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TO: **Arkansas Medicaid Health Care Providers – DDS Alternative Community Services (ACS) Waiver**

DATE: **October 1, 2005**

SUBJECT: **Provider Manual Update Transmittal #54**

REMOVE		**INSERT**	
Section	**Date**	**Section**	**Date**
211.000	10-13-03	211.000	10-1-05
213.000 – 219.100	10-13-03	213.000 – 219.100	10-1-05
221.000	10-13-03	221.000	10-1-05
222.000 – 224.100	10-13-03	222.000 – 224.100	10-1-05
226.000	10-13-03	226.000	10-1-05
226.200	10-13-03	226.200	10-1-05
230.100	10-13-03	230.100	10-1-05
230.211	10-13-03	230.211	10-1-05
230.213	10-13-03	230.213	10-1-05
230.221 – 230.222	10-13-03	230.221 – 230.222	10-1-05
271.000 – 272.100	Dates Vary	271.000 – 272.100	10-1-05

Explanation of Updates

Section 211.000 has been revised to advise that home and community based waiver services are available only to individuals who are not residents of a hospital, nursing facility or intermediate care facility for the mentally retarded only if payment to the facility is being made through private pay or private insurance. Other minor changes have been made to clarify services.

Section 213.000 has been included to change the title of the section to “ACS Supportive Living.”

Section 213.100 has been included to change the title of the section to “ ACS Supportive Living Exclusions.”

Section 213.200 has been included to change the title of the section to ACS Supportive Living Array.”

Section 214.000 has been included to change the title of the section to “Community Experiences.”

Section 215.000 has been included to change the title of the section to “ACS Respite Care.”

Section 215.100 has been included to change the title of the section to “ACS Respite Care Child Support Services.”

Section 216.000 has been included to change the title of the section to “ACS Non-Medical Transportation.”

Section 217.000 has been included to change the title of the section to “ACS Waiver Coordination."

Section 217.100 has been included to change the title of the section to “ACS Waiver Coordination Definition – 2 (Fiscal Intermediary/Agent).” Obsolete information has been removed from the section.

Section 218.000 has been included to change the title of the section to “Supported Employment.”

Section 218.100 has been included to change the title of the section to “Supported Employment Exclusions.”

Section 218.200 has been included to change the title of the section to “Documentation Requirements for Supported Employment.”

Section 218.300 has been included to change the title of the section to “Benefit Limits for Supported Employment.”

Section 219.000 has been included to change the title of the section to “ACS Adaptive Equipment (Environmental Accessibility Adaptations).”

Section 219.100 has been included to change the title of the section to “Benefit Limits for ACS Adaptive Equipment.”

Section 221.000 has been included to make minor typographical changes for clarification of services.

Section 222.000 has been included to change the title of the section to “Supplemental Support Service.”

Section 222.100 has been included to change the title of the section to “Supplemental Support Service Exclusions.”

Section 222.200 has been included to change the title of the section to “Supplemental Support Service Benefit Limits.”

Section 223.000 has been included to change the title of the section to “Case Management Services.” Minor text changes have been made to clarify policy within the section, and obsolete information has been removed.

Section 224.000 has been included to change the title of the section to “Consultation Services.”

Section 224.100 has been included to change the title of the section to “Consultation Services Benefit Limits.”

Section 226.000 has been included to change the title of the section to “Crisis Center.”

Section 226.200 has been included to change the title of the section to “Crisis Center Plan of Care.”

Section 230.100 has been included to add information that for supportive living arrangements, the Medicaid eligibility date is retroactive to the date the Medicaid application is received at the DDS Medicaid Unit or no more than three months prior to the receipt of the Medicaid application, whichever is less.

Sections 230.211 has been included to add information that one sublevel of the pervasive level of care is that of individuals who meet the pervasive level of care as defined in the waiver document and as determined eligible based on the Inventory for Client and Agency Planning (ICAP) assessment process.

Section 230.213 has been included to remove obsolete information from the section.

Sections 230.221 and 230.222 have been included to remove obsolete information from the sections.

Sections 271.000 and 272.000 have been included to remove obsolete information from the sections.

Section 272.100 has been included to add new procedure codes and to advise that the unit of service for the new codes (**A0080**, **S5151**, **T2020**, **T2020-UA** and **T2024**) is one year. Several old codes have been revised and have a unit of service of one year (**H2016**, **H2016-UB**, **T2028** and **T2034**). Arkansas Medicaid descriptions have been added to several procedure codes that currently have only a national procedure code description.

Paper versions of this update transmittal have updated pages attached to file in your provider manual. See Section I for instructions on updating the paper version of the manual. For electronic versions, these changes will be automatically incorporated.

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 or 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.

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.

Thank you for your participation in the Arkansas Medicaid Program.

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Roy Jeffus, Director

SECTION II - DDS ALTERNATIVE COMMUNITY SERVICES (ACS) WAIVER

CONTENTS

211.000 Scope 10-1-05

The Arkansas Medical Assistance Program (Medicaid) offers certain home and community based services as an alternative to institutionalization. These services are available for eligible individuals with a developmental disability who would otherwise require an intermediate care facility for the mentally retarded (ICF/MR) level of care. The home and community based services to be provided through this waiver are described herein as the DDS Alternative Community Services Waiver Renewal, hereafter referred to as DDS ACS Waiver.

42 CFR §441.301(b)(1)(ii) states that home and community based waiver services are available **only** to individuals who are **not inpatients** (residents) of a hospital, nursing facility (NF) or intermediate care facility for the mentally retarded (ICF/MR) only if payment to the hospital, nursing facility or ICF/MR is being made through private pay or private insurance.

Services provided under this program are as follows:

A. ACS Supportive Living

B. Community Experiences

C. ACS Respite Care

D. ACS Non-Medical Transportation

E. ACS Waiver Coordination

F. Supported Employment

G. Adaptive Equipment

H. Environmental Modifications

I. ACS Specialized Medical Supplies

J. Supplemental Support Service

K. Case Management Services

L. Consultation Services

M. Crisis Intervention Services

N. Crisis Center

213.000 ACS Supportive Living 10-1-05

Supportive living is an array of individually tailored services and activities provided to enable eligible individuals to reside successfully in their own homes, with their families, or in an alternative living residence or setting. The services are designed to assist individuals in acquiring, retaining and improving the self-help, socialization and adaptive skills necessary to reside successfully in the home and community based setting.

213.100 ACS Supportive Living Exclusions 10-1-05

Only hired caregivers may be reimbursed for supportive living services provided.

Payments for supportive living services will not be made to the parent, stepparent or legal guardian of a person less than 18 years old.

Payments will not be made to a spouse or to the guardian or guardian's spouse when the spouse is named as co-guardian and has the authority to act in such manner for an individual over age 18.

The payments for these services exclude the costs of room and board, including general maintenance, upkeep or improvement to the individual's own home or that of his or her family.

Routine care and supervision for which payment will not be made are defined as those activities that are necessary to assure a person's well being but are not activities that directly relate to active treatment goals and objectives.

See section 270.000 for billing information.

213.200 ACS Supportive Living Array 10-1-05

There are three broadly defined service models that are covered through supportive living services. They include residential habilitation supports, residential habilitation reinforcement supports and companion and activities therapy services.

A. Residential Habilitation Supports

Residential habilitation supports are aimed at assisting the person to acquire, retain or improve his or her skill in a wide variety of areas that directly affect his or her ability to reside as independently as possible in the community. These services provide the supervision and support necessary for a person to live in the community. The supports that may be provided to an eligible individual include the following habilitation areas of need:

1. Self direction, which includes the identification of and response to dangerous or threatening situations, making decisions and choices affecting the person's life and initiating changes in living arrangement or life activities.
2. Money management that consists of training, assistance or both in handling personal finances, making purchases and meeting personal financial obligations.
3. Daily living skills that include habilitative training in accomplishing routine housekeeping tasks, meal preparation, dressing, personal hygiene, self administration of medications (to the extent permitted under state law) and other areas of daily living including proper use of adaptive and assistive devices, appliances, home safety, first aid and emergency procedures.
4. Socialization that includes training, assistance or both in participation in general community activities and establishing relationships with peers. Training associated with participation in community activities includes assisting the person to continue to participate in such activities on an ongoing basis.

5. Community integration, which includes activities, intended to instruct the person in daily living and community living skills in integrated settings. Included are such activities as shopping, church attendance, sports, participation in clubs, etc. The habilitation objectives to be served by such training must be documented in the person's service plan.
6. Mobility, including training, assistance or both, aimed at enhancing movement within the person's living arrangement, mastering the use of adaptive aids and equipment, accessing and using public transportation, independent travel or movement within the community.
7. Communication, which includes training in vocabulary building, use of augmentative communication devices and receptive and expressive language.
8. Behavior shaping and management that includes training, assistance or both in appropriate expressions of emotions or desires, compliance, assertiveness, acquisition of socially appropriate behaviors or reduction of inappropriate behaviors.

B. Residential Habilitation Reinforcement Supports

Residential habilitation reinforcement supports may be provided to eligible individuals. The services include the following:

1. Reinforcement of therapeutic services which consist of conducting exercises or reinforcing physical, occupational, speech and other therapeutic programs.
2. Performance of tasks to assist or supervise the person in such activities as meal preparation, laundry, shopping and light housekeeping that are incidental to the care and supervision of the participant, but cannot be performed separately from other waiver services.
    a. Assistance is defined as hands-on care of both a supportive and health-related nature, supports that substitute for the absence, loss or diminution or impairment of a physical or cognitive function, homemaker/chore services, fellowship and protection that includes medication oversight permitted under state law.
    b. Services are furnished to individuals who receive these services in conjunction with residing in the home.
    c. The total number of individuals (including participants served in the waiver) living in the home who are unrelated to the principal care provider cannot exceed 4.
    d. General household work on behalf of the participant is incidental and cannot exceed 20% of the total weekly hours worked.

NOTE: This does not include nursing services available through Medicaid State Plan.

C. Companion and Activities Therapies

D. Companion and activities therapy services and activities provide reinforcement of habilitative training being received by participants. This reinforcement is accomplished by using animals as modalities to motivate and to meet functional goals established for the individual's habilitative training.

E. Through the utilization of an animal's presence, enhancement and incentives are provided to persons to practice and accomplish such functional goals as:

1. Language skills
2. Increased range of motion
3. Socialization by developing the interpersonal relationships skills of interaction, cooperation, trust and the development of self-respect, self-esteem, responsibility,

confidence and assertiveness. Purchases of animals, animal feed or items used to care for or routinely equip an animal are not covered services.

214.000 Community Experiences 10-1-05

Community experiences services are a flexible array of supports designed to allow individuals to gain experience and abilities that will prevent institutionalization. Through this broad base of learning opportunities, participants will identify, pursue and gain skills and abilities in activities that reflect their interests.

This model helps to improve community acceptance, employment opportunities and general well-being. The services are preventive, therapeutic, diagnostic and habilitative and will create an environment that will promote a person's optimal functioning.

The model also teaches developmental and living skills in the natural environment or clinic setting to ensure maximum learning and generalization. The services focus on enabling the person to attain or maintain his or her potential functional level and must be coordinated with any physical, occupational or speech therapies listed in the plan of care. These services reinforce skills or lessons taught in school, therapy or other settings.

When supports are provided in a clinic setting and the individual receives four or more hours of support, a noon meal is included in the service.

Services include activities and supports to accomplish individual goals or learning areas, including recreation and/or for specific training or leisure activities. To participate in community experiences activities, an individualized plan of treatment is required. Each activity is then adapted according to the participant's needs. Activities include:

A. Community Based Time Management

B. Home Safety (sanitation, food handling, laundry, chemical storage)

C. Etiquette/Manners

D. Physical Exercise

E. Literacy

F. Job Interviewing Skills

G. Interpersonal Skills

H. Sex Education

I. Self Care/Proper Attire

J. Budgeting

K. Diet/Nutrition

L. Verbal Communication Skills

M. Self Improvement

N. Mental Health Support Groups

O. Adapted Curriculum AA Groups

P. Understanding Medications (e.g., what medication is used for, side effects, how to contact the physician or emergency services, how to communicate with a physician, understanding various lab and X-ray procedures, fear abatement, etc.)

Q. Disability Support Groups

See section 270.000 for billing information.

215.000 ACS Respite Care 10-1-05

ACS respite care is defined as services provided to or for waiver participants, regardless of their age, who are unable to care for themselves. It is furnished on a short-term basis because of the absence or need for relief of non-paid individuals, including parents of minors, primary caregivers and spouses of participants, who normally provide the care.

ACS respite care may be provided in the individual's home or place of residence, a foster home, Medicaid certified ICF/MR, group home, licensed respite care facility or licensed/accredited residential mental health facility for participants who have a dual diagnosis.

Room and board is not a covered service except when provided as part of respite care furnished in a facility that is not a private residence but is approved by the state as a respite care facility.

215.100 ACS Respite Care Child Support Services 10-1-05

ACS respite care service includes child care support services, which are services that promote access to and participation in child care through a combination of basic child care and support services required to meet the needs of a mentally retarded, developmentally disabled child aged birth to 18 years.

These services are not intended to supplant the responsibility of the parent or guardian. Parents or guardians will be responsible for the cost of basic child care, which is defined as fees charged for services provided in a specific childcare setting the same as for a child who does not have a developmental disability, mental retardation or both.

The services will be provided only in the absence of the primary caregiver during those hours when the caregiver is at work, in job training or at school.

Child care support services may be provided in a variety of settings including a licensed daycare facility, licensed daycare home, the child's home or other lawful childcare setting.

Medicaid pays only for support staff required due to the individual's developmental disability, not for daycare fees.

Services are separate and distinct from educational services provided at a school where attendance is mandated and the primary focus of the institution is the accomplishment of specified educational goals.

The services are separate and distinct from respite care services that are provided on a short-term basis because of the need for relief of those unpaid individuals normally providing the care.

Parents of minors, primary caregivers or a spouse of a participant may not be covered as respite care providers.

See section 270.000 for billing information.

216.000 ACS Non-Medical Transportation 10-1-05

ACS non-medical transportation services are provided to enable individuals served to gain access to DDS ACS and other community services, activities and resources. Activities and resources **must** be identified and specified in the plan of care.

This service is offered in addition to medical transportation as required under 42 CFR 431.53 and transportation services under the Medicaid State Plan, defined at 42 CFR 440.170(a) (if applicable), and must not replace them.

ACS transportation services must be offered in accordance with the individual's plan of care. Whenever possible, family, neighbors, friends or community agencies that can provide this service without charge must be utilized. In no case will a parent or legal guardian be reimbursed for the provision of transportation for a minor.

See section 270.000 for billing instructions.

217.000 ACS Waiver Coordination 10-1-05

ACS waiver coordination services include the responsibility for ensuring the delivery of all direct care services. This responsibility includes:

A. The coordination of all direct service workers who provide care through the direct service provider

B. Serving as liaison among the individual, parents or legal representatives, case management entities and DDS officials

C. Coordinating schedules for both DDS ACS Waiver and other Medicaid service categories

D. Providing direct planning input and preparing all direct service provider segments of any initial plan of care and annual continued stay review

E. Providing assistance relative to the obtaining of waiver Medicaid eligibility and ICF/MR level of care eligibility determination

F. Assuring the integrity of all direct service Medicaid wavier billing in that the service delivered must have DDS prior authorization and meet required waiver service definition and must be delivered before billing can occur

G. Arranging for all alternative living settings

H. Assuring transportation as identified in individual's plan of care

I. Assuring submission of timely (advance) and comprehensive behavior/assessment reports, continued plans of care, revisions as needs change and information and documents required for ICF/MR level of care and waiver Medicaid eligibility determination

J. Reviewing the participant's records and environment(s) in which services are provided by accessing appropriate professional sources to determine whether the individual is receiving appropriate support in management of medication

K. Minimum components of medication management include:

1. Staff is aware of the medications being used by the person.
2. Staff is knowledgeable of potential side effects of the medications being used by the person.
3. All medications consumed are prescribed or approved by the person's physician or other health care practitioner.
4. The person and/or the person's guardian(s) are informed about the nature and effect of medications being consumed and consent to the consumption of those medications.
5. Staff is implementing the service provider's policies and procedures as to medication management, appropriate to the person's needs.
6. If psychotropic medications are used, appropriate restrictive measures and positive behavior programming are present and in use.
7. The consumption of medications is monitored to ensure that they are accurately consumed as prescribed.

8. Any administration of medication or other nursing tasks or activities are performed only by staff to which a nurse has delegated the duty and under the nurse's supervision.
9. Medications are regularly reviewed to monitor their effectiveness to address the reason for which they are prescribed and for possible side effects.
10. An appropriate response is made to medication errors.

L. Serving as fiscal intermediary when the person or guardian elects to act as the employer for the hire and retention of caregivers when accessing supportive living services. When the person elects self-direction and fiscal intermediary services, the waiver coordination service definition applies.

Fiscal intermediary responsibilities include:

1. Technical assistance and training in interview and hiring techniques
2. Supervision
3. Taking corrective action
4. Dismissal
5. Record keeping
6. Tax withholding and reporting
7. Assistance for compliance with all state, federal and Department of Human Services and Division of Developmental Disabilities Services laws, regulations, policies and rules that apply to employment

See section 270.000 for billing information.

217.100 ACS Waiver Coordination Services Definition – 2 (Fiscal Intermediary/Agent) 10-1-05

This service assists the individual or guardian to manage and distribute funds contained in the individual Supportive Living budget (inclusive of Respite, Transportation and Community Experiences Services). When the individual or their guardian elects this option, the Division of Disabilities Services will establish a contract with the chosen provider and the person or their guardian. The contract shall address requirements and responsibilities for the following:

A. Implementation of the individual service agreement;

B. Specific qualifications, training and supervision required for the service providers;

C. Quality assessment and improvement activities;

D. Documentation of service provision and administrative activities;

E. Compensation amounts and procedures for paying in-home support providers;

F. Intermediary services such as preparing and disbursing payroll checks, facilitation of the employment of service workers, federal, state and local tax withholding payment, unemployment compensation fees, wage settlements, fiscal accounting, collecting and verifying worker timesheets, processing criminal background checks on prospective workers and expenditures reports;

G. Compliance with applicable federal and state laws and regulations including delegation of tasks by a nurse to unlicensed providers per Arkansas Nurse Practice Act;

H. Procedures for review and revision of the contract as deemed necessary by any of the parties;

I. Provision for any of the people to dissolve the contract with notice;

J. Provision for back-up support plan in the event of emergency due to worker absenteeism;

K. Notice that service providers must be hired without regard to prohibited federal and state discrimination laws and

L. Provision that the individual or their guardian is the EMPLOYER OF RECORD and as such is legally responsible for compliance with non-discrimination laws, Federal Wage and Hour laws and any injury or illness arising out of the course of employment.

The rate of compensation for this service shall be $100 per month plus up to 20% of the supportive living service budget.

See section 270.000 for billing information.

218.000 Supported Employment 10-1-05

Supported employment is designed for individuals for whom competitive employment at or above the minimum wage is unlikely or who, because of their disabilities, need intensive ongoing support to perform in a competitive work setting.

The services consist of paid employment conducted in a variety of settings, particularly work sites in which individuals without disabilities are employed. In accordance with the federal definition, DDS supports integrated work settings where the employment situation provides frequent, daily social interaction among people with and without disabilities.

The federal standard for integration requires that an individual work in a place where no more than eight people with disabilities work together and where co-workers without disabilities are present in the work setting or in the immediate vicinity.

When supported employment is provided at a work site where individuals without disabilities are employed, payment will be made only for the adaptations, supervision and training required by individuals receiving waiver services as a result of their disabilities. Coverage will not include payment for the supervisory activities rendered as a normal part of the business setting.

Supported employment includes:

A. Activities needed to sustain paid work by waiver individuals, including supervision and training;

B. Re-training for job retention or job retention or job enhancement;

C. Job site assessments and

D. Job maintenance visits with the employer for purposes of obtaining, maintaining and/or retaining current or new employment opportunities.

The employer is responsible for making reasonable accommodations in accordance with the Americans with Disabilities Act.

Transportation will be provided between the individual's place of residence and the site of the habilitation services, or between habilitation sites when the person receives habilitation services in more than one place, as a component part of the habilitation services. The cost of this transportation is included in the rate paid to providers of the appropriate type of habilitation service (non-medical transportation service).

Supported employment provided as a long-term support must be monitored, at a minimum, to consist of two meetings with the individual participating in supported employment and one employer contact a month.

The job coach, after consultation with each person in supported employment, can determine on a case-by-case basis how to best acquire current information relevant to assessing job stability and the individual's needs.

If on-site monitoring is not necessary to assess stability, alternative methods of gathering information for the twice-monthly assessment may be permitted. This may take a variety of forms, including telephone calls with supervisors and off-site meetings with the individual participating in supported employment as well as visits to the work site.

218.100 Supported Employment Exclusions 10-1-05

Supported employment requires related activities to be identified and included in outcomes with an accompanying work plan submitted as documentation of need for service.

Payment for employment services excludes:

A. Incentive payments made to an employer of waiver individuals to encourage or subsidize an employer's participation in the program.

B. Payments that are passed through to waiver individuals.

C. Payments for vocational training that are not directly related to the waiver individual's employment. In addition, reimbursement cannot be claimed if the individual is not able to perform the essential functions of the job. The functions of a job coach are to "coach," not to do the work for the person.

D. Eligible individuals may not receive ACS Waiver-supported employment services when the same services are otherwise funded under the Rehabilitation Act of 1973 or Public Law 94-142. This means that such services must be exhausted before waiver-supported employment services can be approved or reimbursement can be claimed.

218.200 Documentation Requirements for Supported Employment 10-1-05

Supported employment providers must maintain documentation in each waiver participant's personnel file to support that the individual is not receiving and has exhausted, either by reaching authorized limits, by denial or unavailability, services otherwise funded by P.L. 94-142.

Documentation must include proof from the funded provider where services were exhausted.

See Section 202.200 for other information to be retained for recipient's file.

218.300 Benefit Limits for Supported Employment 10-1-05

Individuals are limited to a maximum of thirty-two (32) units (8 hours) of supported employment services per date of service.

See section 270.000 for billing information.

219.000 ACS Adaptive Equipment (Environmental Accessibility Adaptations) 10-1-05

ACS adaptive equipment service provides for the purchase, leasing and, as necessary, repair of adaptive, therapeutic and augmentative equipment required to enable individuals to increase, maintain or improve their functional capacity to perform daily life tasks that would not be possible otherwise.

Adaptive equipment needs for supportive employment for a person are also included. This service may include specialized medical equipment such as devices, controls or appliances that will enable the person to perceive, to control or to communicate with the environment in which they live.

Equipment may only be covered if not available to the individual from any other source. Professional consultation must be accessed to ensure that the equipment will meet the needs of the individual. All items must meet applicable standards of manufacture, design and installation.

Computer equipment may be approved when it allows the participant control of his or her environment, assists in gaining independence or when it can be demonstrated that it is necessary to protect the health and safety of the person. Computers will not be purchased to improve socialization or educational skills.

Printers may be approved for non-verbal persons.

Computer desks or other furniture items will not be covered.

Communication boards are allowable devices. Computers may be approved for communication when there is substantial documentation that a computer will meet the needs of the person more appropriately than a communication board.

Software will be approved only when required to operate the accessories included for environmental control or to provide text-to-speech capability.

Personal emergency response systems (PERS) may be approved when they can be demonstrated as necessary to protect the health and safety of the participant. PERS are electronic devices that enable individuals to secure help in an emergency. The individual may also wear a portable “help” button to allow for mobility. The system is connected to the individual’s telephone and programmed to signal a response center once a “help” button is activated. The response center must be staffed by trained professionals.

PERS services are limited to individuals who live alone or who are alone for significant parts of the day and have no regular caregiver for extended periods of time and who would otherwise require extensive routine supervision.

219.100 Benefit Limits for ACS Adaptive Equipment 10-1-05

The annual expenditure for adaptive equipment is $7500.00 per person. If the person is also receiving environmental modification services, the COMBINED annual expenditure cannot exceed $7500.00.

221.000 ACS Specialized Medical Supplies 10-1-05

ACS specialized medical supplies include items necessary for life support and the ancillary supplies and equipment necessary for the proper functioning of such items. Non-durable medical equipment not available under the Medicaid State Plan may also be provided as an ACS specialized medical supply. All items provided must be specified in the individual's multi-agency plan of service (MAPS) and must be in addition to any medical equipment and supplies covered as a Medicaid State Plan service. Items that are not of direct medical or remedial benefit to the individual are excluded from this service.

Additional supply items are covered as a waiver service when they are considered essential for home and community-care. Covered items include:

A. Disposable incontinence undergarments such as adult diapers and reusable briefs with disposable liners

B. Ostomy and colostomy supplies

C. Nutritional supplements

D. Non-Prescription medications

E. Drug and/or alcohol screening

Incontinence undergarments, ostomy and colostomy supplies, nutritional supplements and non-prescription medications must be ordered by a physician for recipients. A physician, psychologist or court of law must order drug and/or alcohol screening.

Item(s) must be included in the plan of care. When the items are included in Medicaid State Plan services, this service will be an extension of such services.

222.000 Supplemental Support Service 10-1-05

The supplemental support service helps improve or enable the continuance of community living, allow the opportunity to participate in integrated leisure, recreational, social and educational activities and make a positive difference in the life of the waiver participant. Supplemental support service includes:

A. Emergency medical costs, including prescription drug co-pay.

B. Transitional expenses for initial integration into the community when transitioning from an ICF/MR or nursing facility to the waiver, or prevention of a need for or return to a more restrictive environment.

C. Ancillary supports to assure continued health and safety in crisis situations caused by acts of nature or events beyond the person's control.

D. Fees for activities that complement and reinforce community living or specific habilitation needs. (The activities must be therapeutic in nature and support needs as identified through multi-agency planning. Fees may be paid only for the waiver participant. Family membership fees are not included in the service. Renewal of this component must require documentation of prior use.)

Up to two meals each day is an allowable service. As an example, food that is obtained from restaurants, catering services and fast food outlets and which may be consumed on or off the site where the purchase is made is allowable.

The supplemental support service will be based upon demonstrated needs as identified in a person's treatment plan to be included in the plan of care as emergencies arise.

222.100 Supplemental Support Service Exclusions 10-1-05

The supplemental support service is not allowed to be used for rent, lease or house payments or for the purchase of food (groceries, such as purchased at a grocery store, market, farm, etc.) or any other room-and-board type of services.

222.200 Supplemental Support Service Benefit Limits 10-1-05

This service can be accessed only as a last resort. Lack of other available resources must be proven.

The maximum annual allowance is $1200.00 and this reimbursement must reduce the maximum allowable for the service, specialized medical needs, by the same amount of dollars that are used for this service. The total dollars used for the two services combined CANNOT exceed $3600.00 annually.

223.000 Case Management Services 10-1-05

Case management services refer to a system of ongoing monitoring of the provision of services included in the waiver participant's multi-agency plan of service (MAPS). Case managers initiate and oversee the process of assessment of the individual's level of care and the review of MAPS at specified reassessment intervals.

Case management services include responsibility for locating, coordinating and monitoring:

A. All proposed waiver services

B. Other Medicaid State Plan services

C. Needed medical, social, educational and other publicly funded services regardless of the funding source

D. Informal community supports needed by individuals and their families

The intent of case management services is to enable waiver participants to receive a full range of appropriate services in a planned, coordinated, efficient and effective manner.

Case management services consist of the following activities:

A. Arranging for the provision of services and additional supports

B. Monitoring and reviewing participant services

C. Facilitating crisis intervention

D. Guidance and support

E. Case planning

F. Needs assessment and referral for resources

G. Follow-along to ensure quality of care

H. Case reviews that focus on the individual's progress in meeting goals and objectives established through the case plan

I. Assuring the integrity of all case management Medicaid waiver billing in that the service delivered must have prior authorization and meet required waiver service definitions and must be delivered before billing can occur

J. Assuring submission of timely (advance) and comprehensive behavior and/or assessment reports, continued plans of care, revisions as needs change and information and documents required for ICF/MR level of care and waiver Medicaid eligibility determination

K. Arranging for access to advocacy services as requested by consumer in the event that case management and direct service are the same provider entry

Case management services are optional for some level categories and are available at three levels of service. They are:

A. Pervasive – Minimum of one personal visit AND one other contact monthly

B. Extensive – Minimum of one personal visit OR one other contact monthly

C. Limited – Minimum of one personal visit each quarter

The level is determined by the needs or options of the person receiving waiver services as defined in sections 230.000 through 230.300.

See section 270.000 for billing information.

224.000 Consultation Services 10-1-05

Consultation services assist waiver participants, parents and/or guardians and/or responsible individuals, community living services providers and alternative living setting providers in carrying out the participant's service plan.

A. Consultation activities may be provided by professionals who are licensed as:

1. Psychologists
2. Psychological examiners

3. Mastered social workers
4. Professional counselors
5. Speech pathologists
6. Occupational therapists
7. Physical therapists
8. Registered nurses
9. Certified parent educators
10. Certified communication and environmental control adaptive equipment/aids providers.

B. Activities involved in consultation services include:

1. Provision of updated psychological/adaptive behavior testing
2. Screening, assessing and developing therapeutic treatment plans
3. Assisting in the design and integration of individual objectives as part of the overall individualized service planning process
4. Training of direct services staff or family members in carrying out special community living services strategies identified in the person's service plan
5. Providing information and assistance to the individuals responsible for developing the participant's overall service plan
6. Participating on the interdisciplinary/multi-agency plan of service (MAPS) team, when appropriate
7. Consulting with and providing information and technical assistance with other service providers or with direct service staff and/or family members in carrying out a participant's service plan
8. Assisting direct services staff or family members in making necessary program adjustments in accordance with the person's service plan
9. Determining the appropriateness and selection of adaptive equipment to include communication devices and computers
10. Training and/or assisting persons, direct services staff or family members in the set up and use of communication devices, computers and software
11. Assisting in dealing with person's behavioral challenges and in the development of a behavioral management plan for the person
12. Training of direct services staff and/or family members by a professional consultant in:
    a. Activities to maintain specific behavioral management programs applicable to the person
    b. Activities to maintain speech pathology, occupational therapy or physical therapy program treatment modalities specific to the person
    c. The provision of newly identified medical procedures necessary to sustain the person in the community

224.100 Consultation Services Benefit Limits 10-1-05

Eligible individuals may receive twenty-five (25) hours of consultation services per waiver-eligible year.

See section 270.000 for billing information.

226.000 Crisis Center 10-1-05

Crisis center is a service provided in a crisis center equipped to provide short-term intervention.

Services include 24-hour emergency care services for individuals eligible for waiver services with priority given to individuals with a dual diagnosis or based upon clinical judgment that a high probability exists that further evaluation and assessment will identify a dual diagnosis.

Individuals who are court ordered for alternate placement or who are involved with the court system in Arkansas, according to Act 609 of 1995, may be considered eligible.

Individuals served by the waiver who have significant behavioral disorders and are in need of temporary intensive management or transition may also receive services.

This service will accommodate individuals who, by the nature of the emergency or court order time frames, have not been incorporated into the typical level of care categorical eligibility process or who are in need of transition.

Admission is limited to individuals in a crisis situation where their current placement is no longer viable and an immediate alternate placement cannot be identified. Individuals, depending on the crisis situation or intensity, may receive services in one of three levels.

Placement in the crisis center may only be approved in no greater than 3-month increments. This does not imply that a person must remain for a minimum of 3 months. This period of time must be used for stabilization, identification of alternate placements with emphasis on family reunification (when appropriate) and identification of support mechanisms to facilitate transition. A person may be transitioned to the least restrictive environment available at the earliest possible time that will assure the highest probability of success.

226.200 Crisis Center Plan of Care 10-1-05

All persons must have a pre-approved interim plan of care that permits options based upon the level of need. Each plan is specific to pre-identified treatment needs with the amount or intensity of each service option adjustable within a maximum daily reimbursement rate. Appropriate psychiatric supports will be available. Medical needs will be met through private, Medicaid State Plan or other funding sources.

A. Crisis Center Level I - Interim Plan of Care Menu:

1. Assessments
   a. Behavioral
   b. Needs
   c. Psychological
2. Consultation
3. Therapeutic Programming
   a. Psychotherapy
   b. Behavioral Management
   c. Day Habilitation
   d. Medication Management
4. Transportation
5. Waiver Coordination
6. Case Management

B. Crisis Center Level II - Interim Plan of Care Menu:

1. Assessment
   a. Behavioral
   b. Needs
   c. Psychological
2. Consultation
3. Therapeutic Programming
   a. Psychotherapy
   b. Behavioral Management
   c. Medication Management
   d. Day Habilitation
   e. Supportive Living
   f. Community Integration
   g. Transportation
   h. Waiver Coordination
   i. Case Management

C. Crisis Center Level III - Interim Plan of Care Menu:

1. Assessment
   a. Behavioral
   b. Needs
   c. Psychological

2. Therapeutic Programming
    a. Psychotherapy
    b. Behavioral Management
    c. Medication Management
    d. Day Habilitation
    e. Supportive Living
    f. Alternate Living
    g. Community Integration
3. Transportation
4. Waiver Coordination
5. Case Management

See section 270.000 for billing information.

230.100 Categorical Eligibility Determination 10-1-05

Current eligibility for the Arkansas Medicaid Program must be verified as part of the in-take and assessment process for admission into the ACS Waiver Program. Medicaid eligibility is determined by the Division of Developmental Disabilities Services or by the Social Security Administration for SSI Medicaid eligibles.

Failure to obtain any required eligibility determination, whether initial or subsequent (time bound) re-assessments, will result in the individual's case being closed. Once closure has occurred, the affected person will have to make a new request for services through the waiver program intake process.

For the supportive living arrangements, the Medicaid eligibility date is retroactive to the date the Medicaid application is received at the DDS Medicaid Unit or no more than three months prior to the receipt of the Medicaid application, whichever is less.

230.211 Pervasive Level of Care 10-1-05

The pervasive level of care is defined as needs that require constant supports provided across environments that are potentially life sustaining in nature. Supports are intrusive and long term and include a combination of any available waiver supports provided 24 hours a day, 7 days a week for 365 days a year with case management at the highest level (minimum of one personal visit and one other contact monthly). Sublevels are:

A. People who are adjudicated under Act 609; are receiving Department of Human Services (DHS) Integrated Supports; are civil commitments; are children in custody of the Division of Children and Family Services (DCFS) and who are receiving services through the Children's Adolescents Special Services Programs.

B. Human Development Center (HDC) residents transitioning to community living.

C. Nursing facility residents transitioning to community living.

D. Individuals who have compulsive behavior disorder that is life threatening and appropriate care in a group setting would be a violation of the rights of others.

E. People who meet the pervasive level of care as defined in the waiver document and as determined eligible based on the Inventory for Client and Agency Planning (ICAP) assessment process.

230.213 Limited Level of Care 10-1-05

The limited level of care is defined as supports that are anticipated to be consistent for the foreseeable future. They are individually time-limited and may be intermittent in nature and are subject to re-evaluation every 12 months. This level of support requires parental support, group settings and community assistance available to the individual.

Intermittent and time-limited supports are supports for primary caregiver relief, employment training, transitional supports, crisis behavior management and assisted living supports.

Case management for this Level I is a minimum of one visit per quarter. When case management is not chosen as a service component there must be a willing, responsible adult to assume all case management functions. Sublevels are:

Supported living arrangements: Provided for beneficiaries of DDS-funded supported living arrangements. General revenue must be available and in use for the existing service level with supporting general revenue to be used for the payment of Medicaid match in order for waiver conversion to occur. There are two categories of supported living arrangements:

A. Moderate supported living services level – 15 days of service per month inclusive of case management and

B. Minimal supported living services level – 10 days of service per month inclusive of case management.

230.221 Traditional Service Model 10-1-05

In the traditional service model, services are delivered through a DDS and Medicaid licensed service provider network with all services coordinated and obtained through a case management provider.

Individuals or guardians determine provider choice from this network and may change providers upon written notice to DDS. In the traditional service model, the direct care service provider is responsible to advertise for, interview, hire, supervise, train and otherwise manage an employment workforce who provides supported living care.

Services are provided on a fee for service or cost reimbursement methodology. In this model, providers may provide both case management and direct care services.

230.222 Self-Directed Model 10-1-05

Through the self-directed model, individuals needing supported living services have the option of hiring and otherwise managing their direct caregivers. When this option is chosen, the person, their parent or legal guardian is responsible for advertisement, interviewing, supervising and otherwise directing the caregiver(s).

They are responsible for compliance with all state and federal laws, rules and regulations pertaining to employment and compensation inclusive of drug screens and criminal background checks, withholdings and reporting to the government.

The individual's chosen direct service provider fiscal intermediary/agent will be responsible to assist in all aspects as fiscal intermediary. Responsibilities include:

A. Serving as payee for the authorization and dispensation of payment to the caregivers

B. Providing required caregiver training

C. Maintaining payroll records with completion

D. Submitting all required government (federal, state or local) reports and remuneration

The self-directed model option applies to non-medical transportation and respite care. Waiver coordination is included as a function of the direct service provider.

271.000 Introduction to Billing 10-1-05

DDS ACS Waiver providers use the CMS-1500 claim form to bill the Arkansas Medicaid Program on paper for services provided to eligible Medicaid recipients. Each claim should contain charges for only one recipient.

Section III of this manual contains information about Provider Electronic Solutions (PES) and other available options for electronic claim submission.

272.000 CMS-1500 Billing Procedures 10-1-05

272.100 DDS ACS Waiver Procedure Codes 10-1-05

The following procedure codes and any associated modifier(s) must be billed for DDS ACS Waiver Services. Prior authorization is required for all services.

Procedure Code	M1	M2	PA	Description	Unit of Service	POS for Paper Claims	POS for Electronic Claims
A0080			Y	ACS Non-Medical Transportation	1 Year	0	99
H2016			Y	ACS Supportive Living (Individual)	1 Year	4, 0	12, 99
H2016	UB		Y	ACS Supportive Living (Group)	1 Year	4, 0	12, 99
H2023[1]			Y	Supported Employment	15 Minutes	0	99
S5151			Y	ACS Respite Care	1 Year	4, 0	12, 99
T2020			Y	Community Experiences	1 Year	4, 0	12, 99
T2020	UA		Y	Community Experiences	1 Year	4, 0	12, 99
T2022			Y	Case Management Services	1 Month	4, 0	12, 99
T2024			Y	ACS Waiver Coordination	1 Year	4, 0	12, 99
T2025[2]			Y	Consultation Services	1 Hour	4, 0	12, 99
T2028[3]			Y	ACS Specialized Medical Supplies	1 Year	4, 0	12, 99
T2034			Y	Crisis Center	1 Year	0, 4	99, 12
T2034[4]	U1	UA	Y	ACS Crisis Intervention Services	1 Hour	0, 4	99, 12

NOTE Providers may continue to use modifiers 22 and 52 for claims with dates of service through October 31, 2005. Effective for claims with dates of service on and after November 1, 2005, modifier 22 will be replaced with UA and modifier 52 will be replaced with UB.

[1] Individuals are limited to a maximum of 32 units (8 hours) of supported employment services per date of service.

A breakdown of the supported employment units of service includes:

One unit = 15 minutes to 21 minutes
Two units = 22 minutes to 37 minutes
Three units = 38 minutes to 52 minutes
Four units = 53 minutes to 67 minutes

[2] Beneficiaries may receive twenty-five (25) hours of ACS consultation services per waiver-eligible year.

[3] Reimbursement cannot exceed $300 per month.

[4] Crisis intervention services may require a maximum of 24 hours of service during any one day.

The following list contains the procedure codes used for ACS physical adaptations. Physical adaptations have a benefit limit of $7500 per year.

Procedure Code	M1	M2	PA	Description	POS for Paper Claims	POS for Electronic Claims
K0108			Y	⁂(ACS environmental modifications) Other accessories	4	12
S5160			Y	⁂(Adaptive equipment, personal emergency response system [PERS], installation and testing) Emergency response system; installation and testing	4	12
S5161			Y	⁂(Adaptive equipment, personal emergency response system [PERS], service fee, per month, excludes installation and testing) Emergency response system; service fee, per month (excludes installation and testing)	4	12
S5162			Y	⁂(Adaptive equipment, personal emergency response system [PERS], purchase only) Emergency response system; purchase only	4	12
S5165	U1		Y	⁂(ACS adaptive equipment) Home modifications, per service	4	12

⁂(…) This symbol, along with text in parentheses, indicates the Arkansas Medicaid description of the product.

Refer to section 272.200 for definitions of the place of service codes listed above.