Arkansas Department of Health and Human Services

Division of Medical Services

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TO: **Arkansas Medicaid Health Care Providers – ElderChoices Home and Community-Based (H&CB) 2176 Waiver**

DATE: **July 1, 2007**

SUBJECT: **Provider Manual Update Transmittal #79**

REMOVE		**INSERT**	
Section	**Date**	**Section**	**Date**
201.000	12-15-05	201.000	7-1-07
211.000	10-13-03	211.000	7-1-07
212.320	2-1-06	212.320	7-1-07
212.321	2-1-06	212.321	7-1-07
212.322	2-1-06	212.322	7-1-07
212.410	12-15-05	212.410	7-1-07
212.420	12-15-05	212.420	7-1-07
213.100	2-1-06	213.100	7-1-07
213.700	2-1-06	213.700	7-1-07
213.711	12-15-05	213.711	7-1-07
213.713	10-13-03	213.713	7-1-07
—	—	213.800	7-1-07
—	—	213.810	7-1-07
214.000	10-13-03	214.000	7-1-07
262.000	10-13-03	262.000	blank
262.100	4-3-06	262.100	7-1-07

Explanation of Updates:

Changes have been made to ElderChoices policy adding Adult Companion Services as a covered service. Additionally, the number of days of non-participation in the program due to institutionalization or absence from the home for other reasons has been changed from 20 to 30 days before notifying the county office to begin action to close the case.

Update #79 addresses the following changes:

Section 201.000 - The word “EDS” has been added to the address for mailing provider application forms.

Section 211.000 – Adult Companion Services has been added to the list of home and community-based services offered through ElderChoices.

Section 212.320 – A small change has been made in wording.

Section 212.321 – Language has been removed concerning submitting the ElderChoices plan of care to the physician for signature.

Section 212.322 – This section, "Revisions when the Plan of Care Contains Personal Services" has been revised.

Section 212.410 – Changes the number of days of institutionalization before the county office is notified from 20 to 30 days.

Section 212.420 – Changes the number of days absent from the home due to reasons other than institutionalization from 20 to 30 days before notifying the county office to begin closure proceedings.

Section 213.100 – The statement that an individual receiving adult foster care cannot receive waiver adult companion services has been added to policy.

Section 213.700 – A minor wording change has been made, deleting "in or" from the first paragraph.

Section 213.711 – Adds Level II Assisted Living Facilities to the list of locations facility-based respite care may be provided.

Section 213.713 – Adds Level II Assisted Living Facilities to the list of facilities requiring licensed providers.

Section 213.800 – Adds a table showing procedure code and modifier for adult companion services and provides a description of adult companion services and billing requirements.

Section 213.810 – Adds adult companion service certificate requirements.

Section 214.000 – Adds information requiring providers to differentiate between services within the documentation.

Section 262.000 – Removes "(formerly HCFA 1500.)"

Section 262.100 – Adds procedure code and modifier for adult companion services to HCPCS procedure codes for ElderChoices.

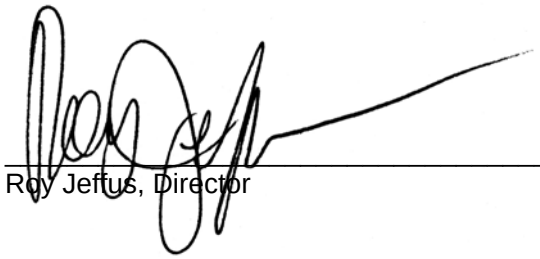
Paper versions of this update transmittal have updated pages attached to file in your provider manual. See Section I for instructions on updating the paper version of the manual. For electronic versions, these changes have already been incorporated.

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.

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.



Roy Jeffus, Director

SECTION II – ELDERCHOICES HOME & COMMUNITY-BASED (H&CB) 2176 WAIVER

CONTENTS

200.000 ELDERCHOICES H&CB WAIVER PROGRAM GENERAL INFORMATION

201.000 Arkansas Medicaid Certification Requirements for ElderChoices H&CB Waiver Program 7-1-07

All ElderChoices home and community-based (H&CB) waiver providers must meet the following criteria to be eligible to participate in the Arkansas Medicaid Program:

A. ElderChoices H&CB Waiver providers must be certified by the Division of Aging and Adult Services (DAAS) as having met all Centers for Medicare and Medicaid Services (CMS) approved provider criteria for the service(s) they wish to enroll to provide.

B. The provider must complete and submit to the EDS Provider Enrollment Unit a provider application (form DMS-652), a Medicaid contract (form DMS-653) and a Request for Taxpayer Identification Number and Certification (Form W-9). A copy of the current certification must accompany the provider application and Medicaid contract. Subsequent certification renewals must be submitted upon receipt. **View or print a provider application (form DMS-652), Medicaid contract (form DMS-653) and Request for Taxpayer Identification Number and Certification (Form W-9).**

Certification by the Division of Aging and Adult Services does not guarantee enrollment in the Medicaid program.

C. Enrollment as a Medicaid provider is conditioned upon approval of a completed provider application and the execution of a Medicaid provider contract. Persons and entities that are excluded or debarred under any state or federal law, regulation or rule are not eligible to enroll, or to remain enrolled, as Medicaid providers.

All providers must maintain their provider files at the EDS Provider Enrollment Unit by submitting current certification, licensure, etc., all DAAS-issued certification renewals and any other renewals affecting their status as a Medicaid-eligible provider. Failure to submit required documents will result in termination of the provider's eligibility for reimbursement of services. Providers may avoid a cancellation of provider eligibility by timely submission of required materials to the EDS Medicaid Provider Enrollment Unit. **View or print the Provider Enrollment Unit contact information.**

Copies of certifications and renewals required by DAAS must be maintained by DAAS to avoid loss of provider certification. These copies must be submitted to DAAS ElderChoices Provider Certification. **View or print the Division of Aging and Adult Services ElderChoices Provider Certification contact information.**

210.000 PROGRAM COVERAGE

211.000 Scope 7-1-07

The Arkansas Medical Assistance (Medicaid) Program offers certain home and community-based outpatient services as an alternative to nursing home placement. These services are available to individuals aged 65 years or older who require an intermediate level of care in a nursing facility. The community-based services offered through the ElderChoices Home and Community-Based 2176 Waiver, described herein as ElderChoices, are as follows:

A. Adult Foster Care

B. Homemaker Services

C. Chore Services

D. Home-Delivered Meals

E. Personal Emergency Response System

F. Adult Day Care

G. Adult Day Health Care

H. Respite Care

I. Adult Companion Services

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

In accordance with 42 CFR 441.301(b)(1)(ii) ElderChoices services may not be provided to inpatients of nursing facilities, hospitals or other inpatient institutions.

212.320 Physician Authorization Of The ElderChoices Plan Of Care with Personal Care Services 7-1-07

The following applies to individuals receiving both personal care services and ElderChoices services.

A. The DHHS RN is responsible for developing an ElderChoices plan of care that includes both waiver and non-waiver services. Once developed, the plan of care may be sent to the applicant's physician of choice for signature, authorizing the services listed if required.

B. If a physician's signature is obtained on an ElderChoices plan of care and personal care services are included on the ElderChoices plan of care when the physician signs it and returns it to the DHHS RN, the signed ElderChoices plan of care will suffice as the "Physician Authorization" for services required in the Personal Care Program. The signature on the ElderChoices plan of care only replaces the need for the physician's signature authorizing personal care services. No other requirements under the Personal Care Program regarding the personal care service plan are modified. The personal care service plan is still required.

C. If a physician's signature is not obtained on an ElderChoices plan of care, the personal care provider will be required to secure a signed authorization from a physician, meeting Medicaid Personal Care Program policy regarding personal care service plans.

D. The ElderChoices plan of care is effective for one year, from the date of the DHHS RN's signature. This signature does not meet the requirements of the Medicaid Personal Care Program. If the ElderChoices plan of care does include an MD's signature, the authorization for personal care services, included on the ElderChoices plan of care, is for one year from the date of the physician's signature, unless revised by the DHHS RN. This policy supersedes information currently found in the Arkansas Medicaid Personal Care provider manual.

This policy does not place the responsibility of developing a personal care service plan with the DHHS RN. The personal care provider is still required to complete a service plan, as described in the Arkansas Medicaid Personal Care provider manual.

212.321 Internal Procedures 7-1-07

A. If personal care services are not currently being provided when the DHHS RN develops the ElderChoices plan of care, the DHHS RN will determine if personal care services are needed. If so, the service, amount, frequency duration and the participant's provider of choice will be included on the ElderChoices plan of care. A copy of the plan of care and a start of care form (AAS-9510) will be forwarded to the personal care provider, as is current

practice for waiver services. The start of care form must be returned to the DHHS RN within 10 working days from mailing, or action may be taken by the DHHS RN to secure another personal care provider or to modify the ElderChoices plan of care. (The ElderChoices plan of care is dated per the date it is mailed.) Before the DHHS RN takes action to secure another provider or modify the plan of care, the applicant and/or family members will be contacted to discuss possible alternatives.

B. If the DHHS RN is aware that personal care services are currently being provided when the ElderChoices plan of care is developed, the DHHS RN will contact the personal care provider to obtain the amount of personal care services currently being provided. It is the personal care provider's responsibility to provide this information to the DHHS RN immediately upon receipt of the request. If this information is not received within five working days of the request, the DHHS RN will take necessary steps to submit the ElderChoices plan of care, as developed by the DHHS RN. .

NOTE: It is the personal care provider's responsibility to place information regarding the agency's presence in the home in a prominent location so that the DHHS RN will be aware that the provider is serving the applicant. Preferably, the provider will place the information atop the refrigerator or under the phone the applicant uses, unless the applicant objects. If so, the provider will place the information in a location satisfactory to the applicant, as long as it is readily available to and easily accessible by the DHHS RN.

C. The personal care service plan provided to the DHHS RN must meet all requirements as detailed in the personal care provider manual. These include, but are not limited to, the amount of personal care services, personal care tasks, frequency and duration. The DHHS RN will not alter the current number of personal care units unless a waiver plan of care cannot be developed without duplicating services or a change in services is necessary in order to establish eligibility. If personal care units must be altered, the DHHS RN will contact the personal care provider to discuss available alternatives prior to making any revisions. The ElderChoices plan of care and the required justification for each service remain the responsibility of the DHHS RN. Therefore, final decisions regarding services included on the ElderChoices plan of care rest with the DHHS RN.

212.322 Revisions when the Plan Of Care Contains Personal Care Services 7-1-07

Requested changes to the personal care services included in the plan of care may originate with the personal care RN or the DHHS RN, depending on the participant's circumstances.

If the change is requested by the DHHS RN, a copy of the revised ElderChoices plan of care and form AAS-9510 will be mailed to the personal care provider. The personal care agency is responsible for securing the required physician's order, according to Arkansas Medicaid Personal Care policy. Once the personal care service begins, the DHHS RN must be notified via the AAS-9511. If any problems are encountered with implementing the requested revisions, the DHHS RN will contact the personal care provider to discuss possible alternatives. These discussions and the final decision regarding the requested revisions must be documented in the nurse's narrative. The final decision, as stated above, rests with the DHHS RN.

212.410 Institutionalization 7-1-07

An individual cannot receive ElderChoices waiver services while in an institution. However, the following policy will apply to active waiver cases when the individual is hospitalized or enters a nursing facility.

A. Hospitalization

When a waiver participant enters a hospital, the DHHS county office will not take action to close the waiver case unless the participant does not return home within 30 days from the date of admission. If the participant has not returned home after 30 days, the DHHS RN

will notify the county office via form DHS-3330 and action will be initiated by the county office to close the waiver case.

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

B. Nursing Facility Admission

When an ElderChoices participant has entered a nursing facility and it is anticipated that the stay will be short, the waiver case will be closed effective the date of admission, but the Medicaid case may be left open until the DHHS county office is notified that the individual has returned home. When the individual returns home, the ElderChoices case may be reopened effective the date of the return home if the DHHS RN has provided the DHHS county office with a copy of Page 2 of the plan of care, showing the election of ElderChoices. A new assessment and medical eligibility determination will not be required unless the last review was completed more than 6 months prior to the participant's admission to the facility.

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

212.420 Non-Institutionalization 7-1-07

When a waiver participant is absent from the home for reasons other than institutionalization, the county office will not be notified unless the participant does not return home within 30 days. If after 30 days the participant has not returned home and the providers can no longer deliver services as prescribed by the plan of care (e.g., the participant has left the state and the return date is unknown), the DHHS RN will notify the county office and action will be taken by the county office to close the waiver case.

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

213.000 Description of Services

213.100 Adult Foster Care 7-1-07

Procedure Code	Description
S5140	Adult Foster Care

Adult foster care provides a family living environment for one or two participants who are functionally impaired and who, due to the severity of their functional impairments, are considered to be at imminent risk of death or serious bodily harm and, as a consequence, are not capable of fully independent living.

Adult foster care adds a dimension of family living to the provision of supportive services such as:

A. Bathing

B. Dressing

C. Grooming

D. Care for occasional incontinence (bowel/bladder)

E. Assistance with eating

F. Enhancement of skills and independence in daily living

Services are provided in a home-like setting. The provider must include the participant in the life of the family as much as possible. The provider must assist the participant in becoming or remaining active in the community.

Services must be provided according to the participant's written ElderChoices plan of care.

One (1) unit of service equals one (1) day. Adult foster care is limited to a maximum of thirty-one (31) units per month. Room and board costs are not included as a part of this service. Service payments are for the provision of daily living care to the participant.

PARTICIPANTS RECEIVING ADULT FOSTER CARE SERVICES ARE NOT ELIGIBLE TO RECEIVE ANY OTHER ELDERCHOICES SERVICE.

213.700 Respite Care 7-1-07

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

Respite care services provide temporary relief to persons providing long-term care for participants in their homes. Respite care may be provided outside of the participant's home to meet an emergency need or to schedule relief periods in accordance with the regular caregiver's need for temporary relief from continuous caregiving. If there is no primary caregiver, respite care services will not be deemed appropriate and subsequently will not be prescribed by the participant's physician.

In the event the in-home medical assessment performed by the DHHS RN substantiates a need for respite care services, the service will be prescribed as needed, via the participant's plan of care, not to exceed an hourly maximum. The DHHS RN will establish the service limitation based on the participant's medical need, other services included on the plan of care and support services available to the client. Respite care services must be provided according to the participant's written plan of care.

213.711 Facility-Based Respite Care 7-1-07

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

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

Facility-based providers rendering services for twenty-four (24) hours per date of service must bill **T1005** for long-term, facility-based respite care. One (1) unit of service for procedure code **T1005** equals 15 minutes. Providers must render provide 96 units of service per date of service in order to bill procedure code **T1005**.

The benefit limit for facility-based respite care services is 2,400 units occurring from July 1 to June 30 of any state fiscal year. This benefit limit is inclusive of procedure code **S5135** or **T1005** or any combination of the two. Facility-based respite care services include short-term and long-term respite care services.

Participants receiving long-term, facility-based respite care services may receive only ElderChoices PERS services concurrently.

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

213.713 Facility-Based Respite Care Certification Requirements 7-1-07

To be certified by the Division of Aging and Adult Services as a provider of facility-based respite care services, a provider must be licensed in their state as one or more of the following:

A. A certified adult foster home

B. A licensed adult day care facility

C. A licensed adult day health care facility

D. A licensed nursing facility

E. A licensed residential care facility

F. A licensed Level I or Level II Assisted Living Facility

G. A licensed hospital

213.800 Adult Companion Services 7-1-07

Procedure Code	Required Modifier	Description
S5135	U1	Adult Companion Services

Adult companion services are non-medical care, supervision and socialization services provided to a functionally impaired adult. Companions may assist or supervise the individual with such tasks as meal preparation, laundry and shopping, but do not perform these activities as discrete services. The provision of companion services does not entail hands-on nursing care. Providers may also perform light housekeeping tasks which are incidental to the care and supervision of the individual. This service is provided in accordance with a therapeutic goal in the plan of care, and is not purely diversional in nature. When required and in accordance with a therapeutic goal in the plan of care, a companion who meets state standards for providing assistance with bathing, eating, dressing and personal hygiene may provide these services when they are essential to the health and welfare of the individual and in the absence of the individual's family. Companion services must be furnished outside the timeframe of other waiver services and state plan personal care. An individual receiving adult companion services cannot receive waiver adult foster care or in-home respite services.

Services must be provided according to the participant's written ElderChoices plan of care.

Providers of Adult Companion Services must bill procedure code **S5135 and the required modifier U1**. One (1) unit of service for procedure code **S5135** equals 15 minutes. Eligible participants may receive up to 1200 hours per SFY of Adult Companion Services, In-Home Respite, Facility Based Respite Care or a combination of the three.

213.810 Adult Companion Services Certification Requirements 7-1-07

To be certified by the Division of Aging and Adult Services as a provider of adult companion services, a provider must hold a current Class A and/or Class B license as providers of home health services as issued by the Division of Health Facility Services, Arkansas Department of Health and Human Services and be enrolled as a Medicaid personal care provider.

214.000 Documentation 7-1-07

In addition to the service-specific documentation requirements previously listed, ElderChoices providers must develop and maintain sufficient written documentation to support each service for which billing is made. This documentation, at a minimum, must consist of:

A. A copy of the participant's plan of care

B. A brief description of the specific service(s) provided

C. The signature and title of the individual rendering the service(s)

D. The date and actual time the service(s) was rendered

If more than one category of service is provided on the same date of service, such as homemaker, personal care, and respite care, the documentation must specifically delineate items A through D above for each service billed. For audit purposes, the auditor must readily be able to discern which service was billed in a particular time period based upon supporting documentation for that particular billing.

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

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

262.000 CMS-1500 Billing Procedures

262.100 HCPCS Procedure Codes 7-1-07

The following procedure codes must be billed for ElderChoices Services:

Procedure Code	Modifiers	Description	Unit of Service	*POS for Paper Claims	*POS for Electronic Claims
S5100		Adult Day Care, 6 to 8 hours per date of service	15 min	5	99
S5100	U1	Adult Day Care, 4 or 5 hours per date of service	15 min	5	99
S5100	TD	Adult Day Health Care, 6 to 8 hours per date of service	15 min	5	99
S5100	TD, U1	Adult Day Health Care, 4 or 5 hours per date of service	15 min	5	99
S5120		Chore Services	15 min	4	12
S5130		Homemaker Services	15 min	4	12

Procedure Code	Modifiers	Description	Unit of Service	*POS for Paper Claims	*POS for Electronic Claims
S5135		Respite Care – Short-Term Facility-Based	15 min	5, 1, 7	99, 21, 32
S5140		Adult Foster Care	1 day	0	99
S5150		Respite Care – In-Home	15 min	4	12
S5160		Personal Emergency Response System – Installation	One instal-lation	4	12
S5161	UA	Personal Emergency Response System	1 day	4	12
S5170		Frozen Home-Delivered Meal	1 meal	4	12
S5170	U1	Emergency Home Delivered Meals	1 meal	4	12
S5170	U2	Home-Delivered Meals	1 meal	4	12
T1005		Respite Care – Long-Term Facility-Based	15 min	1 or 7	21, 32, 99
S5135	U1	Adult Companion Services	15 min	4	12

*Place of service code