mental Health Clinic
S5	Skilled Nursing Facility
S6	SNF Hospital Distinct Part Bed
S1	Surgery - Cardio
S2	Surgery - Colon & Rectal
O2	Surgery - General
14	Surgery - Neurological
20	Surgery - Orthopedic
53	Surgery - Pediatric
54	Surgery - Oncology
24	Surgery - Plastic & Reconstructive
33	Surgery - Thoracic
S4	Surgery - Vascular
C5	Targeted Case Management - Ages 60 and Older
C6	Targeted Case Management - Ages 00 - 20
C7	Targeted Case Management - Ages 21 - 59
T6	Therapy - Occupational
T1	Therapy - Physical
T2	Therapy - Speech Pathologist
TO	Therapy - Occupational Assistant
TP	Therapy - Physical Assistant
TS	Therapy - Speech Pathologist Assistant
A1	Transportation - Ambulance, Emergency
A2	Transportation - Ambulance, Non-emergency
A6	Transportation - Advanced Life Support with EKG
A7	Transportation - Advanced Life Support without EKG
TA	Transportation - Air Ambulance/Helicopter
TB	Transportation - Air Ambulance/Fixed Wing
TC	Transportation - Non-Emergency
T5	Transportation - Non-Public
T7	Transportation - Transportation Intra State Authority
T8	Transportation - Transportation Accessible Van, Intra City
T9	Transportation – Accessible Van, Intra State Authority
34	Urology
V7	Ventilator Equipment
ZZ	Other

200.000 PERSONAL CARE GENERAL INFORMATION

201.000 Arkansas Medicaid Participation Requirements for Personal Care Providers

201.100 Provider Enrollment

A. See Section I of this manual for provider application materials and instructions.

B. An applicant for enrollment in the Arkansas Medicaid Personal Care Program must complete a provider application (form DMS-652) and Medicaid contract (DMS-653).

C. An applicant must submit, in addition to the provider application and Medicaid contract, documents detailed in the appropriate section 201.110 through 201.160.

D. The Medicaid contract and provider application must receive approval from the Arkansas Medicaid Program.

201.110 Class A Home Health Agencies

A. A Class A Home Health agency applying to enroll as a personal care provider must submit a provider application (form DMS-652) and Medicaid contract (form DMS-653).

B. A Class A Home Health agency applying to enroll as a personal care provider must be licensed by the Division of Health Facility Services, Arkansas Department of Health. The applicant must submit a copy of the license with the provider application and Medicaid contract.

C. The Arkansas Home Health State Survey Agency must certify the applicant as a participant in the Title XVIII (Medicare) Program. The applicant must submit a copy of the Medicare certification with the provider application and Medicaid contract.

D. As a condition of continuing enrollment, providers must submit license and certification renewals upon the issuance of those documents. Failure to update license and certification information will result in suspension from the Medicaid Program.

201.120 Private Care Agencies

A. A private care agency enrolling as a personal care provider must submit a provider application (form DMS-652) and Medicaid contract (form DMS-653).

B. A private care agency enrolling as a personal care provider must be licensed by the Arkansas Department of Health. The provider must submit a copy of the license with the provider application and Medicaid contract.

C. Private care agencies must also submit a current license from the Arkansas Department of Labor.

201.120 Private Care Agencies (Continued)

D. Private care agencies must submit proof of Arkansas Department of Labor licensure effective on or before January 1, 1999.

E. Private care agencies must submit a copy of the agency's contract as a provider in the Arkansas Medicaid ElderChoices Program, with an effective date on or before January 1, 1999.

F. Private care agencies must submit proof of liability insurance coverage of not less than one million dollars ($1,000,000.00), covering their employees and independent contractors while they are engaged in providing services.

G. As a condition of continuing enrollment, providers must submit license and certification renewals upon the issuance of those documents. Failure to update license and certification information will result in suspension from the Medicaid Program.

201.130 Residential Care Facilities

A. A residential care facility enrolling as a personal care provider must submit a provider application (form DMS-652) and Medicaid contract (form DMS-653).

B. A residential care facility enrolling as a personal care provider must be licensed by the Arkansas Office of Long Term Care. The provider must submit a copy of the license with the provider application and Medicaid contract.

C. As a condition of continuing enrollment, providers must submit license and certification renewals upon the issuance of those documents. Failure to update license and certification information will result in suspension from the Medicaid Program.

201.140 Developmental Disabilities Services Community Providers

A. A Developmental Disabilities Services Community Provider enrolling as a personal care provider must submit a provider application (DMS-652) and Medicaid contract (DMS-653).

B. A Developmental Disabilities Services Community Provider enrolling as a personal care provider must be licensed by the Arkansas Division of Developmental Disabilities Services. The provider must submit a copy of the license with the provider application and Medicaid contract.

C. As a condition of continuing enrollment, providers must submit license and certification renewals upon the issuance of those documents. Failure to update license and certification information will result in suspension from the Medicaid Program.

201.150 Class B Home Health Agencies

A. A Class B Home Health agency enrolling as a personal care provider must submit a provider application (form DMS-652) and Medicaid contract (form DMS-653).

B. A Class B Home Health agency enrolling as a personal care provider must be licensed by the Arkansas Department of Health. The provider must submit a copy of the license with the provider application and Medicaid contract.

C. As a condition of continuing enrollment, providers must submit license and certification renewals upon the issuance of those documents. Failure to update license and certification information will result in suspension from the Medicaid Program.

201.160 School Districts and Education Service Cooperatives

Effective for dates of service on and after January 1, 2003, school districts and education service cooperatives may enroll as personal care providers.

A. A school district or education service cooperative must be certified as a Local Educational Agency (LEA) by the Arkansas Department of Education. The Arkansas Department of Education will provide verification of LEA certification to the Provider Enrollment Unit of the Division of Medical Services.

B. The school district or education service cooperative must complete a provider application (form DMS-652) and Medicaid contract (form DMS-653) for enrollment as a personal care provider and must be approved by the Arkansas Medicaid Program. (See Section I of this manual.)

201.200 Routine Service Providers

A. Routine service providers may enroll in the program as providers of routine services.

B. Reimbursement may be available for personal care services covered in the Arkansas Medicaid Program.

C. Enrolled providers must file claims in accordance with Section III of this manual. Correct filing of claims includes assignment of ICD-9-CM and HCPCS codes for all services furnished.

201.210 Personal Care Providers in Arkansas

Personal care providers in Arkansas may enroll as routine service providers if they meet all applicable Arkansas Medicaid participation requirements in sections 201.000 through 201.160 of this manual.

201.211 Private Care Agencies

Private care agencies meeting provider enrollment criteria may enroll as routine service providers of personal care for weekend hours only. Medicaid defines weekend hours as the hours from 12:00 AM Saturday through 11:59 PM Sunday.

201.300 Limited Service Providers

Limited service providers may enroll in the Arkansas Medicaid Program to provide emergency services or prior authorized services only.

A. Emergency services are services furnished in response to an emergency medical condition. An emergency medical condition is a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part.

B. With respect to limited service providers, services eligible for prior authorization are medically necessary services that are not available in Arkansas (See part C immediately below for the single exception to this rule). Prior authorization must be obtained before the care is provided.

C. On rare occasions a personal care client may have urgent cause to travel to a locality outside his or her personal care provider's service area. When that locality is in another state, the Arkansas Medicaid Program may allow a personal care provider in that state to enroll as a limited services provider to furnish the client's services for the duration of the stay. Personal care for clients temporarily in another state requires prior authorization and is subject to the additional regulations at sections 213.600 and 213.610.

1. Send written requests for prior authorization to:

Division of Medical Services
Utilization Review Section
P.O. Box 1437, Slot S413
Little Rock, AR 72203-1437

2. Upon notification of the prior authorization, the provider may submit the provider application (form DMS-652) and Medicaid contract (form DMS-653).

3. Prior authorization does not guarantee payment for the service.

   a. The recipient must be Medicaid-eligible on the dates of service and must have available benefits..

   b. The provider must follow the enrollment procedures in Section I of this manual and the billing procedures in Section III of this manual.

201.300 Limited Service Providers (Continued)

4. Limited service providers must submit their claims to:

Division of Medical Services
Utilization Review Section
P.O. Box 1437, Slot S413
Little Rock, AR 72203-1437

201.310 Personal Care Providers Not Licensed in Arkansas

Personal care providers licensed only in other states may not provide services in Arkansas. Providers that are licensed in other states and that are not licensed in Arkansas are eligible to enroll in Arkansas Medicaid as limited service providers only.

202.000 IndependentChoices Waiver; Counseling and Fiscal Agent Enrollment

IndependentChoices is a Cash and Counseling Demonstration and Evaluation Project. IndependentChoices seeks to increase the opportunity for consumer direction and control for Medicaid recipients receiving or needing personal care by offering a cash allowance and counseling services in place of traditionally provided personal care.

A. The goal of the IndependentChoices Program is to evaluate the efficiency and feasibility of a Medicaid personal care program that offers consumer direction and control with a monthly cash allowance.

B. As the single State agency authorized to contract for Medicaid services, the Department of Human Services (DHS) developed and received approval of a Section 1115 research and demonstration waiver to provide IndependentChoices to adults (ages 18 and older) with disabilities and the elderly (aged 65 and older). IndependentChoices is administered by the Division of Aging and Adult Services (DAAS).

C. The Division of Medical Services contracts with counseling agencies to provide counseling and fiscal services. The counseling and fiscal agent services agencies have been selected through a Request for Proposal (RFP) process. One Counseling and Fiscal Agent (CFA) has been selected for each of four regions.

1. Each CFA selected must submit a provider application (form DMS-652) and Medicaid contract (form DMS-653) to the Division of Medical Services, Provider Enrollment Unit for enrollment as a Medicaid provider.

2. Each CFA must submit to Provider Enrollment a letter from DAAS verifying that the CFA has DAAS approval to enroll as a Medicaid provider.

210.000 PROGRAM COVERAGE

211.000 Program Authority

A. Title XIX of the Social Security Act authorizes personal care services as an optional State Plan benefit.

B. The Arkansas Medicaid Program has elected to offer personal care services benefits in conformity with the rules set out in Section II of this manual.

212.000 Program Purpose

A. The purpose of Personal Care Program services is to supplement, not to supplant other resources available to the client.

B. Personal care services are medically necessary services, authorized by an attending physician and individually designed to assist clients with their physical dependency needs as described in section 213.200 and sections 216.100 through 216.140.

213.000 Scope of the Program

A. Personal care services involve primarily "hands-on" assistance by a personal care aide with a client's physical dependency needs (as opposed to purely housekeeping services).

B. The tasks the aide performs are similar to those that a nurse's aide would normally perform if the client were in a hospital or nursing facility.

C. Personal care services may be similar to or overlap some services that home health aides furnish.

1. Home health aides may provide personal care services in the home under the home health benefit.

2. Skilled services that only a health professional may perform are not considered personal care services.

D. Personal care services are services:

1. Authorized for the client by a physician in accordance with a service plan.

2. Furnished in the client's home or other locations identified in sections 213.500 through 213.610.

3. Provided by an individual qualified to provide such services and not a member of the client's family. See section 222.00, part A, for the definition of "a member of the client's family."

E. Personal care for Medicaid-eligible individuals under the age of 21 requires prior authorization. See sections 240.000 through 246.000.

213.100 Individuals Eligible for Personal Care

213.110 Categorically Needy Medicaid Eligibility

A. Only Categorically Needy Medicaid recipients are eligible for personal care services. Recipients in Medically Needy categories are not eligible for personal care services.

B. See section 136 of this manual for the Recipient Aid Categories, including the category codes and abbreviated category descriptions. The suffix "MN" indicates a "Medically Needy" aid category.

1. An AEVCS Eligibility Verification Transaction Response identifies an Aid Category Code and an Aid Category Description for each eligibility segment it lists.

2. The headings, "AID CATEGORY CODE" and "AID CAT DESCRIPTION," appear beneath each eligibility segment.

3. The Aid Category description of a Medically Needy category ends with "EC" (Exceptional Category) or "SD" (Spend Down), as it appears on the AEVCS Eligibility Verification Transaction Response.

213.120 Non-Inpatient, Non-Institutionalized Status

A. Personal care services are services furnished to an individual who is *not* an inpatient or a resident of:

1. A hospital,

2. A nursing facility,

3. An intermediate care facility for the mentally retarded (ICF/MR), or

4. An institution for mental diseases (IMD).

B. Individuals who are inpatients or residents of the foregoing institutions or facilities are ineligible for Personal Care Program services.

1. Under applicable federal statutory and regulatory provisions, the institutional status of an individual controls the individual's exclusion from service eligibility.

2. The location of the personal care service delivery site is not a determinant of the institutionalized individual's ineligibility for services.

C. See sections 213.500 through 213.610 for detailed information regarding allowed personal care service delivery locations.

213.200 Physical Dependency Need Criteria for Service Eligibility

A. The terms "routines," "activities of daily living" and "service" have particular definitions that apply to the Personal Care Program. See sections 216.100 through 216.140 for definitions of these and other terms employed in this manual.

B. Personal care services, described in sections 216.000 through 216.330, must be medically necessary services authorized by a client's attending physician.

C. Personal care services are individually designed to assist with a client's physical dependency needs related to the following routines and activities of daily living:

1. Bathing
2. Bladder and bowel requirements
3. Dressing
4. Eating
5. Incidental housekeeping
6. Laundry
7. Personal hygiene
8. Shopping for personal maintenance items
9. Taking medications*****
10. Mobility and Ambulation

*****Assistance with medications is a personal care service only to the extent that the Arkansas Nurse Practice Act and implementing regulations permit a personal care aide to perform the service.

D. A number of conditions may cause "physical dependency needs."

1. Particular disabilities or conditions may or may not be pertinent to specific needs for individual assistance.
2. In assessing an individual's need for personal care, the question to pursue is whether the individual is unable to perform tasks covered by this program without assistance from someone else.
3. The need for individual assistance indicates whether to consider personal care.

213.300 Client's Consent and Freedom of Choice

A. A Medicaid client has freedom of choice in selecting a personal care provider.

B. Provision of personal care services is contingent upon the written consent of the client or the client's representative.

213.310 IndependentChoices Program, Section 1115 Research and Demonstration Waiver

The Arkansas Department of Human Services (DHS) is conducting a scientific study of a consumer-directed personal care program. The program, called "IndependentChoices," is administered by the Division of Aging and Adult Services (DAAS) and operates under the authority of a Section 1115 research and demonstration waiver.

IndependentChoices offers an opportunity to Medicaid-eligible adults with disabilities (age 18 and older) and the elderly (age 65 and older) to self-direct their personal care. IndependentChoices provides qualifying clients with counseling and training to assist them in administering their own personal care. Participants receive a cash allowance with which they may hire an assistant or purchase other services and items related to their personal care.

Registered nurses (DAAS Outreach RNs) telephone interested parties to provide more information about the program and to answer questions. The DAAS Outreach RNs schedule home visits with those expressing continued interest.

The DAAS Outreach RNs request, from the client's current personal care provider, specific information regarding the individual's personal care services, particularly the amount and frequency of service in the individual's current service plan. **DHS requires Personal Care providers to furnish the information within five working days of receiving the request.** DAAS Outreach RNs are authorized representatives of the Department of Human Services, requesting client information in the performance of their assigned duties. Personal care providers are not violating their clients' confidentiality by disclosing the requested information to the DAAS Outreach RNs. Please refer to section 221 of this manual and to the Medicaid Provider Contract for confirmation of the legal obligation to provide the requested information.

213.500 Personal Care Service Locations

A. Federal regulations (at 42 CFR, 440.167) specifies that states may elect to cover personal care services in a client's home or other locations.

B. Medicaid does not cover personal care services in the following locations:

1. A hospital,

2. A nursing facility,

3. An intermediate care facility for the mentally retarded (ICF/MR) or

4. An institution for mental diseases (IMD).

C. Subject to the exclusions in part B above, the Arkansas Medicaid Program covers personal care services for eligible clients of all ages, in the following locations:

1. The client's residence,

2. A boarding home,

3. A Developmental Disabilities Services (DDS) community-based residential home,

4. A DDS group home or

5. A residential care facility licensed by the Office of Long Term Care.

D. If any of the locations in part C directly above is an institution or facility listed in part B above, *all* individuals residing at that location are ineligible for Personal Care Program services.

E. Individuals who are inpatients or residents of the facilities and institutions listed above in part B are not eligible to receive Personal Care Program services in *any* location.

213.510 Personal Care Service Locations for Clients under Age 21

A. In addition to the locations in section 213.500, part C, eligible individuals under the age of 21 may receive personal care services in other authorized locations, as mandated by the Omnibus Budget Reconciliation Act (OBRA) of 1993.

B. Certain requirements apply to services furnished in Division of Developmental Disabilities Services (DDS) Community Provider Facilities and in public schools. Those requirements comprise sections 213.511 and 213.512.

213.511 Personal Care in Division of Developmental Disabilities Services (DDS) Community Provider Facilities—Clients under Age 21

A. Personal care in a DDS community provider facility is available to eligible individuals under the age of 21.

B. Medicaid Program requirements are the same as for services delivered in the client's home.

C. Personal Care Program requirements are in addition to conditions imposed by other publicly funded programs, including Medicaid, through which the client receives services.

D. Individuals enrolled in DDS community provider facilities may receive a number of services in accordance with an Individualized Plan (IP), an Individualized Family Services Plan (IFSP) or an Individualized Habilitation Plan (IHP).

1. None of these plans may supersede or substitute for the personal care service plan.

2. The Personal Care Program requires a distinct and separate assessment and service plan.

E. Refer to section 312.220 for special billing instructions with respect to personal care in DDS facilities.

213.512 Personal Care in Public Schools—Clients under Age 21

A. Personal care in public schools is available to eligible individuals under the age of 21.

1. School may be an area on or off-site based on accessibility for the child.

2. When an individual's education is the responsibility of the school district in which that individual resides, "public school" as a place of service for Medicaid-covered services is any location, on-site or away from the site of an actual school building or campus, at which the school district is discharging that responsibility.

a. When a child is attending school at a DDS community provider facility because the school district has contracted with the facility to provide educational services, the place of service for Medicaid Program purposes is "public school."

b. When the home is the educational setting for a child who is enrolled in the public school system, "public school" is considered the place of service.

c. The student's home is *not* considered a "public school" place of service when a parent elects to home school a child.

213.512 Personal Care in Public Schools—Clients under Age 21 (Continued)

B. Medicaid Program requirements are the same as for services delivered in the client's home.

C. Personal Care Program requirements are in addition to conditions imposed by other publicly funded programs, including Medicaid, through which the client receives services.

D. Clients receiving personal care in public schools may receive a number of services in accordance with an Individualized Education Program (IEP).

1. The IEP may not supersede or substitute for the personal care service plan.

2. The Personal Care Program requires a distinct and separate assessment and service plan.

E. Refer to section 312.230 for special billing instructions regarding personal care in public schools.

213.600 Personal Care for Clients Temporarily Away from Home

A. On rare occasions a personal care client might have urgent cause to travel to a locality outside his or her personal care provider's service area. If the client's physician authorizes personal care during the client's stay in that locality, the client may choose a personal care provider agency in the service area to which he or she is traveling. The selected provider's services may be covered if all the following requirements are met:

1. The client's personal care provider (the "primary" provider) must request in writing that the selected provider (the "secondary" provider) assume the client's service for the specified duration of the client's stay.

2. The primary provider must forward to the secondary provider a copy of the client's current service plan and service documentation, including logs, for a minimum service period of sixty days prior to the request.

3. The secondary provider must execute a written agreement to assume the client's care on behalf of the primary provider.

4. If the secondary provider requests additional information or documentation, the primary provider must forward the requested materials immediately.

5. The secondary provider must submit its service documentation to the primary provider within ten working days of the client's departure from the temporary locality.

B. All documentation exchanged between the primary and secondary providers must satisfy all Medicaid requirements.

213.610 Personal Care for Clients Temporarily Out of State

A. When the secondary personal care provider is out of state, the secondary provider must request prior authorization from Utilization Review. The secondary provider must submit a written request for prior authorization and a copy of the client's service plan to:

Division of Medical Services
Utilization Review Section
P.O. Box 1437, Slot S413
Little Rock, AR 72203-1437

B. See also section 201.300 for additional instructions.

214.000 The Physician's Role in Personal Care

A personal care service plan is designed to direct an appropriate amount of individual assistance to a client's physical dependency needs.

A. The physician is essential to the determination of what constitutes an appropriate amount of assistance.

1. The physician evaluates the relationships among the client's health status, physical dependency needs and daily routines and activities.

2. The physician helps the client and the personal care provider design an individualized plan to address the client's individual physical dependencies.

B. Personal care services may commence only after their authorization by the client's attending physician.

1. The client's attending physician is responsible for the decision to authorize personal care services.

2. The client's attending physician must be the client's primary care physician (PCP) unless the client is exempt from PCP requirements.

a. In this manual, "physician" and "attending physician" both mean "the physician primarily responsible for the medical management of the patient," unless they are otherwise defined in a particular context.

b. "Primary care physician" and "PCP" are explained in section 180 of this manual and elsewhere in sections 182 through 187.

214.100 Physician Authorization of Personal Care Services

A. An individualized personal care service plan, signed (**original signature**) and dated by the client's PCP or attending physician, constitutes the physician's personal care authorization.

1. The attending physician and the client must have a face-to-face visit before the physician may authorize personal care services, unless the physician has seen the client within the 60 days preceding the beginning date of service established in the proposed service plan.

2. The attending physician must review the assessment and service plan to ensure that the personal care aide's assigned tasks appropriately address the client's individual physical dependency needs.

3. Based on the assessment and the physician's medical evaluation, the attending physician must authorize only individualized personal care services that constitute medically necessary assistance with the client's physical dependency needs in the client's home or certain other authorized locations rather than in an institution.

B. The personal care service plan authorized by the physician must specify:

1. The date services are to begin,

2. The duration of need for services and

3. The expected results of the services.

C. Personal care services **may not begin** before the client's attending physician authorizes the individualized personal care service plan.

D. Services may not commence before the beginning date of service established by the authorized service plan.

E. The physician may change the frequency, scope or duration of service in the service plan.

F. The physician may add to, delete from or otherwise modify the service plan.

G. The physician's authorization of the service plan must be by *dated original signature only*. A stamp or signature initialed by a *locum tenens* is the only acceptable substitute for an original signature by the attending physician.

H. The physician must date and sign or initial any revisions to the service plan, as well as any attachments he or she adds to the service plan.

214.100 Physician Authorization of Personal Care Services (Continued)

I. When a client has two or more personal care providers, each provider must develop an individualized service plan.

1. The service plans must be submitted to the same physician to ensure coordination of care.

2. The physician's medical evaluation of the patient's physical dependency needs determines the scope, frequency and duration of services, whether service delivery is by one provider or multiple providers.

J. The physician must maintain a copy of the signed service plan(s) and signed copies of any subsequent authorized service plan revisions with the client's permanent medical record.

214.110 The Physician's Notification of Service Plan Authorization

The physician may communicate the authorization of a service plan by telephone, fax or e-mail to expedite service delivery.

A. A transmitted facsimile copy of the physician's original signature satisfies the "original signature" requirement (see section 214.100, part G), if the physician maintains the original document with the original signature(s) in his or her files.

B. The physician must forward the completed authorized service plan with original signature and authorization date to the personal care provider no later than 14 working days following the authorized beginning date of personal care service.

214.200 Service Plan Review and Renewal

A. A personal care service plan terminates six (6) months after its initial or revised beginning date of service.

1. The client's physician must review the service plan no less often than every six months.

2. Upon completion of the six-month review, the physician may authorize continued personal care services, either unchanged or with modifications; or the physician may order that services cease.

B. Personal care services may not continue past the six-month anniversary of an initial or revised beginning date of service until the client's physician authorizes a revised service plan or renews the authorization of an existing service plan.

215.000 Personal Care Assessment and Service Plan

215.100 Assessment and Service Plan Formats

A. Form DMS-618, "Personal Care Assessment and Service Plan"; is included in this manual, following section 218.000.

1. Form DMS-618 may be ordered from EDS.

2. See section 304.100 of this manual for instructions regarding ordering forms.

B. The Division of Medical Services (DMS) does not require exclusive use of form DMS-618 to satisfy documentation requirements; however, substituted documentation must meet or exceed DMS requirements as stated in this manual. In addition, there are requirements regarding the use of form DMS-618 in certain instances:

1. See section 242.000 regarding the use of this form when requesting prior authorization of services for clients under the age of 21.

2. See section 217.100 regarding use of this form when requesting extension of benefits.

C. Attachments to form DMS-618 may be necessary to complete assessments and service plans.

1. An assessing RN must sign or initial and date each attachment he or she adds to a personal care assessment or service plan.

2. The authorizing physician must sign (or initial) and date each attachment he or she adds to a service plan.

215.200 Personal Care Assessment

A. A physician's order to assess a client for personal care is a recommendation to evaluate the client's physical dependency needs with regard to necessary routines and activities of daily living. The assessment helps the physician and the personal care provider:

1. To decide whether personal care is an option for the client and if so, to

2. Determine the type, amount, frequency and duration of services the client requires.

B. Initiation of a personal care assessment does not require a physician's order.

C. A physician's referral, order or request to assess a client for personal care services is *neither* a prescription nor an authorization for personal care services.

215.200 Personal Care Assessment (Continued)

D. The provider's assessment of a client's need for personal care services must include a written description of each physical dependency need. The identification of each physical dependency need must include:

1. The extent to which the client can personally perform individual task components of routines and activities of daily living,

2. The extent beyond which the client cannot personally perform individual task components of routines and activities of daily living and

3. The type and amount of assistance the client may need with each task thus identified.

E. A registered nurse must perform the assessment.

F. When a client has two or more personal care providers, the providers should cooperate in the assessment and service-plan development processes.

G. When an individual will receive some or all of his or her services in a congregate setting, the assessment must reflect the RN's determination that the individual is an appropriate candidate for services delivered in that setting. See section 216.201 and sections 220.110 through 220.112.

215.210 Alternative Resources for Assistance

A. The following requirements regarding alternative resources for assistance do not apply, or apply only insofar as they are legal, practical and practicable when the identifiable resources are prohibited from assisting the client by law or by a facility's or organization's rules or bylaws. For example, a relative of the client is an alternative resource in the client's home or the relative's home but not in the public school.

B. The personal care assessment must include written evidence that the client or the client's representative, and the provider have considered alternative resources available to assist or partially assist the client with physical dependency needs identified in the assessment.

1. The provider must determine whether voluntary third-party resources are available and if so, the extent of the third party's willingness to devote time to the benefit of the client. The provider must:

a. Consider other members of the client's household as well as nearby relatives and friends,

b. Indicate the usual times of their availability to assist the client and the frequency and duration of their assistance, and

215.210 Alternative Resources for Assistance (Continued)

c. Explain the circumstances of any individual household member's inability to provide any assistance or to provide less than complete assistance with the client's physical dependency needs.

2. The provider must also consider such alternative community resources as public and private community agencies and organizations, whether secular or religious, paid or volunteer.

a. Consider entities that provide not only in-home services, but also such services as adult day care or caregiver respite.

b. List the approximate number of hours per week the client receives (or will receive) services from each such community resource.

C. The provider must make reasonable efforts to determine the nature, scope, frequency and duration of other services the individual receives, particularly in-home services.

D. The provider's case record documentation must include the certification that the client's individualized service plan does not duplicate any other in-home services of which the provider is aware.

215.300 Service Plan

A client must receive services in accordance with an individualized service plan.

A. The plan must be acceptable to the client or the client's representative.

B. A registered nurse and other appropriate personnel of the personal care provider agency, in concert with the client or the client's representative, must design the individualized service plan to correlate with the physical dependency needs identified in the assessment.

C. The individualized service plan must be limited to assistance with the client's individual physical dependency needs.

D. The service plan must clearly identify which of the client's physical dependency needs will be met by each task performed by a personal care aide.

1. This requirement does not necessarily mandate writing a unique statement for each task or task component. Indexing the assessment may expedite documentation by permitting one to reference the relevant section of the assessment for the explanatory detail. For example:

215.300 Service Plan (Continued)

a. "Task 1 (corresponds to) Physical Dependency 2."

b. "Task 6 (corresponds to) Physical Dependency 3."

2. In addition to establishing its correspondence to the assessment (*i.e.*, designing individualized services for a client's physical dependency needs); the service plan must describe for each routine or activity listed:

a. The individual tasks the aide is to *perform for* the client,

b. The individual tasks with which the aide is *to assist* the client, and

c. The frequency and duration of service of each routine and activity, including:

1) The number of days per week each routine or activity will be accomplished and

2) The maximum and minimum estimated aggregate time the aide should spend on all authorized tasks each service day.

E. The service plan must include written instructions for the personal care aide specifying how and when to execute or assist with the client's routines or activities including:

1. The number of days per week to accomplish each routine or activity (as well as which days when relevant) and

2. The time of day to accomplish the routine or activity when the time is pertinent, such as when to prepare meals.

F. The service plan must include written instructions describing whether and to what extent the aide's function in individual task components of each routine or activity is:

1. To assist the client to perform the task,

2. To perform the task for the client, or

3. To observe the client perform the task.

215.300 Service Plan (Continued)

G. The service plan must require the client to perform all tasks within the client's capability. Medicaid does not cover assistance with any task a client can perform unless the client's physician authorizes the assistance. For example:

1. A client can manage his own laundry but he cannot extract wet items from the washer while leaning over the machine.

   a. The assessment notes that he needs assistance with the task of removing wet items from the washing machine.

   b. The service plan describes the assistance designed for his individual physical dependency need with his laundry.

   c. The registered nurse instructs the aide to perform the task(s) constituting the service.

2. Loading the washer, emptying the dryer, folding and ironing clothing and linens are not covered tasks for this particular client.

3. Removing laundry from the washer and loading it in the dryer *are* covered tasks for this client if those tasks are described in his service plan and authorized by his physician.

H. The assessment must support the service plan and the RN's instructions to the aide(s) regarding the delivery of services. The plan must reflect whether the individual is receiving services in more than one setting. If a client is receiving services in more than one setting, it must be clear in which setting a client receives a particular service or assistance. See part G of section 215.200, section 216.201 and sections 220.110 through 220.112.

I. The provider must revise a service plan if a client's average daily service time consistently varies from the service plan's maximum *or* minimum estimated service time by ten percent (10%) or more over a period exceeding or expected to exceed thirty days.

1. During *brief* periods (less than 30 days duration) of service interruption or service-time variation, the provider must document any extenuating circumstances and explain each service plan deviation for each day of the period of service interruption or service alteration.

2. See section 215.330 for more service plan revision requirements.

215.310 Identifying Individual Physical Dependency Needs

A. A personal care provider must identify and describe (*assess*) a client's need for assistance (*physical dependency need*) with individual task components of routines and activities of daily living.

B. The provider must describe the type, amount, frequency and duration of assistance required for each task thus identified (*individualized service plan*).

C. A personal care aide furnishes assistance (*service*) with the individual task components of routines and activities of daily living, in accordance with the individualized service plan authorized by the client's physician.

D. The following examples illustrate how to facilitate service plan development and service documentation by assessing the client at the level of individual task performance:

A client is unable to pick up slender items, such as spoons and toothbrushes, and sometimes loses his grip on those objects.

1. This condition causes similar physical dependency needs in different routines.

Sample Assessment Entry

Eating:	The client needs someone to place eating utensils in his grasp and to retrieve them when he drops them.
Oral hygiene:	The client needs someone to place his toothbrush in his grasp and to retrieve it when he drops it.

2. The service plan will contain instructions to the aide similar to this *Sample Service Plan Entry*.

Sample Service Plan Entry

Eating:	Place the (*object*) in (*client's name*)'s grasp.
Oral hygiene:	Retrieve the (*object*) when *(client's name)* drops it and replace the (*object*) in his grasp.

E. Medicaid Program staff reviewing a personal care provider's records must be able to readily observe that the service plan logically follows the assessment, which is possible only if the provider assesses the client at the individual task performance level.

1. Additionally, the aide's daily service documentation and the registered nurse's case notes must address the requirements and objectives of the service plan.

2. There must be a clear and logical relationship of each component of this documentation to each other component and to the service continuum.

215.320 Service Initiation and Service Initiation Delay

A. The provider will begin personal care services on the authorized beginning date of service.

B. If services do not begin on that date, the provider must advise the client (or the client's representative) and the physician of the reason for the delay.

1. The provider must furnish immediate notification in person, or by telephone, e-mail or fax, within 24 hours following the date and time that personal care services were to have begun.

2. The provider must also furnish the same individuals with a written statement, over an *original* authorized signature, within five (5) working days following the date personal care services were to have begun.

215.330 Service Plan Revisions

A. The attending physician must authorize permanent service plan changes before the provider amends service delivery.

1. For purposes of this requirement, a permanent service plan change is one expected to last 30 days or more.

2. Service plan revisions must be made if a client's condition changes to the extent that the personal care provider must modify, add or delete tasks.

3. Service plan revisions must be made if the provider identifies a need to increase or decrease the amount, frequency or duration of service.

a. An increase or a reduction of 10% or less in the average amount of service (measured in service time) over a period of less than 30 days does not in itself require a service plan revision.

b. However, the reasons for the service variances must be written daily in the service documentation.

B. Providers may reduce a client's services without the physician's *prior* authorization only by meeting the following conditions:

1. The provider must advise the physician of the reduction in services in writing, within 14 working days following the first day of reduced services.

2. The provider must request the physician's written approval of the reduction.

a. The provider is responsible for obtaining the physician's signed authorization.

b. The physician may fax the signed authorization to the provider and maintain the original in the client's file in the physician's office.

215.330 Service Plan Revisions (Continued)

C. The physician must document medical reasons for service plan revisions.

D. The new beginning date of service is the date authorized by the physician.

E. Service plan revisions and updates since the previous assessment must remain with the service plan. Updates since the previous assessment must include documentation of when and why the change occurred.

215.340 Termination of Services

A. If the provider, the client or the client's representative terminates services the provider must advise the physician of the termination.

B. Notification must occur immediately and no later than 24 hours after the scheduled time for the first service canceled by the termination action.

1. Initial notification may be in person, or by telephone, e-mail or fax.

2. The provider must also submit the notification by original signed document within five (5) working days following the initial notification.

3. Notification of Medicaid service delay or termination must occur even if the patient will continue to receive personal care services from another source.

215.350 Service Plan Requirements for Multiple Service Locations

A. Only one service plan for personal care services is necessary when a single provider is delivering services to a client in more than one authorized location.

B. The service plan must identify which tasks the aide performs in each location.

1. When the aide performs the same or similar tasks in each location, the service plan must separately identify the tasks in each location in accordance with the criteria in sections 215.300 and 215.310.

2. The aide's service documentation must reflect the service location distinctions.

C. If a client receives services at multiple locations from more than one personal care provider, each provider must design an individualized service plan and submit it to the attending physician for authorization.

1. The providers should cooperate in the development of the service plans.

2. Authorization of both service plans must be by the same physician.

215.360 Service Plan Requirements for Multiple Providers

A. A client may have two personal care providers at a single location if one of the providers is a private care agency furnishing personal care on weekends. Weekend hours are the hours from 12:00 AM Saturday through 11:59 PM Sunday.

B. Each provider must design an individualized service plan.

1. The providers should cooperate in the development of the service plans.

2. Authorization of both service plans must be by the same physician.

216.000 Coverage

A. Personal care services are covered by the Arkansas Medicaid Program when they are:

1. Authorized by a physician in accordance with a service plan,

2. Prior authorized by DMS or its designee when the recipient is under the age of 21,

3. Provided by an individual who is

a. Qualified to provide the services,

b. Supervised by a registered nurse (RN) or a Qualified Mental Retardation Professional (QMRP),

c. Not a member of the individual's family; and

4. Furnished in the client's home or other location as specified in this manual.

B. Medicaid restricts coverage of personal care to services directly helping a client with only certain routines and activities regardless of the client's ability or inability to execute other non-covered routines and activities.

216.100 Definitions of Terms

216.110 Routines

In the Arkansas Medicaid Personal Care Program, essential chores are referred to as "routines." Clients must eat, dress, void the bladder and bowels, bathe and perform other personal hygiene chores.

216.120 Activities of Daily Living

In the Arkansas Medicaid Personal Care Program, certain chores are referred to as "activities of daily living" or "activities." For example, clients need to wash their clothes and linens (laundry), clean their immediate living area (incidental housekeeping), and purchase the items necessary to maintain themselves (shopping).

216.130 Tasks

A. "Tasks" are components of routines and activities of daily living. *For example*:

1. Meal preparation is a routine that involves a number of tasks: removing food from the refrigerator or pantry, opening food containers and packages, processing meats or vegetables, mixing ingredients, setting oven temperatures and adjusting stovetop settings; setting out, using, washing and putting away cooking and eating utensils, etc.

2. Laundry is an activity of daily living. Some tasks associated with the laundry activity are: sorting items to be washed, measuring detergent and additives, adjusting machine settings, extracting wet items from the washer and dry items from a dryer, hanging wet items on a line to dry, etc.

B. "Individual task component" and "task component" have the same meaning as "task." The words "routine," "activity" and "task," retain their meaning regardless of whether the person performing them is the client, the aide or any other person.

216.140 Service

A. A personal care "service" is a covered task or a related group of covered tasks.

B. A "personal care aide service" is a personal care service.

1. "Personal care services" and "personal care aide services" are interchangeable expressions that mean "covered tasks."

2. Only a certified personal care aide, or an individual who meets or exceeds the qualifications of a personal care aide, as defined in section 222.00; who is also in the employ of a Medicaid-enrolled personal care provider, may provide covered personal care services or personal care aide services as defined in this manual.

216.200 Tasks Associated with Covered Routines

216.201 Simultaneous Services and Congregate Settings

Simultaneous services to two clients or to more than two clients in a congregate setting may be covered provided the service plan and the scope, duration and frequency of each individual's services are directly related to the needs of the individual as reflected in the RN's assessment of the individual's physical dependency needs. Part G of section 215.200, sections 216.211, sections 220.110 through 220.112, and section 220.200 provide additional information and include instructions for determining the relative amount of coverage available per client for tasks performed for multiple clients.

216.210 Eating

216.211 Meal Preparation

A. Meal preparation is a covered personal care service if the aide's logged service time meets certain conditions:

1. The aide must make reasonable efforts to prepare servings of a size or an amount commensurate with the client's nutritional needs and normal appetite. For the purpose of these rules a provider will be presumed to have made a reasonable effort unless the quantity of food prepared exceeds by more than 100% the client's need for a meal or meals. An example follows.

   a. An aide prepares soup for a client.

   b. The client typically consumes 8 oz. of soup per meal.

   c. If the aide prepares 16 oz. or less per meal, the provider will be presumed to have made reasonable efforts to limit the service to the client's needs.

   d. However, if the aide prepares 3 quarts of soup per meal, the time required is presumed unreasonable and the provider is not entitled to reimbursement. R*efer to part E of this section for rules regarding simultaneous services for two or more clients.*

2. Medicaid does not cover an aide's time at meal preparation tasks or assisting at meal preparation tasks for individuals who are not personal care clients or whose personal care service plans do not include meal preparation tasks or assistance with meal preparation tasks.

   a. The aide must document the meal preparation tasks in the client's personal care service record.

   b. Refer to part E of this section for rules regarding simultaneous services for two or more clients.

216.211 Meal Preparation (Continued)

B. This routine includes the tasks involved in:

1. Preparing and serving a meal, and

2. Cleaning articles and utensils used in the preparation of the meal.

C. To be eligible to receive personal care assistance with meal preparation, a client's physical dependency needs must prevent or substantially impair his or her ability to perform meal-preparation tasks or to clean up the utensils and preparation area.

D. The aide's service in the client's meal preparation routine is hands-on assistance with meal preparation tasks the client cannot physically perform, according to the detailed physical dependency needs described in the assessment.

E. Simultaneous services to two clients or to more than two clients in a congregate setting may be covered if the rules below and the regulations stated at sections 216.201, sections 220.110 through 220.112 and section 220.200 are followed.

1. Medicaid will cover the actual time attributable to the individual client when services, such as meal preparation, are delivered simultaneously.

2. Refer to section 220.200 for the methodologies required to determine the amount of time attributable to the individual client.

F. The service plan must correlate each required task with its corresponding physical dependency need. See sections 215.300 and 215.310 and the following example.

1. A client is able to remove items from the refrigerator and pantry and to perform most tasks related to meal preparation.

2. The assessment states, "Client's arthritic condition prevents him from opening bottles and jars with small tops and from gripping eating utensils."

3. A related entry in the service plan would be similar to:

Meal preparation:

a. The aide will open bottles and jars with lids too small for the client to negotiate.

b. The aide will operate cooking and serving utensils the client cannot grip or pick up.

216.211 Meal Preparation (Continued)

G. The complete meal-preparation routine might include additional instructions. These examples are simply to illustrate that instructions at the task level facilitate correlation of physical dependency needs with individualized services.

216.212 Consuming Meals

A. The service related to this routine includes the tasks involved in giving the client hands-on assistance to consume a meal.

B. To receive personal care assistance with this routine, a client's physical dependency needs must prevent or substantially impair his or her ability to execute tasks such as cutting food in bite-size pieces or negotiating food from plate to mouth.

C. The related service is hands-on assistance with the client's physical dependency needs to accomplish eating. The aide may only assist with or perform functional tasks the client cannot physically perform, in accordance with the client's physical dependency needs described in the assessment.

D. The service plan must correlate each required task with its corresponding physical dependency need. See sections 215.300 and 215.310 and the following examples.

1. An assessment states, "Client's arthritis prevents him from gripping slender objects such as eating utensils with either hand." The related task in the service plan is for the aide to "cut items into bite-size pieces and deliver them from plate to mouth for the client."

2. The same assessment also states, "Effects of a recent stroke cause the client to choke or to risk choking unless food is pureed."

    a. The related task in the service plan is for the aide to "puree food items for the client."

    b. A separate statement, "The aide will deliver spoonfuls from plate to mouth for the client," addresses the arthritic condition.

E. Observing a client eat is not a covered service unless the client's physician certifies in the service plan that failure to observe the client's eating places the client at risk of injury or harm.

216.220 Bathing

A. The tasks constituting this service are those involved in hands-on assistance with a client's bath.

1. The time spent reminding a client to bathe is covered only for a client whose service plan requires hands-on assistance to accomplish bathing.

2. Time spent observing a client bathe is not a covered service, unless the client's physician certifies in the service plan, that failure to observe the client's bathing places the client at risk of injury or harm.

B. Clients eligible for this service must have a physical dependency need preventing or substantially impairing their ability to perform some or all of the tasks associated with bathing, such as:

1. Safely entering or exiting the tub or shower and washing, rinsing and towel-drying, or

2. Sponge bathing if the client cannot safely enter or exit a tub or shower under any circumstances and cannot sponge-bathe himself or herself.

C. The aide's service in regard to the client's bathing is hands-on assistance with bathing tasks the client cannot physically perform, according to the detailed physical dependency needs described in the assessment.

D. The service plan must correlate each required task with its corresponding physical dependency need. See sections 215.300 and 215.310.

216.230 Dressing

A. The tasks constituting this service are those involved in hands-on assistance dressing the client or helping the client dress.

1. An aide's time spent reminding a client to dress, or to dress appropriately for a particular setting or for the weather, is not a covered aide service, unless the client's service plan requires hands-on assistance with dressing.

2. An aide's time spent observing a client dress is not a covered aide service, unless the client's physician certifies in the service plan, that failure to observe the client's dressing places the client at risk of injury or harm.

B. Clients eligible for this service must have a physical dependency need preventing or substantially impairing their ability to clothe themselves.

C. The aide's service in regard to the client's dressing is hands-on assistance with dressing tasks the client cannot physically perform, according to the detailed physical dependency needs described in the assessment.

216.230 Dressing (Continued)

D. The service plan must correlate each required task with its corresponding physical dependency need. See sections 215.300 and 215.310.

216.240 Personal Hygiene

A. The tasks constituting this service are those involved in hands-on assistance with the client's personal hygiene.

1. An aide's time spent reminding a client to perform personal hygiene tasks is not a covered service unless the client's service plan includes hands-on assistance with personal hygiene.

2. An aide's time spent observing a client perform personal hygiene tasks is not a covered service unless the client's physician certifies in the service plan that failure to observe the activity places the client at risk of injury or harm.

B. Clients eligible for this service must have a physical dependency preventing or substantially impairing their ability to perform hair and skin care and grooming, oral hygiene, shaving and nail care.

C. The aide's service in regard to this routine is hands-on assistance with personal hygiene tasks the client cannot physically perform, according to the detailed physical dependency needs described in the assessment.

D. The service plan must correlate each required task with its corresponding physical dependency need. See sections 215.300 and 215.310.

216.250 Bladder and Bowel Requirements

A. The tasks constituting this service are those involved in hands-on assistance with the client's elimination routines.

B. Clients eligible for this service must have a physical dependency need preventing or substantially impairing their ability:

1. To safely enter and exit the bathroom, or

2. To properly complete elimination routines without assistance.

C. The aide's service in this routine is hands-on assistance with bladder-and-bowel-voiding tasks the client cannot physically perform alone, according to the detailed physical dependency needs described in the assessment.

D. The service plan must correlate each required task with its corresponding physical dependency need. See sections 215.300 and 215.310.

216.260 Medication

A. Personal care aide services regarding medication routines are covered only to the extent that they are permitted by the Arkansas Nurse Practice Act and implementing rules and regulations.

B. The tasks constituting this service are those involved in hands-on assistance with the client's medications.

C. Clients eligible for this service must have a physical dependency need preventing or substantially impairing their ability to safely and correctly dispense and ingest orally administered prescription medications.

D. The aide's service in regard to the client's medication routines is hands-on assistance with tasks the client cannot physically perform, according to the detailed physical dependency needs described in the assessment.

E. The service plan must correlate each required task with its corresponding physical dependency need. See sections 215.300 and 215.310.

216.270 Mobility and Ambulation

A. The tasks constituting this service are those involved in hands-on assistance with the client's mobility and ambulation.

B. Clients eligible for this service must have a physical dependency need preventing or substantially impairing their ability:

1. To turn themselves in bed,

2. To move from bed to chair (including wheelchair or motorized chair),

3. To walk (alone or with a device) or

4. To operate a push wheelchair or a motorized chair.

C. The aide's service in this routine is hands-on assistance with ambulation and mobility tasks the client cannot physically perform alone, according to the detailed physical dependency needs described in the assessment.

D. The service plan must correlate each required task with its corresponding physical dependency need. See sections 215.300 and 215.310.

216.300 Tasks Associated with Covered Activities of Daily Living

A. The tasks constituting this group of services are those involved in hands-on assistance with the client's incidental housekeeping, laundry and shopping. Tasks associated with activities of daily living *are not covered* if the aide is also performing the tasks for other individuals of the same household, home or facility

1. Who are not Personal Care Program clients, or

2. Who are Personal Care Program clients whose service plans do not require the identical tasks.

B. To be eligible for services associated with activities of daily living:

1. A client must exhibit one or more physical dependency need(s) related to his or her impaired ambulation, mobility or functional capability within the service delivery location;

2. The personal care assessment must describe the impairments that prevent or impede the client's ability to move freely and safely about the living area and to perform necessary tasks; and

3. The service plan must correlate each required task with its corresponding physical dependency need. See sections 215.300 and 215.310.

216.310 Incidental Housekeeping

A. "Incidental housekeeping" means cleaning of the floor and furniture only in the area of the service delivery location occupied by the client. For example, if the client occupies only one room, the service is limited to cleaning only that room.

B. The aide's service in regard to incidental housekeeping is hands-on assistance with covered tasks the client cannot physically perform, according to the detailed physical dependency needs described in the assessment.

C. The assessment must describe the impairments that prevent or impede the client's ability to move freely and safely about their living area and clean the floor and furniture in the area they occupy.

D. The service plan must correlate each required task with its corresponding physical dependency need. See sections 215.300 and 215.310.

216.320 Laundry

A. "Laundry" means laundering only items incidental to the care of the client. Laundry is not a covered service if it includes laundry services for the convenience of non-Medicaid eligible individuals residing in the same service delivery location. For example.

1. A spouse requires assistance with laundry. The remaining cohabiting spouse is not a Medicaid recipient.

   a. The cohabiting spouse is usually considered an alternate resource.

   b. It is presumed that the cohabiting spouse will perform routine laundry services for the household.

2. If, however, the Medicaid-eligible spouse is incontinent of bowel or bladder:

   a. Laundry may be a covered service to the extent that it is a service designed to address the client's immediate needs, *i.e.* cleaning soiled bedding or clothing.

   b. If the laundry service is designed to address the client's immediate needs, the aide may top up an incomplete washer-load by including items used by the remaining cohabiting spouse and the service will still be covered.

B. The aide's service in regard to laundry is hands-on assistance with covered laundry tasks the client cannot physically perform, according to the client's physical dependency needs detailed in the assessment.

216.320 Laundry (Continued)

C. The assessment must also describe the impairment(s) that prevent or impede the client's ability to move freely and safely about his or her living area and to perform some or all of the laundry tasks involved in maintaining his or her own clothing and bed and bath linens.

D. The service plan must correlate each required task with its corresponding physical dependency need. See sections 215.300 and 215.310.

216.330 Shopping

"Shopping" means services to address the client's physical dependency need by assisting the client with shopping or by shopping for the client.

A. Assisting a client with shopping is a covered service only when the client is purchasing items that are necessary for the client's maintenance in the home and that are used primarily by the client or, are used *primarily* by the client and other Personal Care Program clients who reside in the same service delivery location, and whose service plans include assistance with shopping.

1. The aide's service in regard to shopping is hands-on assistance with covered shopping tasks the client cannot physically perform, according to the client's physical dependency needs detailed in the assessment.

2. The assessment must describe the impairment(s) that prevent or impede the client's ability to move freely and safely in stores and perform some or all of the shopping tasks necessary to maintain his or her health and comfort.

3. The service plan must correlate each required task with the client's corresponding physical dependency need. See sections 215.300 and 215.310.

B. If the service plan requires the aide to shop for the client:

1. The client, or the client's representative, has freedom of choice to describe the items to be purchased (within the constraints stated herein) for the client's maintenance in the home.

216.330 Shopping (Continued)

2. The client has freedom of choice to designate the individual stores at which to purchase the items.

   a. If the designated stores are within the client's normal retail service area the service plan need not identify the specific stores.

   b. If the designated stores are outside the normal retail service area for residents of the client's locale, the service plan must include the stores' names and locations.

3. Whether the service plan requires the aide to assist the client at shopping or to shop for the client, Medicaid covers only eight hours per month per client for shopping and travel time.

C. If there are other members of the client's household, the service plan must not include shopping, or assistance with shopping, unless the assessment fully documents all reasons *each* household member can neither:

1. Assist with or do the client's shopping, nor

2. Arrange for someone else to assist with or to do the client's shopping.

D. Medicaid provides no additional coverage for an aide's mileage incurred performing shopping tasks.

216.400 Personal Care Aide Service and Documentation Responsibility

It is the responsibility of the personal care aide to accomplish *all* the following:

A. Perform authorized tasks as instructed by the supervising RN or QMRP.

B. Maintain a service log.

1. The service log must be completed at the time services are delivered.

2. If the service log is not completed concurrently with service delivery coverage may be denied.

3. Refer to sections 220.110 through 220.112 for service log requirements.

C. Provide necessary documentation showing the date, time, nature and scope of authorized services delivered.

216.400 Personal Care Aide Service and Documentation Responsibility (Continued)

D. Provide necessary documentation showing the date, time, nature and scope of emergency services delivered.

1. If an emergency requires the personal care aide to perform a personal care service task not included on the personal care service plan, the personal care aide must receive when possible, prior approval from the supervising registered nurse or QMRP to perform the task.

2. When prior approval is not possible, the personal care aide may perform the emergency service task, but she or he must receive post-service approval from the supervising registered nurse or QMRP.

3. Document the circumstances in detail, describing:

a. The nature of the emergency,

b. The action or task required to resolve the emergency and

c. The justification for the unscheduled service.

E. If a personal care aide does not perform a particular task scheduled on the service plan, the personal care aide must document why she or he did not perform the task that day.

217.000 Benefit Limit

A. Medicaid imposes a 64-hour benefit limit, per month, per client, on personal care aide services for clients aged 21 and older.

B. The 64-hour limitation applies to the monthly aggregated hours of personal care aide services at all authorized locations.

C. Providers may request extensions of this benefit for reasons of medical necessity. Submit written requests for benefit extensions to:

Division of Medical Services
Utilization Review Section
P.O. Box 1437, Slot S413
Little Rock, AR 72203-1437

217.100 Benefit Extension Requests for Clients Aged 21 and Older

A. Submit to DMS:

1. A completed form DMS-618 (all pages), including the current new or revised physician authorization for personal care services, signed by the client or the client's representative, the assessing registered nurse, and the client's PCP or attending physician.

2. The supervising RN's or QMRP's case documentation, as described in section 220.100, for the ninety days preceding the new beginning date of service established in the service plan that generated the benefit extension request. This documentation is not required if the service plan is the client's initial service plan for personal car services.

3. The personal care aide's service log and documentation, as described in sections 216.400 and 220.110 through 220.112, of the ninety days preceding the new beginning date of service established in the service plan generating the benefit extension request. This documentation is not required if the service plan is the client's initial service plan for personal care services.

B. Subsequent to a benefit extension approval, if the need arises for additional personal care service, revise the service plan and initiate the extension request process, *whether or not* the previously approved period of extended benefits has expired.

217.110 Provider Notification of Benefit Extension Approval

A. DMS will notify the requesting provider within two weeks, approving or denying the request or asking for additional information. Notification of approval or denial is by means of the Provider Notification page (Section XIII) of form DMS-618. Benefit extension approval includes:

1. The procedure code approved,

2. The total number of service-time increments approved for each procedure code,

3. The Benefit Extension Control Number and

4. The approved beginning and ending dates of service.

B. The DMS reviewers responsible for the determination sign and date the form.

217.120 Duration of Benefit Extension

A. Benefit extensions are granted for six months or the life of the service plan, whichever is shorter.

B. When the client's diagnosis indicates a permanent disability, DMS may assign a Benefit Extension Control Number effective for one year. For these permanently disabled clients, benefit extension requests will be necessary only once every 12 months unless the service plan changes.

1. If there is a service plan revision, the provider must submit a benefit extension request for the number of hours in the revised service plan.

2. Upon approval of the requested extension, the updated benefit extension approval file is valid for 12 months from the beginning of the month in which the revised service plan takes effect.

3. If there is a service plan revision before 12 months have passed, the provider must initiate the benefit extension approval process again.

218.000 Recipient Appeal Process for Denial of Service Coverage or Benefit Extension

When DMS denies coverage of personal care services or denies a benefit extension request for personal care services, and the client wishes to appeal the denial, the client may request a fair hearing.

The appeal request must be in writing and received by the Appeals and Hearings Section of the Department of Human Services within thirty days of the date on the letter from DMS explaining the denial. Appeal requests must be submitted to:

Department of Human Services
Appeals and Hearings Section
P.O. Box 1437, Slot N401
Little Rock, AR 72203-1437

Personal Care Assessment and Service Plan

I. Client and Provider Information

Client	**Medicaid ID #**	**Service Plan Status** **Initial** ❑ **Revision** ❑ **Renewal** ❑
Name (Last/First/Middle)		**Date Of Birth** (MM/DD/YYYY)
County of Residence	**Telephone Number(s)**	**Parent(s) / Guardian(s) Name(s)**
Complete Mailing Address		

Client Resides: ☐ Alone ☐ With Relatives ☐ Boarding Home ☐ Group Home
☐ Community-Based Residential Home ☐ Residential Care Facility (RCF)
☐ Other (Describe):_____

PCP	**Name**	**Provider Number**	**Date of Last Exam**

Personal Care Provider	**Name**
Provider Number	**Mailing Address**

II. Service Locations

Personal Care Service Location(s): ☐ Private Residence ☐ Residential Care Facility
☐ School ☐ DDS Facility ☐ Other (describe):_____

Service Location(s) Address(es):_____

III. Dates of Service

Start of Care Date(s)	**Original (Required):**_____	**Per this Service Plan:**_____

Projected End Date of Service (If less than 6 months):_____
Current Assessment Date:_____ **Assessing RN:**_____
Attending Physician (if other than the PCP):_____
Attending Physician's Medicaid Provider Number:_____
Date of the Order or Referral for Assessment:_____
Referral Source (If other than attending physician):_____

Client's Name: _____ **Medicaid ID #:**_____

IV. Client Freedom of Choice

I hereby select the agency named in Section I of this document as my personal care provider. To help assure a complete and accurate assessment of my physical dependency needs and an individualized service plan to address those needs, I hereby authorize the release of any medical information by or to the attending physician and/or the PCP named above.

Signature:_____ **Date:**_____
Client or Client's Representative

_____ _____
Witness Signature *(Two witnesses required if signed by mark)* *Witness Signature*

V. Medical Diagnoses

ICD-9 codes and descriptions. List in the order of significance to the medical necessity for assistance with the client's physical dependency needs.

ICD-9 Code	Description

VI. Mental Status

- ❑ Clear
- ❑ Somewhat confused
- ❑ Moderately confused
- ❑ Markedly confused
- ❑ Hyperactive
- ❑ Withdrawn
- ❑ Needs restraint
- ❑ Needs supervision for personal safety

Comments:_____

Special Administrative Section

Use this section when requesting prior authorization.			
Procedure Codes Requested	**Hours**	**Minutes**	**Frequency**

Client's Name: _____ **Medicaid ID #:**_____

VII. Physical Dependency Status

Bedridden	Ambulation	Continence Status
❑ Bedfast	❑ Walks alone	❑ Catheter ❑ Colostomy
❑ Requires turning in bed	❑ Walks with device	❑ **Incontinent**
❑ Bed to chair with help	❑ Walks with help	❑ Bladder ❑ Bowels
❑ Bed to chair without help	❑ Wheelchair (self)	**Training**
❑ Must be lifted into chair	❑ Wheelchair (push)	❑ Cannot Train
	❑ Motorized chair	❑ Trained
		❑ Needs Training

Grooming	Client Needs:	No Help	Partial Help	Total Help
Bathing:	❑ Tub ❑ Shower ❑ Bed	❑	❑	❑
Dressing		❑	❑	❑
Shaving		❑	❑	❑
Care of hair		❑	❑	❑

Eating

- ❑ Has physical ability to eat without help.
- ❑ Needs partial help to eat.
- ❑ Needs help with eating:
  - ❑ Special diet.
  - ❑ Cannot cut food into bite-size pieces.
  - ❑ Cannot bring food from plate to mouth.

Preparing Meals

- ❑ Has physical ability to cook or prepare food without help.
- ❑ Needs partial help with meal preparation.
- ❑ Physically incapable of cooking or preparing meals.

VIII. Activities of Daily Living

Laundry	Incidental Housekeeping	Shopping
❑ Needs no help.	❑ Needs no help.	❑ Needs no help.
❑ Needs partial help.	❑ Needs partial help.	❑ Needs partial help.
❑ Physically incapable of performing task.	❑ Physically incapable of performing task.	❑ Physically incapable of performing task.

Attach additional pages as needed to describe the client's physical dependency needs. The assessing Registered Nurse must date and initial all attachments.

Client's Name: _____ **Medicaid ID #:** _____

IX. Assessment Narrative

X. Alternate Resources for Assistance

List alternate resources for assistance with the client's physical dependency needs, beginning with other members of the client's household. Repeat as appropriate for other family and community resources, in accordance with instructions found in the Personal Care provider manual. Attach additional pages as necessary to give a full account.

Client's Name: _____ **Medicaid ID #:**_____

XI. Certification of Service Need and Duration

I certify that personal care services are required to:_____

_____

_____

_____

Service Time

Maximum and minimum *daily aggregate* service-time estimates (in hours and minutes or hours and fractional hours for Personal Care Aide services for the client are:

Daily Totals

Weekday #	1	2	3	4	5	6	7
Maximum							
Minimum							

Weekly Totals

Maximum_____ Minimum_____

Additional comments regarding the duration, frequency or scope of personal care services:

_____

_____

_____

Registered Nurse's Signature and Date

XII. Personal Care Service Plan

Attach additional pages as necessary. The PCP or attending physician must sign or initial and date his or her attachments to the service plan. Please give detailed information.

_____

_____

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_____

Client's Name: _____ **Medicaid ID #:**_____

XIII. Personal Care Service Plan (Continued)

Physician Authorization

I have examined this patient within the past 60 days. I have reviewed the assessment and I confirm its accuracy. I authorize the personal care assistance detailed in this service plan, including additions and modifications dated and initialed by myself and excluding deletions dated and initialed by myself. I am aware that all personal care must be medically necessary and that the Utilization Review Section of the Division of Medical Services may review this assessment and service plan.

_____ _____
Signature of Attending Physician Date

Client Acceptance of Authorized Service Plan

I understand that I will receive only medically necessary assistance with my physical dependency needs. I accept this personal care service plan.

_____ _____
Signature of Client or Client's Representative Date

To prior authorize services for recipients under age 21, send completed pages 1 through 6 to:

Arkansas Foundation for Medical Care, Inc.
P.O. Box 180001
Fort Smith, AR 72918-0001
FAX#: (501)-649-0776

For extension of benefits for recipients of age 21 or over, send completed pages 1 through 7 to:

Division of Medical Services
Utilization Review Section
P.O. Box 1437, Slot S413
Little Rock, AR 72203-1437

Client's Name: _____ **Medicaid ID #:** _____

Providers requesting prior authorization of services for clients under the age of 21 *do not* use this page.

Providers requesting extensions of benefits for clients aged 21 and over must complete only the first item—"Additional Service-Time Increments Requested" and dates of service. The remainder of the page is your notification of approval or denial, to be forwarded to you upon the disposition of the benefit extension request.

Additional Service-Time Increments Requested	Begin Date of Service	End Date of Service

XIV. Provider Notification

Notification of Approval

Procedure Code	Service-Time Increments	Begin Date	End Date	Control Number

Signature of UR Nurse:_____ Date:_____

Signature of DMS Medical Director:_____ Date:_____

Notification of Denial

Signature of UR Nurse:_____ Date:_____

Signature of DMS Medical Director:_____ Date:_____

220.000 Service Administration

220.100 Service Supervision

A. The provider must assure that the delivery of personal care services by personal care aides is supervised.

1. Supervision must be performed by a Registered Nurse.

2. Alternatively, a Qualified Mental Retardation Professional (QMRP) may fulfill the RN supervision requirement for personal care services to clients residing in alternative living situations or alternative family homes, authorized or licensed by the Division of Developmental Disabilities Services.

B. The supervisor has the following responsibilities.

1. The supervisor must instruct the personal care aide in

a. Which routines, activities and tasks to perform in executing a client's service plan,

b. The minimum frequency of each routine or activity and

c. The maximum number of hours per month of personal care service delivery, as authorized in the service plan.

2. At least once a month, the supervisor must

a. Review the aide's records,

b. Document the record review and

c. If necessary, further instruct the aide and document the nature of and the reasons for further instructions.

3. At least three times every 183 days (six months) at intervals no greater than 62 days, the supervisor must visit the client at the service delivery location to conduct on-site evaluation.

a. Medicaid requires that at least one of these supervisory visits must be when the aide is not present.

b. At least one visit must be while the aide is present and furnishing services.

220.100 Service Supervision (Continued)

4. When the aide is present during the visit the supervising RN or QMRP must

   a. Observe and document

      1) The condition of the client,

      2) The type and quality of the personal care aide's service provision and

      3) The interaction and relationship between the client and the aide;

   b. Modify the service plan, if necessary, based on the observations and findings from the visit and

   c. If necessary, further instruct the aide and document the nature of and the reasons for further instructions.

5. When the aide is not present during the visit, the supervising RN or QMRP must

   a. Observe and document the condition of the client,

   b. Observe and document, from available evidence, the type and quality of the personal care aide's service provision, and

   c. Query the client or the client's representative and document pertinent information regarding the client's opinion of

      1) The type and quality of the aide's service,

      2) The aide's conduct and

      3) The adequacy of the working relationship of the client and the aide;

   d. Modify the service plan if necessary, based on observations and findings from the visit, and

   e. Further instruct the aide, if necessary, and document the nature of and the reasons for further instructions.

C. The provider must review the service plan and the aide's records as necessary, but no less often than every 62 days. The review will ensure that the daily aggregate time estimate in the service plan accurately reflects the actual average time the aide spends delivering personal care aide services to a client.

220.110 Service Log

Instructions in this section apply to all clients' service logs. See section 220.111 for special documentation requirements regarding multiple clients who are attended by one aide. See section 220.112 for special documentation requirements regarding multiple aides attending one client. The examples in these sections and in section 220.200 are related to food preparation, but personal care clients may receive other services in congregate settings if their individual assessments support their receiving assistance in that fashion.

A. Medicaid covers only service time that is supported by an aide's service log.

B. Service time in excess of the maximum service time estimates in the authorized service plan is covered only when the provider complies with the rules in sections 215.330 and 220.110 through 220.112.

C. The time estimate in the service plan is not service documentation. It is an estimate of the anticipated minimum and maximum daily duration of medically necessary personal care aide service for an individual client.

D. For each service date, for each client, the personal care aide must record the following:

1. The time of day the aide begins the client's services.

2. The time of day the aide ends a client's services. This is the time of day the aide concludes the service delivery, not necessarily the time the aide leaves the client's service delivery location.

3. Notes regarding the client's condition as instructed by the service supervisor.

4. Task performance difficulties.

5. The justification for any emergency unscheduled tasks and documentation of the prior-approval or post-approval of the unscheduled tasks.

6. The justification for not performing any scheduled service plan-required tasks.

7. Any other observations the aide believes are of note or that should be reported to the supervisor.

220.110 Service Log (Continued)

E. If the aide discontinues performing service-plan-required tasks at any time before completing all of the required tasks for the day, the aide will record:

1. The beginning time of the non-service plan-required activities,

2. The ending time of the non-service plan-required activities,

3. The beginning time of the aide's resumption of service plan-required activities and

4. The beginning and ending times of any subsequent breaks in service plan-required aide activities.

F. If the aide discontinues or interrupts the client's service plan-required activities at one location to begin service plan-required activities at another location, the aide must record the beginning and ending times of service at each location.

220.111 Service Log for Multiple Clients

An aide delivering services to two or more clients at the same service location, during the same period (discontinuing or interrupting a client's service plan-required tasks to begin or resume service plan-required tasks for another client, or performing an authorized service simultaneously for two or more clients), must comply with the applicable instructions in parts 1 or 2 below:

A. If providing services for only two clients, the aide must record in each client's service log

1. The name of each individual for whom they are simultaneously performing personal care service and

2. The beginning and ending times of service for each client and the beginning and ending times of each interruption and of each resumption of service.

B. If services are performed in a congregate setting (more than two clients) the service log must state

1. The actual time of day (clock-time) that the congregate services begin and end and

2. The number of individuals, and the name of each individual, both Medicaid-eligible and non-Medicaid eligible, who received the documented congregate services during that period.

220.112 Service Log for Multiple Aides with One Client

When two or more aides attend a single client, each aide must record the beginning and ending times of each service plan-required routine or activity of daily living that she or he performs for the client, regardless of whether another aide is performing a service plan-required routine or activity of daily living at the same time.

220.200 Calculating Individual Service Times for Services Delivered in a Congregate Setting

If services, such as meal preparation in a congregate setting, are delivered simultaneously, only the actual proportionate service time attributable to each individual client is covered.

A. The provider shall compute the covered time by dividing the actual aide clock-hours, attributing a proportionate share to each individual and multiplying each individual's proportionate share by a percentage arrived at from the individual's assessment. For example:

1. If an individual is totally dependent and cannot prepare a meal, the provider would be eligible for 100 percent of the client's proportionate share.

2. If a resident is totally capable of preparing a meal, the provider is not eligible for any reimbursement for any of the client's proportionate share.

3. If the client has an impairment that limits but does not totally prevent meal preparation the provider will be eligible for reimbursement of 50 percent of the individual's proportionate share of the aide's time.

B. The client's assessment must describe, in narrative form, his or her level of impairment with respect to each physical dependency with which the client receives assistance in a congregate setting.

220.210 Incremental Billing System

A. Fifteen minutes of authorized, documented and logged personal care equals one (1) *service-time increment* of personal care aide service.

B. Providers may bill for fifteen minutes of service by means of the *Incremental Billing System*.

C. In a single claim transaction, a provider may bill only for service time accumulated within a single day for a single client.

D. There is no "carryover" of time from one day to another or from one client to another.

E. The estimated daily maximum service time in the client's service plan is the upper limit for daily billing. Providers may bill for no more service time in a day than the average daily maximum service-time estimate in the service plan.

220.210 Incremental Billing System (Continued)

F. The aide's time spent on documentation and logging activities may be included as service time for the service being documented. No other administrative activities qualify as service time.

G. One hour of personal care aide service equals one unit of service.

H. The *Incremental Billing System* is the method by which to calculate the allowed number of service-time increments for billing purposes.

220.211 Calculating Service-time Increments with the Incremental Billing System

Personal Care providers must bill Medicaid by service-time increments of fifteen (15) minutes.

A. Total the aide's daily personal care service-time for a single client in minutes, using the beginning-and-ending-of-service times from the aide's service log.

B. Set your calculator to compute to three decimal places.

C. Divide the total time (expressed in minutes) by fifteen and

D. Bill for the lesser of:

1. The rounded, whole-number quotient of the division or

2. The maximum time estimate in the service plan.

220.212 Rounding Calculated Service-time Increments in the Incremental Billing System

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

A. If the number after the decimal point is 500 (example, 3.500) or less (example, 3.495) round downward to the whole number displayed before the decimal point (3, in this example)

B. If the number after the decimal is 501 (example, 3.501) or greater (example, 3.576) round upward to the whole number one *greater* than the whole number displayed before the decimal point (4 in this example, because it is a whole number one greater than 3).

221 Documentation

The personal care provider must keep and make available to authorized representatives of the Arkansas Division of Medical Services, the State Medicaid Fraud Control Unit and representatives of the Department of Health and Human Services and its authorized agents or officials; records including:

A. If applicable, certification by the Home Health State Survey Agency as a participant in the Title XVIII Program. Agencies that provided Medicaid personal care services before July 1, 1986 are exempt from this requirement.

B. If applicable, licensure as a residential care facility by the Office of Long Term Care.

C. Contract to participate in the Arkansas Medicaid Program.

D. Documents signed by the supervising RN or QMRP, including:

1. The initial and all subsequent assessments.

2. Instructions to the personal care aide regarding:

   a. The tasks the aide is to perform,

   b. The frequency of each task and

   c. The maximum number of hours and minutes per month of aide service authorized by the client's attending physician.

3. Notes arising from the supervisor's visits to the service delivery location, regarding:

   a. The condition of the client,

   b. Evaluation of the aide's service performance,

   c. The client's evaluation of the aide's service performance and

   d. Difficulties the aide encounters performing any tasks.

4. The service plan and service plan revisions,

   a. The justifications for service plan revisions,

   b. Justification for emergency, unscheduled tasks and

   c. Documentation of prior or post approval of unscheduled tasks.

240.000 PRIOR AUTHORIZATION

A. The Arkansas Medicaid Personal Care Program requires prior authorization of services in the home and other locations for clients under the age of 21.

B. Prior authorization does not apply to Arkansas Medicaid Personal Care Program services for clients of ages 21 and older.

C. Prior authorization does not guarantee payment for the service.

1. The recipient must be Medicaid-eligible on the dates of service and must have available benefits.

2. The provider must follow the billing procedures in Section III of this manual.

241.000 Personal Care Program Prior Authorization (PA) Responsibility

A. Arkansas Foundation for Medical Care (AFMC) is responsible for prior authorization of personal care services for clients under the age of 21.

B. AFMC reviews the personal care provider's submitted documentation, authorizes a set amount of service time per month (expressed in service-time increments, four per hour) and issues a prior authorization control number (PA Number) for the approved service.

242.000 Personal Care PA Request Procedure

A. Providers must use pages 1 through 6 of form DMS-618 to request PA.

B. Requests for prior authorization must be submitted within thirty calendar days of the start of care. Approvals will be retroactive to the beginning date of service if the request is received within the 30-day time frame.

Mail or Fax the Required Documents to:

Arkansas Foundation for Medical Care, Inc.
P.O. Box 180001
Fort Smith, Arkansas 72918-0001

243.000 Provider Notification Procedure

Reviews will be completed by AFMC within fifteen (15) working days of receipt of a complete PA request.

A. For approved cases, an approval listing will be mailed to the requesting provider and the authorizing physician, detailing the procedure codes approved, total number of service time increments, beginning and ending dates and the authorization number.

B. For denied cases, a denial letter with reason for denial will be mailed to the requesting provider and the authorizing physician. Reconsideration of the denial may be requested within thirty calendar days of the denial date. Requests must be made in writing and include additional documentation.

244.000 Duration of PA

A. Personal Care PAs are assigned for six months or for the life of the service plan, whichever is shorter; *however*,

B. AFMC may validate a PA for one year if the provider requests an extended PA because the client is permanently disabled.

1. A one-year PA remains valid *only* if the service plan and services remain unchanged and the provider meets all Personal Care Program requirements.

2. Providers receiving extended PAs for permanently disabled clients must continue to follow Personal Care Program policy regarding regular assessments and service plan renewals and revisions.

245.000 Provider Process for Reconsideration of PA Determination

Reconsideration of a denial may be requested within thirty calendar days of the denial date. Reconsideration requests must be made in writing to AFMC and must include additional documentation to substantiate the medical necessity of the requested services.

If the decision is reversed during the reconsideration review, an approval is forwarded to all relevant parties specifying the approved units and services. If the denial is upheld, AFMC issues written notification of the decision to the recipient and provider.

246.000 Recipient Process for Appeal of PA Determination

When an adverse decision is received from AFMC, the recipient may request a fair hearing of the reconsideration decision of the denial of services from the Department of Human Services.

The appeal request must be in writing and received by the Appeals and Hearings Section of the Department of Human Services within thirty days of the date on the letter from AFMC explaining the denial. Appeal requests must be submitted to:

Department of Human Services
Appeals and Hearings Section
P.O. Box 1437, Slot N401
Little Rock, AR 72203-1437

311.400 Completion of HCFA-1500 Claim Form (Continued)

Field Name and Number		Instructions for Completion
24.	A. Dates of Service (Continued)	1. The charge for the period indicated by the sequential dates must be the sum of the charges for *equal service-time increments on each day* (inclusive) within that period. 2. The provider's service logs must support the claim's certification of equal measures of service on each day (inclusive) within the period indicated by the "from" and "to" dates.
	B. Place of Service	Enter the appropriate place of service code. See sections 311.200 and 312.000 through 312.230 for codes.
	C. Type of Service	Enter the appropriate type of service code. See sections 311.200 and 312.000 through 312.230 for codes.
	D. Procedures, Services or Supplies	Enter the procedure code that best describes the service.
	CPT/HCPCS	Enter the correct HCPCS procedure code from sections 312.000 through 312.230.
	Modifier	Not applicable to Personal Care claims.
	E. Diagnosis Code	Enter the diagnosis code corresponding to the diagnosis in Field 21, or enter the corresponding line number from Field 21. Enter only one diagnosis code or one diagnosis-code line number on each line of the claim. If two or more diagnosis codes apply to a service, use the code most appropriate to that service. The diagnosis codes are found in the *ICD-9-CM*.
	F. Charges	Enter the charge for the service. This charge should be the provider's customary fee to private-pay clients. If more than one unit of service is being billed, enter the charge for the total number of units billed.

311.400 Completion of HCFA-1500 Claim Form (Continued)

Field Name and Number	Instructions for Completion
G. Days or Units	Enter the units (in whole numbers) of service rendered within the time frame indicated in Field 24A.
H. EPSDT Screening/Referral and/or Family Planning	Enter "E" if services furnished were a result of a Child Health Services (EPSDT) screening/referral and "F" if services furnished are Family Planning related.
I. Emergency	This field is not required for Medicaid.
J. Coordination of Benefits (COB)	This field is not required for Medicaid.
K. Reserved for Local Use	Not applicable to personal care providers.
25. Federal Tax I.D. Number	This field is not required for Medicaid. This information is carried in the provider's Medicaid file. If it changes, please contact Provider Enrollment.
26. Patient's Account Number	Unique number assigned by the provider's facility for the recipient. Optional field. Up to 16 numeric or alphabetic characters will be accepted.
27. Accept Assignment	This field is not required for Medicaid. Assignment is automatically accepted by the provider when billing Medicaid.
28. Total Charge	Enter the total of Column 24F. This field should contain a sum of charges for all services indicated on the claim form. (See NOTE in Field 30.)

312.000 Personal Care Program Procedure Codes and Billing Specifications

See sections 311.100 through 311.150 for complete AEVCS data element field requirements. See sections 311.300 and 311.400 for claim data element descriptions and requirements, and for paper-claim field requirements.

See sections 220.110 through 220.112 for pertinent service log information. See section 220.200 and sections 220.210 through 220.212 for instructions regarding calculation of billing units ("service-time increments").

312.100 Private Care Agency Billing

Medicaid enrolls private care agencies to provide personal care on weekends only. Medicaid defines a weekend as the hours from 12:00 AM Saturday through 11:59 PM Sunday. Private care agencies may use only the HCPCS procedure codes in this section, 312.100.

Z2623: Weekend Personal Care by a Private Care Agency—Client Under Age 21

Z2623 requires prior authorization (PA)

Place of Service Code	Type of Service Code
4 .....Client's Home C.....Residential Care Facility 0 (Zero) ..... Other Location	0 (Zero).....Personal Care

Z2624: Weekend Personal Care by a Private Care Agency—Client Aged 21 or Older

Place of Service Codes	Type of Service Code
4 .....Client's Home C.....Residential Care Facility 0 (Zero) ..... Other Location	0 (Zero)..... Personal Care

312.200 Full-Time Personal Care Agency Billing

312.210 Personal Care for a Client Aged 21 or Older

Z2474: Personal Care Aide Services—Client 21 or Older

Place of Service Codes	Type of Service Code
4..... Client's Home C ..... Residential Care Facility 0 (Zero) .....Other Location	0 (Zero)..... Personal Care

312.220 Personal Care for a Client Under 21

HCPCS procedure code **Z2325** represents the documented services of a personal care aide for a client under the age of 21. The services are provided in accordance with an individualized service plan authorized by the client's physician.

Z2325: Personal Care Aide Services, Client Under 21

Z2325 requires prior authorization.

Place of Service Codes	Type of Service Code
4.....*Client's Home	
5..... **DDS Facility	0 (Zero)..... Personal Care
O (Zero)..... ***Other Location	

*See section 213.500 for locations deemed the client's home.
**Developmental Disabilities Services Community Provider Facility, for clients under age 21 whose instruction is not the responsibility of the client's school district.
****Not* a public school.

312.230 Personal Care in a Public School

Z2326: Personal Care Aide in a Public School

Z2326 requires prior authorization.

HCPCS procedure code **Z2326** represents the documented services of a personal care aide in a public school. The services are provided in accordance with an Individualized Education Program and an individualized service plan authorized by the client's attending physician.

Place of Service Code	Type of Service Code
S..... Public School	S.....Public School

Procedure code **Z2326** requires place of service code **S** and type of service code **S** for dates of service on and after January 1, 2003.

See section 213.512 for a full explanation of the "public school" place of service.

See sections 220.110 through 220.112, section 220.200 and sections 220.210 through 220.212 for regulations regarding logging and calculating billable service time.

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