ARKANSAS DEPARTMENT OF HUMAN SERVICES

Division of Medical Services
Program Planning & Development

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

DATE: **October 1, 2007**

SUBJECT: **Provider Manual Update Transmittal # 84**

REMOVE		**INSERT**	
Section	**Date**	**Section**	**Date**
201.200	5-1-06	201.200	10-1-07
211.000	5-1-06	211.000	10-1-07
213.000	10-1-05	213.000	10-1-07
213.100	5-1-06	213.100	10-1-07
213.200	10-1-05	213.200	10-1-07
215.000	10-1-05	215.000	10-1-07
215.100	10-1-05	215.100	10-1-07
216.000	10-1-05	216.000	10-1-07
217.000	10-1-05	217.000	10-1-07
217.100	10-1-05	217.100	10-1-07
219.000	10-1-05	219.000	10-1-07
219.100	10-1-05	219.100	10-1-07
221.000	10-1-05	221.000	10-1-07
221.100	10-13-03	221.100	10-1-07
223.000	5-1-06	223.000	10-1-07
226.200	10-1-05	226.200	10-1-07
230.210	5-1-06	230.210	10-1-07
230.211	5-1-06	230.211	10-1-07
230.212	5-1-06	230.212	10-1-07
230.213	5-1-06	230.213	10-1-07
230.220	10-13-03	230.220	10-1-07
230.222	10-1-05	230.222	10-1-07
230.223	5-1-06	—	—
230.400	10-13-03	230.400	10-1-07
230.410	5-1-06	230.410	10-1-07

REMOVE		**INSERT**	
Section	**Date**	**Section**	**Date**
230.420	5-1-06	230.420	10-1-07
251.000	5-1-06	251.000	10-1-07
272.100	7-1-07	272.100	10-1-07

Explanation of Updates

Section 201.200 has been revised to include clarification of the qualifications for an organized health care delivery system (OHCDS) provider.

Section 211.000 has been revised to include information and instructions about how to handle individuals placed in abeyance. Information has been removed about waiver coordination and the acronym ACS has been removed from services provided under the DDS ACS program.

Sections 213.000 and 213.100 have been included to remove the acronym ACS from the title of the sections.

Section 213.200 has been included to include information about direct care supervision. Minor text changes have been made that do not affect policy.

Sections 215.000 and 215.100 have been included to remove the acronym ACS from the title of the sections.

Section 216.000 has been included to remove the acronym ACS from the title of the section.

Sections 217.000 and 217.100 have been included to remove the title and text from the sections because waiver coordination services have been removed from the DDS ACS Program. The sections have been marked “reserved” for future changes.

Sections 219.000 and 219.100 have been included to remove the acronym ACS from the title of the sections.

Sections 221.000 and 221.100 have been included to remove the acronym ACS from the title of the sections.

Section 223.000 has been included to clarify case management activities and the levels of support for case management services. Minor text changes have been made that do not affect policy.

Section 226.200 has been included to remove waiver coordination as an option in the plan of care.

Section 230.210 has been included to revise the section title and text within the section.

Section 230.211 has been included to revise the section title and clarify the description of the pervasive level of support. Text within the section has also been revised for clarification of information.

Section 230.212 has been included to revise the title and clarify the description of the extensive level of support. Text within the section has also been revised for clarification of information.

Section 230.213 has been included to revise the title and clarify the description of the limited level of support. Text within the section has also been revised for clarification of information.

Section 230.220 has been included to show there are two service models, the traditional and supported living arrangement. The self-directed model has been discontinued within the waiver.

Section 230.222 has been revised to transfer the text and title of section 230.223 to this section. Information regarding the self-directed service model has been deleted as the service has been removed from the waiver.

Section 230.223 has been deleted. The text and title of the section has been transferred to section 230.222.

Section 230.400 has been included to add billing rate information for case management and supportive living services. Other minor text changes have been made for clarification of information.

Section 230.410 has been included to clarify instructions for MAPS.

Section 230.420 has been included for minor text changes for clarification of information.

Section 251.000 has been included for minor text changes for clarification of information.

Section 272.100 has been included for several reasons: Procedure code **T2024** has been removed because waiver coordination is no longer a covered service. The acronym ACS has been removed from the descriptions of several services. Information has been included to clarify the reimbursement for supplemental support and to note the combined benefit limit for specialized medical supplies and supplemental support. The units of service descriptions for procedure codes A0080, T2020 (UA), T2028 and T2034 have been changed to comply with waiver language. Other minor corrections in the billing charts and text have been made in the section.

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 have already been 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 (TDD only).

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

TOC required

201.200 Organized Health Care Delivery System Provider 10-1-07

The DDS Alternative Community Services (ACS) Waiver allows a provider who is licensed and certified as a DDS ACS case manager or a DDS ACS supportive living services provider to enroll in the Arkansas Medicaid Program as a DDS ACS organized health care delivery system (OHCDS) provider.

As long as the OHCDS provides at least one waiver service directly utilizing its own employees, an OHCDS provider may provide any other DDS ACS Waiver service via a sub-contract with an entity qualified to furnish the service.

The OHCDS provider furnishes the services as the individual's provider of choice as described in that individual's multi-agency plan of services (MAPS). The OHCDS provider must adhere to DDS ACS Waiver regulations as outlined in this provider manual. The OHCDS assumes all liability for services provided and/or performed by a sub-contracted entity.

211.000 Scope 10-1-07

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.

As stated in the DDS ACS Waiver, "waiver services will not be furnished to persons while they are inpatients of a hospital, Nursing Facility (NF), or Intermediate Care Facility for the Mentally Retarded (ICF/MR) unless payment to the hospital, NF, or ICF/MR is being made through private pay or private insurance."

A person may be placed in abeyance in three (3) month increments (with status report every month) for up to 12 months when a person is in a licensed/certified treatment program for purposes of behavior, physical or health treatment or stabilization. This is an option as long as the following conditions are met:

A. The need for absence must be for the purposes of treatment in a licensed/certified program for the purposes of behavior, physical or health treatment or stabilization, loss of home or primary non-paid caregiver.

B. The request must be in writing with supporting evidence included.

C. The request must be prior approved by DDS to include applicable DDS professionals' advisement.

Example: If the cause is behavior oriented, the request must be reviewed and recommended by DDS Psychological Team member.

D. A minimum of one (1) visit or one (1) contact each month is required.

NOTE: Personal visit versus contact depends upon the circumstances of the abeyance. If the person is receiving treatment out of state or in a facility/hospital where a visit may not be an option, contact with applicable medical/social work personnel, the individual, and the legal representative is permissible. When/if the case management agency cannot be reimbursed, this function will be the responsibility of the DD specialist.

E. Approval will be in 3-month increments with any/each request for continuance to be submitted in writing and supported by evidence of treatment status/progress. Request for

continuance must be in advance and timely to permit review and approval prior to abeyance expiration.

NOTE: This procedure does not stop closure of the Medicaid case relative to Medicaid income eligibility. It simply holds a slot in abeyance for the person's return. Medicaid income eligibility will be closed on the 60th day. If the person does not return to services within 60 days, Medicaid income eligibility must be re-determined once the person is released from treatment and ready to return to Waiver services.

F. All requests for abeyance are to be faxed to the Program Director for Adult and Waiver Services. Monthly status reports are required to be submitted to the DDS Waiver Administration as long as the person is in abeyance.

In order for individuals to continue to be eligible for waiver services while they are in abeyance the following two requirements must be met:

A. It must be demonstrated that an individual needs at least one waiver service as documented in their MAPS Plan of Care.

B. Individuals must receive at least one waiver service per month or monthly monitoring.

As stated in the Medicaid Service Manual, Section 1348, an individual living in a public institution is not eligible for Medicaid.

A. Public institutions include county jails, state and federal penitentiaries, juvenile detention centers, and other correctional or holding facilities.

B. Wilderness camps and boot camps are considered a public institution if a governmental unit has any degree of administrative control.

Thus, a person who is living in a public institution as defined above would be closed under Medicaid and also under the waiver program.

Services provided under this program are as follows:

A. Supportive Living
B. Community Experiences
C. Respite Care
D. Non-Medical Transportation
E. Supported Employment
F. Adaptive Equipment
G. Environmental Modifications
H. Specialized Medical Supplies
I. Supplemental Support Service
J. Case Management Services
K. Consultation Services
L. Crisis Intervention Services
M. Crisis Center

213.000 Supportive Living 10-1-07

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 Supportive Living Exclusions 10-1-07

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.

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 Supportive Living Array 10-1-07

Three broadly defined service models 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. 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.

E. Direct Care Supervision

The Direct Care Supervisor is responsible for ensuring the delivery of all direct care services. This responsibility includes:

1. The supervision of all direct service workers who provide care through the direct service provider

2. Serving as liaison among the individual, parents or legal representatives, case management entities and DDS officials
3. Coordinating schedules for DDS ACS Waiver, Medicaid and other generic service categories
4. Providing direct planning input and preparing all direct service provider segments of any initial plan of care and annual continued stay review
5. Assuring the integrity of all direct service Medicaid Waiver 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
6. Arranging for all alternative living settings
7. Assuring transportation as identified in individual's plan of care
8. 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
9. 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. Minimum components of medication management include:
   a. Staff is aware of the medications being used by the person.
   b. Staff is knowledgeable of potential side effects of the medications being used by the person.
   c. All medications consumed are prescribed or approved by the person's physician or other health care practitioner.
   d. 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.
   e. Staff is implementing the service provider's policies and procedures as to medication management, appropriate to the person's needs.
   f. If psychotropic medications are used, appropriate restrictive measures and positive behavior programming are present and in use.
   g. The consumption of medications is monitored by appropriately licensed/certified professionals to ensure that they are properly consumed as prescribed.
   h. Any administration of medication or other nursing tasks or activities is performed in accordance with the Nurse Practice Act as modified to include consumer directed care.
   i. Medications are regularly reviewed by qualified practitioners to monitor their effectiveness to address the reason(s) for which they were prescribed and for possible side effects.
   j. Effective detection and appropriate response is made to medication errors.

215.000 Respite Care 10-1-07

Respite care is defined as services provided to or for waiver participants who are unable to care for themselves, regardless of their age. 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.

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 Respite Care Child Support Services 10-1-07

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 Non-Medical Transportation 10-1-07

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 RESERVED 10-1-07

217.100 RESERVED 10-1-07

219.000 Adaptive Equipment (Environmental Accessibility Adaptations) 10-1-07

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 Adaptive Equipment 10-1-07

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 Specialized Medical Supplies 10-1-07

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 a 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 beneficiaries. 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.

221.100 Benefit Limits for Specialized Medical Supplies 10-1-07

The maximum annual allowance for specialized medical supplies is $3600.00. This service is a companion service to supplemental support services that has a maximum annual allowance of $1200.00. When both services are accessed in the same plan of care review year, the combined maximum allowance is $3600.00.

See Section 270.000 for billing information.

223.000 Case Management Services 10-1-07

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 guidance and support in all life activities. These activities include 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. Providing assistance relative to obtaining Waiver Medicaid eligibility and ICF/MR level of care eligibility determinations

J. 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

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

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

Service gaps of thirty (30) consecutive days must be reported to the DDS Specialist assigned to the case with a copy of the report sent to the DDS Program Director. The report must include the reason for the gap and identify remedial action to be taken.

Case management services are available at three levels of support. They are:

A. Pervasive – Minimum of one personal visit AND one other contact with the individual/legal representative monthly in the home where the person lives.

B. Extensive – Minimum of one visit with the individual/legal representative each month in the home where the person lives.

C. Limited – Minimum of one personal visit with the individual/legal representative in the home where the person lives each quarter and a minimum of one contact monthly.

D. Abeyance – Minimum of one visit or contact a month as defined in section 211.000.

The level is determined by the needs or options of the person receiving waiver services as defined in sections 230.211, 230.212 and 230.213.

See section 270.000 for billing information.

226.200 Crisis Center Plan of Care 10-1-07

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. 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. 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. Case Management

See section 270.000 for billing information.

230.210 Levels of Support 10-1-07

Coverage is provided within three levels of support. Levels of support are defined as pervasive, extensive and limited.

230.211 Pervasive Level of Support 10-1-07

The pervasive level of support is defined as needs that require constant supports provided across environments that are intrusive, 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.

A. This level may include persons in need of priority consideration who are currently served through Act 609; 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; Intermediate care facility/mental retardation; nursing facilities and persons who have compulsive behavior disorders.

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

C. Procedures for requesting pervasive level of support:

1. To request pervasive level of support, the Case Manager must submit the following items to the DDS Waiver Specialist:
   a. Documentation of any medical, behavioral or other changes that would justify the need for pervasive level of support.
   b. Copy of the current plan of care.
   c. Copy of the person's case management notes for the past year if request is due to behavior.
   d. If the reason for pervasive level of support is in whole or in part due to behavior issues, a copy of the most recent psychological information on behavioral intervention efforts to include:
      (1). A functional/behavior analysis of inappropriate behavior including possible antecedents
      (2). Description of inappropriate behaviors and consequences
      (3). Information related to increases or decreases in inappropriate behavior including time involved and frequency
      (4). Positive programming changes to include a description of the behaviors attempting to be established to replace the inappropriate behavioral expression.
   e. Copy of the computer generated or signed narrative report for the ICAP results which includes:
      (1). ICAP Domain scores (age scores and standard scores)
      (2). Information on problem behaviors recorded in the ICAP
      (3). ICAP Maladaptive Behavior Index Scores
      (4). ICAP Service Score/Level
      (5). The name and relationship of respondent must be clearly noted.
      (6). The name and credentials of the person administering and writing the report must be clearly noted.
2. DDS Waiver Staff will do the following things upon receipt of a request for pervasive level of support:
   a. The Waiver Specialist will check with DDS Licensure to see if any incident reports have been filed related to the individual. If any incident reports have been filed, a copy will be obtained for the plan of care meeting.
   b. The Waiver Manager will check the Incident Reporting Information System (IRIS) to see if any reports have been filed related to the individual. If any reports have been filed on IRIS, a summary will be compiled for the plan of care meeting.
   c. The Waiver Audit staff will check the Medicaid Management Information System (MMIS) and all waiver prior authorizations issued and payments for waiver services for the past year.
3. If the request packet is not complete, it will not be accepted. Retroactive approval will not be granted on pervasive level of support although emergency approval, pending receipt of required documents and determination, may be obtained from the Assistant Director of Adult and Waiver Services. Emergency requests may be made

via fax. For emergency requests, all the required documentation listed in this rule must be submitted within two working days.

4. If the Plan of Care team cannot make a decision on pervasive level of support and needs additional information, they will request assistance from the DDS Psychological team.
5. If assistance is requested from the DDS Psychological Team, the DDS Psychological team will convene within five working days following the Plan of Care meeting.
6. If the Plan of Care team requires additional information due to information not being complete or based on review of Incident Reports or IRIS, the time frame for approving pervasive level of support will start over.
7. All requests for pervasive level of support will be reviewed at the weekly plan of care meetings.

230.212 Extensive Level of Support 10-1-07

The extensive level of support is defined as needs that require daily supports in one or more environments (work, home or community). Supports are less intrusive than the pervasive supports and may require a schedule of weekly supports that may be needed daily, but less than twenty four hours a day, seven days a week.

230.213 Limited Level of Support 10-1-07

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

Supported living arrangements: Provided for beneficiaries of DDS-funded supported living arrangements. General revenue must be available and in use for the existing level of support 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 – at least15 days of service per month inclusive of case management and
B. Minimal supported living services level – at least10 days of service per month inclusive of case management.

230.220 Service Models—Traditional, and Supported Living Arrangement 10-1-07

There are two distinct service models available: traditional and supportive living arrangement.

230.222 Supportive Living Arrangement Model 10-1-07

In the supported living arrangement model, care is provided in DDS-supported living arrangements, in supported living apartments, in home and in group homes up to (but not inclusive of) 15 beds.

Supported living, community experiences, respite, and non-medical transportation are available for one rate of reimbursement with at least one service component being provided on at least 15 days each month for the moderate level or at least 10 days each month for the minimum level.

Under this model, the provider must deliver the level of support needed regardless of minimum service provision requirements. Case management, crisis center and crisis intervention is available and payable in addition to the monthly rates.

Living arrangements include:

A. Existing group homes serving groups of no more than 14 unrelated adults (age 18 and older) with developmental disabilities in the residential setting.

B. Existing DDS licensed supportive living apartments serving up to 4 unrelated adults (age 18 and older) with developmental disabilities in each self-contained apartment unit up to the total number of licensed units in the complex.

C. Adults served in their family home, in their own home or in an integrated apartment complex or in an alternative living setting with no more than 4 unrelated adults with developmental disabilities in the home.

D. Children served in their family home or in the home of an alternative family with no more than 4 unrelated children with developmental disabilities in the home.

Exception: Only those supportive living apartments and group homes licensed by the DDS prior to July 1, 1995, are approved to serve more than 4 adults. No expansions will be approved beyond the July 1, 1995, total capacity (waiver and non-waiver).

230.400 Multi-Agency Plan of Services (MAPS) 10-1-07

During the initial three months of DDS ACS Waiver Services, an individual receives services based on a DDS pre-approved interim plan of care that provides for case management at a rate of $107.00 per month, up to three months; and supportive living services at a rate of $100.00 per month, up to three months.

Prior to expiration of the interim plan of care, each individual eligible for ACS Waiver services must have an individualized, specific, written multi-agency plan of services developed by a multi-agency team and approved by the DDS authority.

The MAPS must be designed to assure that services provided will be:

A. Specific to the individual's unique circumstances and potential for personal growth

B. Provided in the least restrictive environment possible

C. Developed within a process assuring participation of those concerned with the individual's welfare

D. Monitored and adjusted to reflect changes in the individual's need

E. Provided within a system which safeguards the individual's rights

F. Documented carefully, with assurance that appropriate records will be maintained

G. Will assure the individual's and others' health and safety

230.410 MAPS for All Category Types 10-1-07

A. General Information

Identification information must include:

1. Beneficiary's full name and address
2. Beneficiary's Medicaid number
3. Guardian with an address (when applicable)
4. Individuals with MR/DD residing in home of waiver recipient
5. Physician Level of Care Certification/Prescription
6. Names, titles and signatures of the multi-agency team members responsible for the development of the beneficiary's multi-agency plan of service (MAPS)

B. Budget Sheet, Worksheets and Level of Care

Information must include:

1. Identification of waiver services
2. Services provider
3. Total amount by service
4. Total plan amount
5. Beginning and ending date for each service
6. Supported Living Array worksheet listing units and total cost by service
7. Adaptive Equipment/Environmental Modifications and Specialized Medical/Supplemental Support worksheets listing units and total cost by service
8. Level of Care sheet showing case management provider, case manager, supportive living provider, direct care supervisor and level of support.

C. Narrative Justification Initial Plan of Care and Continued Care Reviews

Justification must, at a minimum:

1. Identify progress or regression
2. Detail exceptional events such as major illness, injury, loss of primary caregiver(s), loss of home, graduation, awards, etc., that impacted service delivery and have a direct cause and effect for future needs.
3. Specify justification for requested services and identify consumer satisfaction level.

230.420 MAPS 10-1-07

A. The MAPS for individual and group option categories must include proposed outcomes, immediate and long term needs.

B. In addition to the information detailed in Section 230.410, the following information must also be included:

1. Identification of individual outcomes expected
2. Review date
3. List of medical and other services, including waiver and non-waiver services necessary to obtain expected outcomes.
4. Service barriers

C. Product and service cost effectiveness certification statement, with supporting documentation, certifying that products, goods and services to be purchased meet applicable codes and standards and are cost competitive for comparable quality.

251.000 Approval Authority 10-1-07

For the purpose of plan of care and service approvals, DDS, a Division under the umbrella of the Department Human Services, is the Medicaid authority.

A. The DDS prior authorization process requires that all annual plans of care projected to cost over $50,000.00 must have approval by DDS Plan of Care Review authority. This cost threshold is subject to reduction by DDS.

B. Plans of care projected to cost under $50,000.00 will be subject to a more local level approval process.

C. All waiver services must be needed to prevent institutionalization.

D. All persons receiving medications must also receive appropriate support in the management of medication(s). The use of psychotropic medications will require the development, implementation and monitoring of a written medication management plan.

E. Service requests that will supplant Department of Education responsibilities WILL NOT be approved.

F. All plan of care reviews are subject to review by a qualified physician and random audit scrutiny. In addition, the following activities will occur:

1. Review of provider standards and actions that provide for the assurance of a person's health and welfare
2. Monitoring of compliance with standards for any state licensure or certification requirement for persons furnishing services provided under this waiver
3. Assurance that the requirements are met on the date that services are furnished
4. Quality assurance reviews by DDS staff to include announced and unannounced quarterly on-site visits
5. Random review equal to a percent as prescribed by DDS Licensure/Certification policy

G. All service requests are subject to review by DDS and may necessitate the gathering and submission of additional justification, information and clarification before prior approval is made. In this event, it is the primary responsibility of the case management provider, with cooperation from the procurement source, to satisfy the request(s) within the prescribed time frames.

H. It is the responsibility of the case management services provider with cooperation from the direct services providers to ensure that all requests for services are submitted in a timely manner to allow for DDS prior authorization activities.

I. Initially, an individual receives up to three months of DDS ACS Waiver Services based on a DDS pre-approved interim plan of care. The pre-approved interim plan of care will include case management and supportive living service.

1. At any time during the initial three months, the providers will complete the multi-agency planning process and submit a detailed plan of care that identifies all needed, medically necessary services for the remainder of the annual plan of care year. Once approval is obtained, the additional services may be implemented.
2. ACS Waiver Services will not be reimbursed for any date of service that occurs prior to the date the individual's plan of care is approved or the date the individual is determined ICF/MR level of care and is deemed Medicaid/waiver eligible, whichever date is last.
3. All changes of service or level of support revisions that occur within an approved annual plan of care must also have prior approval. Services that are not prior approved will not be reimbursed.

J. Emergency approvals may be obtained via telephone, facsimile or e-mail, with retroactive reimbursement permitted as long as the notice of emergency, with request for service change, is received by DDS within 24 hours from the time the emergency situation was known. All electronically transmitted requests for emergency services must be followed with written notification and requests must be supported with documented proof of emergency.

272.100 DDS ACS Waiver Procedure Codes 10-1-07

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	National POS Codes
A0080[6]			Y	⁂Non-Medical Transportation	1 Mile	99
H2016[6]			Y	⁂Supportive Living (Individual)	1 Year	12, 99
H2016[6]	UB		Y	⁂Supportive Living (Group)	1 Year	12, 99
H2023[1]			Y	Supported Employment	15 Minutes	99
S5151[6]			Y	⁂Respite Care	1 Year	12, 99
T2020[6]			Y	⁂Community Experiences	1 Year	12, 99
T2020[2]	UA		Y	⁂Supplemental Support Services	1 Month	12, 99
T2022			Y	Case Management Services	1 Month	12, 99
T2025[4]			Y	⁂Consultation Services	1 Hour	12, 99
T2028[3]			Y	⁂Specialized Medical Supplies	1 Month	12, 99
T2034			Y	⁂Crisis Center	1 Day	99, 12
T2034[5]	U1	UA	Y	Crisis Intervention Services	1 Hour	99, 12

[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] Reimbursement for supplemental support cannot exceed $1200.00 per year.

[3] Reimbursement for specialized medical supplies cannot exceed $300 per month.

Specialized medical supplies and supplemental support has a combined benefit limit of $3600.00 per year.

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

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

[6] The supportive living array, which includes transportation, respite care, community experiences, and supportive living services, cannot exceed the $356.32 per day maximum (pervasive level).

The following list contains the procedure codes used for environmental modifications and adaptive equipment which has a combined benefit limit of $7500 per year.

Procedure Code	M1	M2	PA	Description	National POS Codes
K0108			Y	⁂(ACS environmental modifications) Other accessories	12
S5160			Y	⁂(Adaptive equipment, personal emergency response system [PERS], installation and testing) Emergency response system; installation and testing	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)	12
S5162			Y	⁂(Adaptive equipment, personal emergency response system [PERS], purchase only) Emergency response system; purchase only	12
S5165	U1		Y	⁂(ACS adaptive equipment) Home modifications, per service	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.