ARKANSAS DEPARTMENT OF HUMAN SERVICES

Division of Medical Services
Program Planning & Development
P.O. Box 1437, Slot S-295 · Little Rock, AR 72203-1437
501-682-8368 · Fax: 501-682-2480

TO: **Arkansas Medicaid Health Care Providers – Alternatives for Adults with Physical Disabilities (AAPD)**

DATE: **July 15, 2009**

SUBJECT: **Provider Manual Update Transmittal #85**

REMOVE		**INSERT**	
Section	**Date**	**Section**	**Date**
211.000	7-1-07	211.000	7-15-09
212.000	6-1-06	212.000	7-15-09
212.200	7-1-07	212.200	7-15-09
212.300	7-1-07	212.300	7-15-09
212.400	7-1-07	212.400	7-15-09
213.100	7-15-07	—	—
213.200	7-15-07	213.200	7-15-09
213.300	7-1-07	213.300	7-15-09
213.330	7-1-07	213.330	7-15-09
213.400	7-1-07	213.400	7-15-09
214.100	10-13-03	214.100	7-15-09
215.000	7-1-07	215.000	7-15-09
215.100	7-1-07	215.100	7-15-09
216.300	7-1-07	—	—
219.000	7-1-07	219.000	7-15-09
232.000	6-1-06	232.000	7-15-09
242.320	7-1-07	232.320	7-15-09

Explanation of Updates

Effective for claims received on or after July 15, 2009, the following provider manual waiver revisions are implemented.

Section 211.000 has been updated to delete the "Note" in the section. Individuals who are active participants in the Alternatives for Adults with Physical Disabilities (AAPD) at the time they turn age 65 will no longer be allowed to remain on the AAPD waiver.

Section 212.000 has been updated to change "Health and Human Services" to "Human Services" and "DHHS" to "DHS." In addition, the term "client's" has been changed to "beneficiary's."

Section 212.200 has been updated to change "DHHS" to "DHS." In addition, the term "client" has been changed to "beneficiary."

Section 212.300 has been updated to change "Health and Human Services" to "Human Services" and "DHHS" to "DHS."

Section 212.400 has been updated to change "DHHS" to "DHS."

Section 213.100 has been deleted.

Section 213.200 has been updated to change “DHHS” to “DHS.”

Section 213.300 has been updated to change “DHHS” to “DHS.”

Section 213.330 has been updated to change “Health and Human Services” to “Human Services.”

Section 213.400 has been updated to change “DHHS” to “DHS.”

Section 214.100 has been updated to change “Health and Human Services” to “Human Services.” In addition, the term “client” has been changed to “beneficiary.”

Section 215.000 has been updated to change “DHHS” to “DHS.”

Section 215.100 has been updated to change “DHHS” to “DHS.”

Section 216.300 has been deleted.

Section 219.000 has been updated to change “Health and Human Services” to “Human Services” and “DHHS” to “DHS.”

Section 232.000 has been updated to change “Health and Human Services” to “Human Services” and “DHHS” to “DHS.”

Section 242.320 has been updated to change “DHHS” to “DHS.”

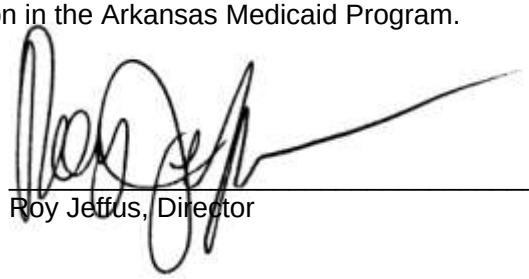
Paper versions of this update transmittal have updated pages attached to file in your provider manual. See Section I for instructions on updating the paper version of the manual. For electronic versions, these changes have already been incorporated.

If you need this material in an alternative format, such as large print, please contact our Americans with Disabilities Act Coordinator at (501) 682-8323 (Local); 1-800-482-5850, extension 2-8323 (Toll-Free) or obtain access to these numbers through voice relay, 1-800-877-8973 (TTY Hearing Impaired).

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 - ALTERNATIVES FOR ADULTS WITH PHYSICAL DISABILITIES WAIVER

CONTENTS

211.000 Scope 7-15-09

The Arkansas Medicaid Program offers certain home and community-based outpatient services as an alternative to nursing home placement. These services are available to disabled individuals age 21 through 64 who have received a determination of physical disability by SSI/SSA or DHS Medical Review Team (MRT) and who, without the provision of home and community-based services, would require a nursing facility (NF) level of care. The participant's income must be equal to or less than 300% of the SSI eligibility limit.

The community-based services offered through the Alternatives for Adults with Physical Disabilities Home and Community-Based Waiver, described herein as Alternatives, are as follows:

1. Environmental Accessibility Adaptations/Adaptive Equipment
2. Agency Attendant Care – Consumer-Directed
3. Agency Attendant Care – Traditional and Consumer-Directed
4. Case Management/Counseling Support

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

Please note that in accordance with 42 CFR 441.301 (b)(l)(ii), alternatives services are not covered for inpatients of nursing facilities, hospitals or other inpatient institutions.

212.000 Eligibility Assessment 7-15-09

The client intake and assessment process includes application for waiver services at the Department of Human Services (DHS) county office in the beneficiary's resident county, a determination of categorical eligibility, a nursing facility level of care determination, the development of a plan of care, a cost comparison to determine the cost-effectiveness of the plan of care and notification of a choice between home and community-based services and institutional services.

212.200 Plan of Care 7-15-09

A. Each beneficiary eligible for services must have an individualized Alternatives Plan of Care (AAS-9503). The authority to develop an Alternatives plan of care is given to the Medicaid state agency's designee, the Division of Aging and Adult Services Rehab Counselor or RN. The alternatives plan of care is developed in negotiation with the Alternatives participant or legal representative or both and, at the discretion of the participant, or the participant's family.

B. The Alternatives plan of care supersedes all other plans of care developed for a participant. The information in the plan of care will include, but is not limited to, the following:

1. Participant identification information to include full name and address, Medicaid number and the participant's waiver eligibility effective date and expiration date.
2. Primary and secondary diagnosis.
3. Contact person.

4. Physician's name and address.
5. The medical and other services to be provided, their frequency and duration and the name of the service provider chosen by the participant to provide each service.
6. The name and title of the DAAS Rehab Counselor or RN responsible for the development of the participant's plan of care.
7. Physician's signature (must be an original signature).

C. The DAAS Rehab Counselor or RN will forward the plan of care to the participant's attending physician for approval and original signature. The plan of care must be approved and signed by the physician before services are rendered.

D. A copy of the signed plan of care will be forwarded to the waiver participant and the service provider(s) chosen by the participant or the participant's legal representative if waiver eligibility is approved by the DHS county office. The service provider and the Alternatives participant must review and follow the signed authorized plan of care. The original plan of care will be maintained by the DAAS Rehab Counselor or RN.

E. The implementation of the plan of care by a provider must ensure that services are:

1. Individualized to the participant's unique circumstances.
2. Developed within a process assuring participation of those concerned with the participant's welfare.
3. Monitored and adjusted to reflect changes in the participant's need.
4. Provided in a way that safeguards the participant's rights.
5. Documented carefully, with appropriate records maintained according to Medicaid policy regarding record retention.

F. The DAAS Rehab Counselor or RN and the case manager are responsible for monitoring the participant's status on a regular basis for changes in service need, referring the participant for reassessment if necessary and reporting any participant complaints of violations of rules and regulations to the Director, Division of Medical Services. The provider is responsible for requesting all changes in services and reporting all changes in the participant's status or condition immediately upon learning of the change.

NOTE: Revisions to a participant's plan of care may only be made by the DAAS Rehab Counselor or RN.

G. Each service must be provided in accordance with the participant's plan of care. As detailed in the Medicaid Program provider contract, providers may bill for services in the amount and frequency that is detailed in the participant's plan of care and only after services are rendered.

212.300 Temporary Absences From the Home 7-15-09

Once an application has been approved, waiver services must be provided in order for eligibility to continue. Unless stated otherwise below, the county Department of Human Services (DHS) office must be notified immediately by the DAAS Rehab Counselor or RN when waiver services are discontinued and action will be initiated by the DHS county office to close the waiver case.

A. Absence from the Home – Institutionalization

An individual cannot receive waiver services while in an institution. The following policy applies to active waiver cases when the participant is hospitalized or enters a nursing facility for an expected stay of short duration.

1. When a waiver beneficiary is admitted to a hospital, the DHS county office will not take action to close the waiver case, unless the beneficiary does not return home within 30 days from the date of admission. If, after 30 days, the beneficiary has not returned home, the DAAS Rehab Counselor or RN will notify the DHS county office via form DHS-3330 and action will be initiated by the DHS county office to close the waiver case.

2. If the DHS county office becomes aware that a participant has been admitted to a nursing facility and it is anticipated that the stay will be short (30 days or less), the waiver case will be closed effective the date of admission, but the Medicaid case will be left open. When the participant returns home, the waiver case may be reopened effective the date the participant returns home.

   NOTE: The Arkansas Medicaid Program considers an individual an inpatient of a facility beginning with the date of admission. Therefore, payment to the hospital begins on the date of admission. Payment to the hospital does not include the date of discharge.

   If Attendant Care Services are billed on the same day the waiver participant is admitted to the hospital or any other inpatient facility, Attendant Care Services are not billable. If Attendant Care services are provided on the same day the waiver participant comes home from the inpatient facility, Attendant Care Services are billable.

   All payments for waiver services provided during an inpatient stay will be subject to Recoupment. Recoupments will include the date of admission.

When a waiver participant is absent from the home for reasons other than institutionalization, the DHS 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 DAAS Rehab Counselor or RN will notify the DHHS county office. Action will be taken by the DHHS county office to close the waiver case. No alternatives services are covered during a participant's absence.

212.400 Reporting Changes in Participant's Status 7-15-09

Because the provider has more frequent contact with the participant, the provider may become aware of changes in the participant's status sooner than the DAAS Rehab Counselor or DHS County Office. It is the provider's responsibility to report these changes immediately so proper action can be taken. Providers must complete the Provider Communication Form (AAS-9502) and send it to the DAAS Rehab Counselor or RN. A copy must be retained in the provider's participant case record. Whether the change may or may not result in action by the DHS county office, providers must report all changes in the participant's status to the DAAS Rehab Counselor or RN.

213.200 Attendant Care Service 7-15-09

Attendant Care Service is assistance to a medically stable, physically disabled participant in accomplishing tasks of daily living that the participant is unable to complete independently. Assistance may vary from actually doing a task for the participant, to assisting the participant to perform the task or to providing safety support while the participant performs the task. Housekeeping activities that are incidental to the performance of care may also be furnished. Housekeeping activities as described above may not exceed 20% of the Attendant's overall time worked as authorized on the waiver plan of care. Attendant Care Services may also include supervision, companion services, socialization, and transportation assistance when it is incidental to providing Attendant Care services, accompanying a participant to assist with shopping, errands, etc.

A. If Attendant Care Service is selected, a consumer-directed approach will be used in the provision of Attendant Care services. The participant is free to select the tasks to be performed and when these tasks will be accomplished. Each participant who elects to receive Attendant Care Services must agree to and be capable of recruiting, hiring, training, managing and terminating Attendants. The participant must also monitor Attendant Service timesheets and approve payment to the Attendant for services provided by signing the timesheets.

   Participants who can comprehend the rights and accept the responsibilities of consumer-directed care may wish to have Alternatives Attendant Care Services included on their plan of care. The participant's plan of care will be submitted to the attending physician for his or her review and approval.

B. The Evaluation of Need for Nursing Home Care Form (DHS-703) completed by the DAAS Rehab Counselor or RN for each Alternatives Waiver applicant will contain information relative to the participant's functional, social and environmental situation.

C To aid in the Attendant Care recruitment process, participants will be apprised of the minimum qualifications set forth for provider certification (See section 213.220) and the Medicaid enrollment and reimbursement process. The participant will be instructed to notify the DAAS Rehab Counselor or RN when an attendant has been recruited. The DAAS Waiver Counselor or RN will facilitate the development of a formal service agreement between the participant and the Attendant, using the form AAS-9512, Attendant Care Service Agreement. Instructions are provided with the Attendant Care packet.

D When the AAS-9512, Attendant Care Service Agreement, is finalized, the Attendant will apply for DAAS certification and Medicaid provider enrollment. The DAAS Rehab Counselor or RN or designee will assist as needed to expedite this process. As an enrolled Medicaid provider, the attendant will be responsible for all applicable Medicaid participation requirements, including claims submission.

   Service agreements and required tax documents do not transfer from one waiver client to another or from one waiver provider to another. All service agreements and tax forms are specific to each employer and employee working arrangement.

E. Refer to section 241.100 of this manual for the procedure code to be used with filing claims for this service.

213.300 Agency Attendant Care 7-15-09

Agency Attendant Care services are the provision of assistance to a medically stable and/or physically disabled person to accomplish those tasks of daily living that the individual is unable to complete independently and that are performed by an Attendant Care employee hired by an agency selected by the waiver participant. Assistance may vary from actually doing a task for the individual to assisting the individual with the task or to providing safety support while the individual performs the task. Housekeeping activities that are incidental to the performance of care may also be furnished. Housekeeping activities as described above may not exceed 20% of the attendant's overall time worked as authorized on the waiver plan of care. Agency Attendant Care Services may also include supervision, companion services, socialization, and transportation assistance when it is incidental to providing Attendant Care Services while accompanying a participant to assist with shopping, errands, etc.

If Agency Attendant Care Services are selected, participants may choose to have their services provided through an agency that is certified by the Division of Aging and Adult Services to provide Agency Attendant Care. When the participant chooses to have Attendant Care Services provided through an agency, the participant may choose one of two agency Attendant Care Services options: 1) participant/co-employer where the participant functions as the co-employer (managing employer) of employees hired by an Attendant Care agency, and the agency manages the hiring and fiscal responsibilities or 2) a traditional agency model for Attendant Care Services where the agency performs both the managing of the Attendant Care employee and hiring and fiscal responsibilities.

A. If the participant chooses the participant/co-employer (managing employer) option, the participant performs duties such as determining the Attendants' duties consistent with the service specification in the approved plan of care, scheduling Attendants, orienting and instructing Attendants' duties, supervising Attendants, evaluating Attendants' performance, verifying time worked by Attendants, approving time sheets and discharging Attendants from providing services. The participant may also recruit prospective Attendant Care Aides who are then referred to the agency for consideration for hiring. The agency chosen by the participant to provide Attendant Care Services is the employer of participant-selected/recruited staff and performs necessary payroll and human resources functions.

   If the participant chooses the traditional agency model option, the agency performs both the responsibilities of managing the Attendant Care employee and the hiring and fiscal responsibilities. Participants who decide to have their Attendant Care services provided through an agency may wish to have Alternatives Agency Attendant Care Services included on their plan of care. The participant's plan of care is submitted to the participant's attending physician for his or her review and approval.

B. The Evaluation of Need for Nursing Home Care Form (DHS-703) completed by the DAAS Rehab Counselor or RN for each Alternatives Waiver applicant contains information relative to the participant's functional, social and environmental situation.

C. The Attendant Care agency must staff and notify the DAAS Rehab Counselor or RN via the DAAS-9510, according to established program policy, when an Attendant has been assigned to a waiver participant. In addition, prior to Medicaid reimbursement, an agency must secure a service agreement, signed by the agency representative and the waiver participant. This agreement must be sent to the DAAS Central Office prior to claims submission.

D. As an enrolled Medicaid provider, the Attendant Care agency is responsible for all applicable Medicaid participation requirements, including claims submission.

E. Refer to section 244.100 of this manual for the procedure code to be used when filing claims for this service.

213.330 Provider Qualifications Agency Attendant Care 7-15-09

Class A or Class B Home Health Agencies licensed by the Arkansas Department of Human Services to provide personal care and enrolled in the Arkansas Medicaid Program as a personal care provider may apply to enroll as a Medicaid Alternatives Agency Attendant Care provider.

Private Care agencies licensed by the Arkansas Department of Human Services to provide personal care and enrolled in the Arkansas Medicaid Program as a personal care provider may apply to enroll as a Medicaid Alternatives Agency Attendant Care provider.

213.400 Covered Case Management /Counseling Support Services 7-15-09

The responsibilities of the providers of case management services include, but are not limited to:

- Orientation to the concept of consumer-direction
- Providing skills training on how to recruit, interview, hire, evaluate, manage or dismiss Attendants
- Providing support services
- Assessing the individual's service needs to assist in accessing services that currently may or may not be in place. This does not refer to a medical assessment or replace any eligibility requirements for any Medicaid program
- Routinely monitoring Alternatives participants' needs, employer status, and circumstances and reporting findings according to program policy to DAAS
- Providing management reports to DAAS
- Reporting changes and required information to DAAS, as required by policy
- Attending training as provided or required by DAAS
- Referring the waiver participant to resources to assist in meeting their needs
- Scheduling appointments related to gaining access to medical, social, educational and other services appropriate to the participant's needs. This includes, but is not limited to, medical appointments, transportation services and appointments with DHS.
- Performing face to face or telephone contacts with the participant and/or other individuals for the purpose of assistance in meeting the participant's needs
- Assisting a waiver participant in completing the application for types of assistance
- Conferencing with others, on behalf of the applicant, to assist in the application process for accessing services
- Referring waiver participant for community resources, such as energy assistance, legal assistance, emergency housing

- Training Attendant Care provider in proper billing procedures
- Explaining APD program policy and monitoring compliance
- Securing 3 separate bids for environmental modifications/adaptive equipment service as required by policy. If the case manager is an employee of a provider type 84 that is submitting a bid to provide a waiver service, the case manager may not assist the waiver participant in securing the other two required bids.

214.100 Retention of Records 7-15-09

Providers must maintain all records regarding the participation of the beneficiary and the provider in the Arkansas Medicaid Program for a period of five (5) years from the date of service or until all audit questions, appeal hearings, investigations or court cases are resolved, whichever is longer. The records must be made available to authorized representatives of the Arkansas Division of Medical Services, the Arkansas Division of Aging and Adult Services, the state Medicaid Fraud Control Unit, representatives of the Department of Human Services and its authorized agents or officials.

All documentation must be made available to representatives of the Division of Medical Services at the time of an audit by the Medicaid Field Audit Unit. All documentation must be available at the provider's place of business. If an audit determines that recoupment is necessary, there will be only thirty (30) days after the date of the recoupment notice in which additional documentation will be accepted. Additional documentation will not be accepted at a later date.

215.000 Record Keeping Requirements 7-15-09

DHS requires retention of all records for six (6) years. All medical records shall be completed promptly, filed and retained for a minimum of six (6) years from the date of service or until all audit questions, appeal hearings, investigations or court cases are resolved, whichever is longer. Failure to furnish records upon request may result in sanctions being imposed.

A. The provider 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 any Medicaid participant.

B. Providers furnishing any Medicaid-covered good or service for which a prescription is required by law, by Medicaid rule, or both, must have a copy of the prescription for such good or service. The provider must obtain a copy of the prescription within five (5) business days of the date the prescription is written.

C. The provider must maintain a copy of each relevant prescription in the Medicaid participant’s records and follow all prescriptions and care plans.

D. Providers must adhere to all applicable professional standards of care and conduct.

E. The provider must make available to the Division of Medical Services, its contractors and designees and the Medicaid Fraud Control Unit all records related to any Medicaid beneficiary.

1. All documentation must be available at the provider’s place of business.
2. When records are stored off-premise or are in active use, the provider may certify in writing that the records in question are in active use or in off-premise storage and set a date and hour within three (3) working days, at which time the records will be made

available. However, the provider will not be allowed to delay for matters of convenience, including availability of personnel.

3. If an audit determines that recoupment is necessary, there will be no more than thirty (30) days after the date of the recoupment notice in which additional documentation will be accepted.

215.100 Requirements for Time Records and the Tickler System 7-15-09

Each Case Manager (CM) must maintain a tickler system for tracking purposes.

A. The tickler system must track and notify the CM of the following activities:

1. Each active participant in the case manager's caseload
2. Date Case Management/Counseling Services began
3. Expiration date of any Medicaid waiver plan of care applicable to a given participant
4. Medicaid eligibility date and waiver eligibility date
5. The participant's case reevaluation date, as established by DHS, Division of County Operations
6. Name, address and telephone number of each Attendant or Agency providing Attendant Care Services to waiver participant

B. It is the responsibility of the Case Manager to maintain a tickler system as described above for those beneficiaries in their specific caseload. However, the record keeping requirements and documentation requirements must be maintained in the participant's file.

219.000 Client Appeal Process 7-15-09

When Alternatives for Adults with Physical Disabilities Waiver services are denied, the participant may request a fair hearing from the Department of Human Services according to sections 191.000 – 191.006 of the Arkansas Medicaid Provider Manuals.

Appeal requests must be submitted to the Department of Human Services Appeals and Hearings Section. **View or print DHS Appeals and Hearings Section contact information.**

232.000 Rate Appeal Process 7-15-09

A provider may request reconsideration of a Medicaid Program decision by writing to the Assistant Director, Division of Medical Services. This request must be received within 20 calendar days following the application of policy and/or procedure or the notification to the provider of its rate. Upon receipt of the request for review, the Assistant Director will determine the need for a Program/Provider conference and, if necessary, will contact the provider to arrange a conference. Regardless of the Program decision, the provider will be afforded the opportunity for a full explanation of the factors involved and the Program decision. Within 20 calendar days of receipt of the request for review, the Assistant Director will notify the provider of the action to be taken by the Division or the date for the Program/Provider conference.

If the decision of the Assistant Director, Division of Medical Services is unsatisfactory, the provider may then appeal the question to a standing Rate Review Panel established by the Director of the Division of Medical Services which will include one member of the Division of Medical Services, a representative of the provider association and a member of the Department of Human Services (DHS) Management Staff, who will serve as chairman.

The request for review by the Rate Review Panel must be postmarked within 15 calendar days following the notification of the initial decision by the Assistant Director, Division of Medical Services. The Rate Review Panel will meet to consider the question(s) within 15 calendar days after receipt of a request for such appeal. The question(s) will be heard by the panel and a recommendation will be submitted to the Director of the Division of Medical Services.

242.320 Environmental Modifications/Adaptive Equipment 7-15-09

Prior to payment for this service, the waiver participant is required to secure 3 separate itemized bids for the same service. The bids are reviewed by the DHS Rehab Counselor, DHS RN or designee prior to submission for Medicaid payment.

Each claim must be signed by the provider, the waiver participant, and the DHS Rehab Counselor, DHS RN, or designee. A statement of satisfaction form must be signed by the waiver participant prior to any claim being submitted.