Arkansas Department of Health and Human Services

Division of Medical Services

P.O. Box 1437, Slot S-295
Little Rock, AR 72203-1437

Fax: 501-682-2480 **Internet Website: www.medicaid.state.ar.us**

TO: **Arkansas Medicaid Health Care Providers – Personal Care**

DATE: **October 1, 2007**

SUBJECT: **Provider Manual Update Transmittal #94**

REMOVE		**INSERT**	
Section	**Date**	**Section**	**Date**
202.000	blank	202.000	blank
202.200	3-1-05	202.200	10-1-07
202.201	3-1-05	—	—
202.202	3-1-05	—	—
202.210	3-1-05	202.210	10-1-07
204.000	3-1-05	204.000	10-1-07
—	—	213.530	10-1-07
215.350	10-13-03	215.350	10-1-07
—	—	215.351	10-1-07
215.360	3-1-05	215.360	10-1-07
216.000	10-13-03	216.000	10-1-07
216.200	10-13-03	216.200	10-1-07
221.000	10-13-03	221.000	10-1-07
262.100	7-1-07	262.100	10-1-07
—	—	262.105	10-1-07
262.110	7-1-07	262.110	10-1-07

Explanation of Updates

Section 202.000: This section has been renamed.

Section 202.200: This section has been renamed to reflect the amended rule that personal care providers not licensed in Arkansas may enroll in Arkansas Medicaid as closed-end providers only.

Sections 202.201 and 202.202 have been deleted because were rendered obsolete by the rule amendment in section 202.200.

Section 202.210: This section defines closed-end providers in the Personal Care Program.(The generic definition of “closed-end provider” is in Section V of this manual) This amended section describes and refers to participation requirements and enrollment procedures for the 2 types of closed-end Personal Care providers.

Section 204.000: This section has been renamed to indicate its purpose more accurately. Additionally, it has been comprehensively revised to help providers readily locate and more easily understand the rules that all Arkansas Medicaid providers must observe regarding maintaining documentation and records and making requested documentation and records available to authorized individuals and entities, Documentation requirements unique to the Personal Care Program are in pertinent and applicable locations throughout this provider manual..

Section 213.530: This new section establishes and sets forth the rules for providing employment-related personal care outside the home.

Section 215.350: This section has been renamed and shortened to include only one rule.

Section 215.351: This is a very important new section based on a second rule formerly comprising part of section 215.350. The Personal Care Program’s growing multiplicity of providers and places of service has necessitated a major rule amendment regarding a single beneficiary with multiple providers at multiple service locations.

Section 215.360: This major rule amendment became necessary for the same reason that required the amendment at section 215.351.

Section 216.000: This section is included only for editing that affects neither the meaning nor the application of the rules stated therein.

Section 216.200: This section is included to extend the range of sections of the manual that may contain certain rules from which Residential Care Facility Personal Care providers are exempt.

Section 221.000: This section is included to delete rules that have been moved to section 204.000, to incorporate the Division of Medical Service’s rules regarding record-keeping requirements and to identify specific exemptions and exclusive rules for Residential Care Facility Personal Care providers.

Section 262.100: This section is included in an attempt to help Personal Care providers ensure that they bill Medicaid correctly. Most personal care providers need little or none of this information. Providers affected by any of the circumstances described must read this section carefully to ensure that their Medicaid billings report their services as accurately as is possible under current circumstances.

Section 262.105: This new section establishes the procedure code and modifier for billing for employment-related personal care outside the home, and it describes the service represented by the procedure code and modifier.

Section 262.110: The title of this section has been changed to enable the section to be comprehensive. Part D has been added to explain place-of-service coding for employment-related personal care outside the home.

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

202.000 Routine Services Providers and Closed-End Providers

202.200 Personal Care Providers not Licensed in Arkansas 10-1-07

A. Personal care providers not licensed in Arkansas may participate in Arkansas Medicaid only as closed-end providers.

B. Personal care providers not licensed in Arkansas may become closed-end providers under two sets of circumstances.

1. Personal care providers not licensed in Arkansas may become Arkansas Medicaid closed-end providers in accordance with the rules that follow in section 202.210 and any applicable rules set forth between sections 200.000 and 202.000, exclusive.

2. Personal care providers not licensed in Arkansas may become Arkansas Medicaid "secondary" closed-end providers in accordance with the rules at sections 213.600 through 213.610 and any applicable rules set forth between sections 200.000 and 202.000, exclusive.

202.210 Closed-End Personal Care Providers 10-1-07

A. See the participation requirements at sections 213.600 through 213.610 for the means by which personal care providers not licensed in Arkansas may become eligible to enroll as Arkansas Medicaid Personal Care "secondary" closed-end providers.

B. With the exception of the participation requirements for "secondary" closed-end providers, personal care providers in states not bordering Arkansas may enroll in Arkansas Medicaid as closed-end providers only after they have served an Arkansas Medicaid beneficiary and they have a claim or claims to file for reimbursement.

1. Enrollment as a closed-end provider automatically expires after a year unless they perform and bill for subsequent services for Arkansas Medicaid beneficiaries during the year. See part C below.

2. To enroll, providers must download the Personal Care provider manual (which includes provider application materials in Section V) from the Arkansas Medicaid website, **www.medicaid.state.ar.us**, and then submit all required documentation, including a completed provider application, a Medicaid contract and their claim(s) to the Medicaid Provider Enrollment Unit. **View Medicaid Provider Enrollment Unit contact information.**

C. Closed-end providers remain enrolled for one year.

1. If a closed-end provider serves another Arkansas Medicaid beneficiary during the provider's year of enrollment and bills Arkansas Medicaid for the service, the provider's enrollment may continue for one year past the most recent date of service, conditioned upon the provider's keeping the enrollment file current.

2. During a closed-end enrollment period, a closed-end provider may file any subsequent claims directly to EDS.

3. Closed-end providers are strongly encouraged to submit any such subsequent claims by available electronic means or through the Arkansas Medicaid website because Arkansas Medicaid's front-end processing of electronic and web-based claims ensures prompt adjudication and facilitates reimbursement.

204.000 Record Maintenance and Availability 10-1-07

A. Personal Care providers are required to keep documentation and records as described in this section, in section 221.000 and elsewhere in this manual and in official correspondence pending incorporation into this manual.

B. Providers must contemporaneously create and maintain records that completely and accurately explain all evaluations, care, diagnoses and any other activities of the provider in connection with delivery of medical assistance to any Medicaid beneficiary.

C. Providers furnishing any Medicaid-covered good or service for which a prescription, admission order, physician's order, care plan, service plan or other order for service initiation, authorization or continuation is required by law, by Medicaid rule, or both, must obtain a copy of the aforementioned prescription, care plan, service plan or order within five business days of the date it is written (or of the date given orally, when an oral order is permitted).

D. Providers also must maintain a copy of each prescription, care plan, service plan or order in the beneficiary's medical record and follow all prescriptions, care plans, service plans and orders as required by law, by Medicaid rule, or both.

E. All required records must be kept for a period of five years from the ending date of service or until all audit questions, appeal hearings, investigations or court cases are resolved, whichever period is longer.

F. Providers must make available, on request, to any of the individuals and entities identified in subparts F1 through F3 below, all records related to any Medicaid beneficiary to whom the provider has furnished Medicaid-covered services for which the provider has sought and/or obtained reimbursement from Arkansas Medicaid, or for which the provider intends to bill Medicaid.

1. The Arkansas Division of Medical Services, which includes the Division's Medicaid Program Integrity Unit and authorized employees, contractors and designees of the Division
2. The Medicaid Fraud Control Unit of the Arkansas Office of the Attorney General
3. Representatives of the Secretary of Health and Human Services

G. When requested records are stored off-premise or are in active use, the provider must certify in writing that the records in question are in active use or in off-premise storage; and the provider must set a date and hour when the records shall be made available to the requesting authority.

1. The date and hour when the records shall be made available to the requesting authority must be within 3 working days of the time that access to the records was requested.
2. Providers are not allowed to delay access to requested records for reasons related to the provider's convenience.
3. Providers are not allowed to delay access to requested records by claiming the unavailability of sufficient personnel to fulfill the request.

H. Furnishing records on request to authorized individuals and agencies is a contractual obligation of providers enrolled in the Medicaid Program.

I. Sanctions will be imposed for failure to furnish records in accordance with official Medicaid guidelines. Section I of this manual contains detailed information regarding provider and beneficiary sanctions.

J. If any authorized audit determines that recoupment of Medicaid payments is necessary, the Division of Medical Services will accept additional documentation for only thirty days after the date of the notification of recoupment. Additional documentation will not be accepted later.

213.530 Employment-related Personal Care Outside the Home 10-1-07

No condition of this section alters or adversely affects the status of individuals who are furnished personal care in sheltered workshops or similarly authorized habilitative environments. There may be a few beneficiaries working in sheltered workshops solely or primarily because they have access to personal care in that setting. This expansion of personal care outside the home may enable some of those individuals to move or attempt to move into an integrated work setting.

A. Personal care may be provided outside the home when the requirements in subparts A1 through A5 are met and the services are necessary to assist a disabled individual to obtain or retain employment.

1. The beneficiary must have an authorized, individualized personal care service plan that includes the covered personal care services necessary to and appropriate for an employed individual or for an individual seeking employment.

2. The beneficiary must be aged 16 or older.

3. The beneficiary's disability must meet the Social Security/SSI disability definition.

a A beneficiary's disability may be confirmed by verifying his or her eligibility for SSI, Social Security disability benefits or a Medicaid disability aid category, such as Working Disabled or DDS Alternative Community Services waiver.

b. If uncertain whether a beneficiary qualifies under this disability provision, contact the Department of Human Services local office in the county in which the beneficiary resides.

4. One of the following two conditions must be met.

a. The beneficiary must work at least 40 hours per month in an integrated setting (i.e., a workplace that is not a sheltered workshop and where non-disabled individuals are employed or are eligible for employment on parity with disabled applicants).

b. Alternatively, the beneficiary must be actively seeking employment that requires a minimum of 40 hours of work per month in an integrated setting.

5. The beneficiary must earn at least minimum wage or be actively seeking employment that pays at least minimum wage.

B. Personal care aides may assist beneficiaries with personal care needs in a client's workplace and at employment-related locations, such as human resource offices, employment agencies or job interview sites.

C. Employment-related personal care associated with transportation is covered as follows.

1. Aides may assist beneficiaries with transportation to and from work or job-seeking and *during* transportation to and from work or for job-seeking.

2. All employment-related services, including those associated with transportation, must be included in detail (i.e., at the individual task performance level; see section 215.300, part F) in the service plan and all pertinent service documentation.

3. Medicaid does not cover mileage associated with any personal care service.

4.. Authorized, necessary and documented assistance with transportation to and from work for job-seeking and during transportation to and from work or for job-seeking is neither subject to nor included in the eight-hour per month benefit limit that applies to shopping for personal care items and transportation to stores to shop for personal care items, but it is included in the 64-hour per month personal care benefit limit for beneficiaries aged 21 and older.

D. All personal care for beneficiaries under age 21 requires prior authorization.

E. Providers furnishing both employment-related personal care outside the home and non-employment related personal care at home or elsewhere for the same beneficiary must comply with the applicable rules at sections 215.350, 215.351, 215.360 and 262.100.

215.350 Service Plan Requirements for a Single Provider and a Single Beneficiary at Multiple Service Locations 10-1-07

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

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

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

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

215.351 Service Plan Requirements for Multiple Providers and a Single Beneficiary at Multiple Service Locations 10-1-07

When a client receives services at multiple locations from more than one personal care provider, each provider must comply with the following guidelines.

A. Design an individualized service plan and collaborate with the beneficiary's other personal care provider(s) to incorporate into the document the service plan(s) of the other provider(s) and develop a composite service plan.

1. In a composite service plan, providers must clearly distinguish which provider provides which services, where and on which day(s) they do so, which time(s) of day they furnish services and the maximum and minimum amount of time per day and per week, each such identified provider has estimated it will take to perform those services.

3. Each provider's composite service plan must be authorized, signed and dated by the client's primary care physician (PCP) unless the beneficiary is among those not required to enroll with a PCP, in which case the composite service plan must be authorized, signed and dated by the same attending physician..

B. Each time a personal care provider revises or renews a service plan, that provider must notify the beneficiary's other personal care providers to revise or renew (as applicable) their composite service plans and to have their plans authorized, signed and dated by the authorizing physician.

215.360 Service Plan Requirements for Multiple Providers 10-1-07

A. A client may have two or more personal care providers at a single location if the secondary (and tertiary etc.) provider furnishes services during hours in which the primary provider does not operate or does not have an available personal care aide, such as on weekends or at night.

B. Each provider must comply with the following guidelines.

1. Design an individualized service plan and collaborate with the beneficiary's other personal care provider(s) to incorporate into the document the service plan(s) of the other provider(s) and develop a composite service plan.

2. In a composite service plan, providers must clearly distinguish which provider provides which services, on which day(s) they do so, which time(s) of day they furnish services and the maximum and minimum amount of time per day and per week, each such identified provider has estimated it will take to perform those services.

3. Each provider's composite service plan must be authorized, signed and dated by the client's primary care physician (PCP) unless the beneficiary is among those not required to enroll with a PCP, in which case the composite service plan must be authorized, signed and dated by the same attending physician..

4. Each time a personal care provider revises or renews a service plan, that provider must notify the beneficiary's other personal care providers to revise or renew (as applicable) their composite service plans and to have their plans authorized, signed and dated by the authorizing physician.

216.000 Coverage 10-1-07

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

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

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

3. Provided by an individual who is

a. Qualified to provide the services,

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

c. Not a member of the beneficiary's family and

4. Furnished in the beneficiary's home or, at the State's option, at other locations.

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

216.200 Tasks Associated with Covered Routines 10-1-07

Effective for dates of service on and after July 1, 2007, from this section (section 216.200) through section 221.000, all regulations regarding personal care aides' logging beginning and ending times (i.e., time of day) of individual services, and all references to any such regulations, do not apply to Residential Care Facility Personal Care providers.

221.000 Documentation 10-1-07

Personal care providers must maintain all applicable documentation identified in this section (section 221.000) and comply with all applicable provisions and requirements of Section I and section 204.000 of this manual.

A. When applicable, and exempting all agencies that provided Arkansas Medicaid Personal Care services before July 1, 1986, proof of certification by the Home Health State Survey Agency as a participant in the Title XVIII (Medicare) Program

B. When applicable, proof of current licensure by the Office of Long Term Care as a Residential Care Facility (RCF), a Level I Assisted Living Facility or a Level II Assisted Living Facility

C. A valid provider agreement and a valid Medicaid contract

D. Effective for dates of service on and after July 1, 2007, RCF Personal Care providers' payroll records constitute documentation required to enable validation of their service plans and service logs.

E. Documents signed by the supervising RN or QMRP, including

1. The initial and all subsequent assessments
2. Instructions to the personal care aide regarding
    a. The tasks the aide is to perform
    b. The frequency of each task
    c. The maximum number of hours and minutes per month of aide service authorized by the client's attending physician
3. Notes arising from the supervisor's visits to the service delivery location, regarding
    a. The condition of the client
    b. Evaluation of the aide's service performance
    c. The client's evaluation of the aide's service performance
    d. Difficulties the aide encounters performing any tasks
4. The service plan and service plan revisions
    a. The justifications for service plan revisions
    b. Justification for emergency, unscheduled tasks
    c. Documentation of prior or post approval of unscheduled tasks

F. Any additional or special documentation required to satisfy or to resolve questions arising during, from or out of an investigation or audit. "Additional or special documentation," refers to notes, correspondence, written or transcribed consultations with or by other healthcare professionals (i.e., material in the client's or provider's records relevant to the client's personal care services, but not necessarily specifically mentioned in the foregoing requirements). "Additional or special documentation," is not a generic designation for inadvertent omissions from program policy. It does not imply and one should not infer from it that, the State may arbitrarily demand media, material, records or documentation irrelevant or unrelated to Medicaid Program policy as stated in this manual and in official program correspondence.

G. The personal care aides' training records, including

1. Examination results
2. Skills test results

3. Personal care aide certification

H. Excluding Residential Care Facility Personal Care providers, whose personal care aides log services and make required notations on form DMS-873 in accordance with that form's instructions, the personal care aide's daily service notes for each client, which shall include all of the following items applicable to each service date

1. The date of service
2. The routines performed on that date of service, noted to affirm completion of each task
3. The time of day the aide began performing the first service-plan-required task for the client
4. The time of day the aide stopped performing any service-plan-required task to perform any non-service-plan-required function
5. The time of day the aide stopped performing any non-service-plan-required function to resume service-plan-required tasks
6. The time of day the aide completed the last service-plan-required task for the day for that client

I. Notes, orders and records reflecting the activities of the physician, the supervising RN or QMRP, the aide and the client or the client's representative as those activities affect delivering personal care services

262.100 Personal Care Billing 10-1-07

A. Providers must use applicable HCPCS procedure codes and modifiers listed in the following subsections.

B. All billing by any media requires the correct 2-digit national standard place of service code.

C. When a beneficiary's individualized service plan provides for services at more than one location (note the exception at part C5), the provider must bill separately for services furnished at each location, except when billing for services that occurred on the same day and unique place of service codes or unique procedure code modifiers for each service do not exist.

1. When billing for services that occurred on the same day and unique procedure code modifiers for each place of service do not exist, bill for each service that has a unique procedure modifier on a separate detail (line).
2. When billing for services that occurred on the same day in different locations and each location does not have a unique place of service code, bill for each service that is associated with a unique place of service code on a separate detail.
3. When billing for services that occurred on the same day in different locations and each location does not have a unique place of service code, add the units of service that must be billed with place of service code **99** (Other Locations) and bill for the sum of those units on a separate detail.
4. When personal care services are furnished at different locations on different days and the locations have the same place of service code, bill for each day's services on a separate claim detail. (Note the exception at part C5)
5. Employment-related personal care services occur at a variety of locations, but providers are to bill for them as if they occurred at only one location (**99**) because of the lack of specific place of service codes applicable to those services.

a. **Always bill for employment related services separately from all other personal care.**

b. Employment related services may be billed on the same claim and (when applicable) for the same day as other personal care services, but they must be billed as separate claim details, because employment related services have their own procedure code modifier for identification and tracking purposes.

C. Only services occurring within the same calendar month may be billed for on the same claim detail.

262.105 Employment-Related Personal Care Outside the Home 10-1-07

Procedure Code	Modifier	Service Description
T1019	U5	Employment-related personal care outside the home, beneficiary aged 16 or older, per 15 minutes. This service (requires prior authorization for beneficiaries under age 21)

262.110 Coding Personal Care Places of Service 10-1-07

A. The client's home is the client's residence, subject to the exclusions in section 213.500, part B. For example, if a client lives in a residential care facility (RCF) or an assisted living facility (ALF), then the RCF or the ALF is the client's home and is so indicated on a claim by place of service code **12**.

B. Section 213.520, part A, explains and describes special circumstances under which the place of service is deemed "public school."

1. The Arkansas Department of Education (ADE) sometimes deems a student's home a "public school," a place of service to be coded **03.**

2. Under certain circumstances, the ADE deems a Division of Developmental Disabilities Services community provider facility ("DDS facility") a "public school," also a place of service that is coded **03.**

C. When beneficiaries receiving personal care in a DDS facility are not in the charge of a school district (for example, they are older than school age or have graduated), the place of service code is **99**, "Other Places of Service," because there is no national code for a community provider facility for the developmentally disabled.

D. The place of service code is **99**, "Other Places of Service," when the personal care is employment-related outside the home as described in section 213.530 of this manual and in the following subparts D1 and D2, because there are no national standard place of service codes for employment-related locations outside the home.

1. When a personal care aide is assisting a client with personal care needs in a client's workplace, or at an employment-related location outside the home, such as a human resource office, an employment agency or a job interview site, use place of service code **99.**

2. Use place of service code **99** when a personal care aide is assisting a client with transportation to and from work or job-seeking or during transportation to and from work or job-seeking.