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 (ACS) Waiver**

DATE: **March 1, 2010**

SUBJECT: **Provider Manual Update Transmittal #120**

REMOVE		**INSERT**	
Section	**Date**	**Section**	**Date**
201.000	11-1-09	201.000	3-1-10
201.100	10-13-03	201.100	3-1-10
201.200	10-1-07	201.200	3-1-10
202.000	11-1-09	202.000	3-1-10
202.100	11-1-09	202.100	3-1-10
202.200	11-1-09	—	—
203.000	11-1-09	—	—
211.000	10-1-07	211.000	3-1-10
212.000	10-13-03	212.000	3-1-10
213.000	10-1-07	213.000	3-1-10
213.100	10-1-07	213.100	3-1-10
213.200	10-1-07	213.200	3-1-10
—	—	213.300	3-1-10
214.000	5-1-06	214.000	3-1-10
—	—	214.100	3-1-10
215.000	10-1-07	215.000	3-1-10
215.100	10-1-07	215.100	3-1-10
—	—	215.200	3-1-10
—	—	215.300	3-1-10
216.000	10-1-07	216.000	3-1-10
—	—	216.100	3-1-10
—	—	216.200	3-1-10
—	—	216.300	3-1-10
217.000	10-1-07	217.000	3-1-10
217.100	10-1-07	217.100	3-1-10
—	—	217.200	3-1-10

REMOVE		**INSERT**	
Section	**Date**	**Section**	**Date**
218.000	10-1-05	218.000	3-1-10
218.100	10-1-07	218.100	3-1-10
218.200	10-1-05	—	—
218.300	10-1-05	—	—
219.000	7-1-09	219.000	3-1-10
219.100	7-1-09	219.100	3-1-10
219.200	7-1-09	219.200	3-1-10
220.000	10-13-03	220.000	3-1-10
220.100	10-13-03	220.100	3-1-10
220.200	10-13-03	220.200	3-1-10
221.000	10-1-07	221.000	3-1-10
221.100	10-1-07	221.100	3-1-10
222.000	10-1-05	222.000	3-1-10
222.100	10-1-05	—	—
222.200	10-1-05	—	—
223.000	2-1-09	223.000	3-1-10
—	—	223.100	3-1-10
224.000	10-1-05	224.000	3-1-10
224.100	10-1-05	—	—
225.000	10-13-03	—	—
226.000	10-1-05	—	—
226.100	10-13-03	—	—
226.200	10-1-07	—	—
230.100	10-1-05	230.100	3-1-10
230.200	10-13-03	230.200	3-1-10
230.210	10-1-07	230.210	3-1-10
230.211	10-1-07	230.211	3-1-10
230.212	10-1-07	230.212	3-1-10
230.213	10-1-07	230.213	3-1-10
230.220	10-1-07	—	—
230.221	10-1-05	—	—
230.222	10-1-07	—	—
230.300	10-13-03	230.300	3-1-10
230.400	10-1-07	230.400	3-1-10
230.410	10-1-07	230.410	3-1-10

REMOVE		**INSERT**	
Section	**Date**	**Section**	**Date**
230.420	10-1-07	—	—
—	—	240.000	3-1-10
—	—	241.000	3-1-10
250.000	10-13-03	250.000	blank
251.000	10-1-07	251.000	3-1-10
—	—	252.000	3-1-10
260.000	blank	260.000	blank
261.000	10-13-03	261.000	3-1-10
262.000	5-1-06	262.000	3-1-10
—	—	262.100	3-1-10
—	—	262.200	3-1-10
—	—	262.210	3-1-10
—	—	262.300	3-1-10
270.000	blank	—	—
271.000	7-1-07	—	—
272.000	blank	—	—
272.100	12-1-07	—	—
272.200	7-1-07	—	—
272.300	7-1-07	—	—
272.310	6-1-08	—	—
272.400	10-13-03	—	—

Explanation of Updates

In all sections of the provider manual, any reference to “individual”, “recipient”, “consumer”, “client”, etc. have been updated to “beneficiary”.

In all sections of the provider manual, reference to “Multi-agency Plan of Services (MAPS)” and “plan of care “ have been updated to reflect a change as it appears in the waiver renewal to “person centered service plan”.

The DDS ACS waiver was recently renewed by CMS. Changes to the provider manual reflect updates as they appear in the waiver.

Section 201.000: Added clarifying language regarding DDS certification of willing and qualified providers of waiver services.

Section 201.100: Corrected grammatical errors.

Section 201.200: Added clarifying language regarding Organized Health Care Delivery Service (OHCDS) providers. Removed obsolete information.

Section 202.000: Added information to clarify where information regarding documentation requirements in Section I are located.

Section 202.100: Removed obsolete information and corrected grammatical errors.

Section 202.200: Removed “Reserved” section.

Section 203.000: Removed “Reserved” Section.

Section 211.000: Removed obsolete information and added clarifying language.

Section 212.000: Updated obsolete language. Added list of services currently available under the DDS ACS waiver (moved from section 211.000).

Section 213.000: Added clarifying information as it appears in the waiver. Moved information from Section 213.200 (Supportive Living Array) and Section 230.220 (Service Models Traditional and Supported Living Arrangements) to this section as the information all pertains to supportive living services.

Section 213.100: Moved information previously under Section 230.222, Supportive Living Arrangement Model, to this subsection of Supportive Living Services.

Section 213.200: Updated information regarding Supportive Living Exclusions.

Section 213.300: Information regarding Supportive Living Array was moved to section 213.000. Information regarding benefit limits for supportive living services was added. Included reference to new section regarding payment for relatives or legal guardians (section 228.000).

Section 214.000: Renumbered this service’s section number. Updated title of service from Respite Care to Respite Services. Added clarifying language.

Section 214.100: Added this section, Benefit Limits for Respite Services, specifying limits.

Section 215.000: Renumbered. Previously this was the section for Respite Care, it is now the section for Supported Employment. Added clarifying language.

Section 215.100: Removed obsolete section (Respite Care Child Support Services) and renumbered. Inserted Supported Employment Exclusions as outlined in the waiver.

Section 215.200: New section. Added to include information pertaining to Documentation Requirements for Supported Employment.

Section 215.300: New section. Added to include information pertaining to Benefit limits for Supported Employment as it.

Section 216.000: Non-medical transportation is no longer offered as a distinct service of the DDS ACS waiver. Computation of this service is included in the daily rate for supportive living. Relabeled this section. This is now where information regarding Adaptive Equipment service is found. Updated to include clarifying language.

Section 216.100: New section. Provides specific information on vehicle modifications service under Adaptive Equipment. Title of service updated.

Section 216.200: New section. Provides information specific to the Personal Emergency Response System (PERS) service under Adaptive Equipment.

Section 216.300: New section. Provides information on the Benefit Limits for the Adaptive Equipment service.

Section 217.000: Previously labeled as Reserved this section now contains information pertaining to Environmental Modifications. Title of service has been updated.

Section 217.100: Previously labeled as Reserved this section now contains information specific to Environmental Modification Exclusions.

Section 217.200: New Section. Provides information on the Benefit Limits for the Environmental Modification service.

Section 218.000: Previously labeled as Supported Employment which has been moved to section 215.000. This is now labeled as Specialized Medical Supplies. Language has been added.

Section 218.100: Previously labeled as Supported Employment Exclusions. Now labeled as Benefit limits for Specialized Medical Supplies. Language has been added.

Section 218.200: Removed section. Information moved to section 215.200.

Section 218.300: Removed section. Information moved to section 215.300.

Section 219.000: Previously reserved for Adaptive Equipment. This section now refers to Supplemental Support Service. Added clarifying language.

Section 219.100: Previously reserved for Benefit Limits for Adaptive Equipment. This section now refers to Supplemental Support Service Exclusions. Language has been added to clarify exclusions.

Section 219.200: New section added. Title of section is Benefit limits for Supplemental Support Service. Language has been added to provide benefit limits.

Section 220.000: Previously reserved for Environmental Modifications. Now refers to case management services. Updated language to include clarifying language.

Section220.100: Previously used for Environmental Modifications Exclusions. Now refers to a new service approved with the waiver renewal - Transitional Case Management. This is a new service offered under the DDS ACS waiver. Language from the waiver has been added.

Section 220.200: Previously used for Benefits Limits for Environmental Modifications. Now refers to Benefit Limits for Case Management services.

Section 221.000: Previously this section referred to Specialized Medical Supplies. Now refers to Consultation Services. Included clarifying language.

Section 221.100: Previously this section referred to Benefit Limits for Specialized Medical Supplies. Now refers to Benefit Limits for Consultation Services. Added in approved benefit limits from approved waiver document.

Section 222.000 Previously this section referred to Supplemental Support Services. Now refers to Crisis Intervention Services. Added language.

Section 222.100: Removed this section. Information is now found in Section 219.100

Section 222.200: Removed this section. Information is now found in Section 219.200

Section 223.000: Previously this section referred to Case Management and now references Community Transition Services. This is a new service offered under the DDS ACS waiver. Language from the waiver has been added.

Section 223.100: This is a new section titled Benefit Limits for Community Transition Services. Language from the waiver has been added specifying limits for this service.

Section 224.000: Previously this section referred to Consultation service. This section now provides direction of payment to relatives and legal guardians.

Sections 224.100, 225.000, 226.000, 226.100 and 226.200 were removed.

Section 230.100: Added clarifying language and updated obsolete terminology

Section 230.200: Updated obsolete terminology.

Section 230.210: Added clarifying language.

Section 230.211: Added clarifying language.

Section 230.212: Corrected grammatical error.

Section 230.231: Updated obsolete terminology.

Sections 230.220, 230.221 and 230.222 were removed.

Section 230.300: Added clarifying language and updated obsolete terminology.

Section 230.400: Updated obsolete terminology, added clarifying language.

Section 230.410: Updated terminology, added clarifying language.

Section 230.420 was removed.

Section 240.000 is added as the result of renumbering.

Section 240.100 is added as the result of renumbering.

Section 250.000: Renumbered Prior Authorization Section to 240.000 to correct misnumbering.

Section 251.100: Renumbered Approval Authority to 241.000 to correct misnumbering. Updated obsolete terminology, added clarifying language.

Section 252.000 is added as the result of renumbering.

Section 260.000: Renumbered Reimbursement section to 250.000 to correct misnumbering.

Section 261.000: Renumbered Method of Reimbursement section to 251.000 to correct misnumbering, added in clarifying information.

Section 262.000: Renumbered Rate Appeal Process to 252.000 to correct misnumbering, corrected grammatical errors, removed obsolete terminology.

Sections 262.100, 262.200, 262.210 and 262.300 were added as the result of renumbering.

Section 270.000: Renumbered Billing Procedures to 260.000 to correct misnumbering, corrected grammatical error.

Section 271.000 was removed.

Section 272.100: Renumbered DDS ACS Waiver Procedure Codes to 262.100 to correct misnumbering, add additional place of service codes, revise descriptions of services, removed services no longer offered number the waiver, added new services to waiver. Updated footnotes to reflect information as it appears in the approved waiver document.

Section 272.200: Renumbered National Place of Service (POS) Codes to 262.200 to correct misnumbering, added new POS codes.

Section 272.300: Renumbered Billing Instructions – Paper Only section to 262.300 to correct misnumbering. Changed references to EDS to fiscal agent as EDS has had a company-wide name change. Corrected grammatical errors.

Section 272.310: Renumbered Completion of CMS-1500 Claim form to 262.310 to correct misnumbering. Updated obsolete terminology.

Section 272.400: Renumbered Special Billing Procedures to 262.400 to correct misnumbering.

The paper version of this update transmittal includes revised pages that may be filed 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 to 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 HP 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

201.000 Arkansas Medicaid Program Participation Requirements for DDS ACS Waiver Program 3-1-10

All Division of Developmental Disabilities Services (DDS) Alternative Community Services (ACS) waiver providers must meet the enrollment criteria detailed in Section 1, subsection 141.000 in order to participate in the Arkansas Medical Assistance (Medicaid) program.

All willing and qualified providers have the opportunity to enroll as a waiver provider. DDS provides continuous open enrollment for waiver service providers. Potential providers should contact DDS Quality Assurance staff for information on the ACS certification standards. Once a provider is certified by DDS, the provider may contact the DMS Provider Enrollment Unit to enroll as a Medicaid provider.

Certified and enrolled providers are allowed to specify the maximum number of persons they can serve, the areas of the state they can serve, the services they can provide and the service levels they can offer based on staff availability. Waiver beneficiaries have the freedom of choice of service providers. Once a provider is chosen by a beneficiary and who meets the designations made by the provider, the provider cannot refuse to provide services unless the provider cannot assure the health and safety of the beneficiary. It is incumbent upon the provider to prove the individual cannot be served by the provider. The burden of proof also requires written identification of the cause for the failure to provide health and safety supported by documentation that attests to that condition.

Before a provider can decrease the maximum number of persons they will serve, drop an existing area of the state they serve, a service, or service level, the provider must identify any beneficiary currently being served that would be affected. The provider will be required to continue providing services to any persons that would be affected by the changes until such time as DDS can secure a new provider and services are in place under the new provider. DDS will freeze new referrals when a provider requests to make changes in the above items but will not approve the changes for existing persons until such time as the transition has occurred to a new provider. Further, when less than an entire county is deleted from coverage, the provider must articulate in writing a business reason for making the change and demonstrate that the selection process is not capricious or arbitrary, does not result in discrimination and does not unfairly distinguish between levels of care. The process cannot be used to eliminate difficult families or persons. Other than business reasons for closing entire counties or programs, people can only be discontinued if the provider cannot assure health and safety.

Option: Based on individual choice, a provider may continue to serve a person without serving others in the county, when the individual served relocates their place of residence.

201.100 Providers of DDS ACS Waiver Services in Arkansas and Bordering States Trade Area Cities 3-1-10

DDS ACS waiver services are limited to Arkansas and bordering state trade area cities. The DDS must certify providers located in a bordering state trade area city as ACS waiver providers before services may be provided for Arkansas Medicaid beneficiaries.

Bordering state trade area cities are Monroe and Shreveport, Louisiana; Clarksdale and Greenville, Mississippi; Poplar Bluff and Springfield, Missouri; Poteau and Sallisaw, Oklahoma; Memphis, Tennessee and Texarkana, Texas.

201.200 Organized Health Care Delivery System Provider 3-1-10

The DDS ACS waiver allows a provider who is licensed and certified as a DDS ACS case management entity 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.

The option of OHCDS is available to any current or future provider through a written agreement between DDS and the provider entity. The agreement requires each OHCDS provider to guarantee that any sub-contractor will abide by all Medicaid regulations and provides that the OHCDS provider assumes all liability for contract noncompliance. The OHCDS provider must also have a written contract that sets forth specifications and assurances that work will be completed timely and with quality maintained. The OHCDS provider is responsible for ensuring that services were delivered and proper documentation, including a signed customer satisfaction statement, has been submitted prior to billing.

As long as the OHCDS provider delivers 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 primary use of OHCDS is consultation, adaptive equipment, environmental modifications, supplemental support and specialized medical supplies.

The OHCDS provider furnishes the services as the beneficiary's provider of choice as described in that beneficiary's person centered service plan

202.000 Documentation Requirements 3-1-10

DDS ACS waiver providers must keep and properly maintain written records. Along with the required enrollment documentation, which is detailed in Section 1, subsection 141.000, the following records must be included in the beneficiary's case files maintained by the provider.

202.100 Documentation in Beneficiary's Case Files 3-1-10

DDS ACS waiver 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 beneficiary's person centered service plan

B. The specific services rendered

C. The date, and actual time, the services were rendered

D. The name and title of the individual who provided the service

E. The relationship of the service to the treatment regimen of the beneficiary's person centered service plan

F. Updates describing the beneficiary's progress or lack thereof. Updates should be maintained on a daily basis or at each contact with or on behalf of the beneficiary. Progress notes must be signed and dated by the provider of the service

G. Completed forms as required by DDS

H. Certification statements, narratives and proofs that support the cost effectiveness and medical necessity of the service to be provided

Additional documentation and information may be required dependent upon the service to be provided.

211.000 Scope 3-1-10

The Medicaid program offers certain home and community based services (HCBS) as an alternative to institutionalization. These services are available for eligible beneficiaries with a developmental disability who would otherwise require an intermediate care facility for the mentally retarded (ICF/MR) level of care.

The purpose of the ACS waiver is to support beneficiaries of all ages who have a developmental disability, meet the institutional level of care, and require waiver support services to live in the community and thus preventing institutionalization.

The goal is to create a flexible array of services that will allow people to reach their maximum potential in decision making, employment and community integration; thus giving their lives the meaning and value they choose.

The objectives are as follows:

A. To transition eligible persons who choose the waiver option from residential facilities into the community;

B. To provide priority services to persons who meet the pervasive level of service (imminent danger and requiring supports 24 hours a day, seven days a week); and

C. To enhance and maintain community living for all persons participating in the waiver program.

DDS is responsible for day-to-day operation of the waiver. All waiver services are accessed through DDS Adult Services, DDS Children's Services or the ICF/MR services intake and referral staff.

All ACS waiver services must be prior authorized by DDS. All services must be delivered based on the approved person centered service plan.

Waiver services will not be furnished to persons while they are inpatients of a hospital, nursing facility (NF), or 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 month increments (with status report every month) for up to 12 months when the following conditions are met:

A. The need for absence must be for the purposes of treatment in a licensed or certified program or facility for the purposes of behavior stabilization, physical or mental health treatment.

B. The loss of home or loss of the primary non-paid caregiver.

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

D. The request must be prior approved by DDS.

E. A minimum of one visit or one contact each month is required.

NOTE: The DDS Specialist is responsible for conducting or assuring the conducting of the contacts or monitoring visits with applicable documentation filed in the case record.

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

request for continuance must be submitted in writing and supported by evidence of treatment status or progress. Requests for continuance must be made prior to the expiration of the abeyance period.

In order for beneficiaries 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 a beneficiary needs at least one waiver service as documented in their person centered service plan.

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

As stated in the Medical Services 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.

C. Inmate status will continue until the indictment against the individual is dismissed or until he or she is released from custody either as “not guilty” or for some other reason (bail, parole, pardon, suspended sentence, home release program, probation, etc.)

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

212.000 Description of Services 3-1-10

DDS ACS services provide the support necessary for a beneficiary to live in the community. Without these services, the beneficiary would require institutionalization.

Services provided under this program are as follows:

A. Supportive Living

B. Respite Services

C. Supported Employment

D. Adaptive Equipment

E. Environmental Modifications

F. Specialized Medical Supplies

G. Supplemental Support Service

H. Case Management Services

I. Consultation Services

J. Crisis Intervention Services

K. Community Transition Services

213.000 Supportive Living 3-1-10

Supportive living is an array of individually tailored services and activities provided to enable eligible beneficiaries to reside successfully in their own homes, with their family, or in an alternative living residence or setting. Alternative living residences include

apartments, homes of primary caregivers, leased or rented homes, or provider group homes. Supportive living services may also be provided in clinic and integrated community settings. The services are designed to assist beneficiaries in acquiring, retaining and improving the self-help, socialization and adaptive skills necessary to reside successfully in the home and community based setting. Services are flexible to allow for unforeseen changes needed in schedules and times of service delivery. Services are approved as maximum days that can be adjusted within the annual plan year to meet changing needs. Waiver funding will not reimburse for overtime. The payments for these services exclude the costs of the person's room & board expenses including general maintenance, upkeep or improvement to the person's home or their family's home.

A. Residential Habilitation Supports

Care and supervision of activities that directly relate to treatment goals & objectives. The supports that may be provided to a beneficiary include the following:

1. Decision making including the identification of and response to dangerously threatening situations, making decisions and choices affecting the person's life and initiating changes in living arrangement or life activities;
2. Money management consists of training, assistance or both in handling personal finances, making purchases and meeting personal financial obligations;
3. Daily living skills including habilitative training in accomplishing routine housekeeping tasks, meal preparation, dressing, personal hygiene, 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, including training, assistance or both, in participation in general community activities, and establishing relationships with peers. Activity training includes assisting the person to continue to participate on an ongoing basis;
5. Community experiences include activities intended to instruct the person in daily living and community living skills in a clinic and integrated setting. Included are such activities as shopping, church attendance, sports, participation in clubs, etc. Community experiences include activities and supports to accomplish individual goals or learning areas including recreation and specific training or leisure activities. Each activity is then adapted according to the beneficiary's individual needs.
6. Non-medical transportation to or from community integration experiences is an integral part of this service and is included in the daily rate computation. DDS will assure duplicate billing between waiver services and other Medicaid state plan services will not occur. The habilitation objectives to be served by such training must be documented in the person's service plan;
7. 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;
8. Communication including training in vocabulary building, use of augmentative communication devices and receptive and expressive language;
9. Behavior shaping and management includes training, assistance or both in appropriate expressions of emotions or desires, compliance, assertiveness,

acquisition of socially appropriate behaviors or reduction of inappropriate behaviors;

10. Reinforcement of therapeutic services which consist of conducting exercises or reinforcing physical, occupational, speech and other therapeutic programs;
11. Performance of tasks to assist or supervise the person in such activities as meal preparation, laundry, shopping and light housekeeping that are incidental to (not to exceed 20% of the total weekly hours worked) the care and supervision of the beneficiary but cannot be performed separately from other waiver services.
12. Health maintenance activities may be provided by a supportive living worker. All health maintenance activities (to include oral medication administration or assistance, shallow suctioning, maintenance and use of intra-feeding and breathing apparatus or devices), except injections and IV's, can be done in the home by a designated care aide, such as a supportive living worker. With the exception of injectable medication administration, tasks that beneficiaries would otherwise do for themselves, or have a family member do, can be performed by a paid designated care aide at their direction, as long as the criteria specified in the Arkansas Nurse Practices Consumer Directed Care Act has been met. Health maintenance activities are available in the Arkansas Medicaid State Plan as self directed services. State plan services must be exhausted before accessing waiver funding for health maintenance activities.

B. Companion and Activities Therapies

Companion and activities therapy services provide reinforcement of habilitative training. This reinforcement is accomplished by using animals as modalities to motivate persons to meet functional goals as follows:

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

NOTE: This service does not include the purchase of animals, veterinary or other care, food, shelter or ancillary equipment that may be needed by the animal that is providing reinforcement.

C. Direct Care Supervision

The direct care supervisor employed by the supported living provider is responsible for assuring the delivery of all supported living direct care services including the following activities:

1. The coordination of all direct service workers who provide care through the direct service provider;
2. Serving as liaison between the beneficiary, parents, legal representatives, case management entity and DDS officials;
3. Coordinating schedules for both waiver and 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 care service Medicaid waiver billing;
6. Arranging for staffing of all alternative living settings;

7. Assuring transportation as identified in person centered service plan specific to supportive living services;
8. Assuring timely collaboration with the case management entity to obtain comprehensive behavior and assessment reports, continued stay reviews, revisions as needs change and information and documents required for ICF/MR level of care and waiver Medicaid eligibility determination;
9. Reviewing the person's records and environments in which services are provided by accessing appropriate professional sources to determine whether the person is receiving appropriate support in the management of medication. Minimum components are as follows:
   a. Staff, at all times, are aware of the medications being used by the beneficiary.
   b. Staff are knowledgeable of potential side effects of the medications being used by the person through the prescribing physician, nurse and pharmacist at the time medications are ordered.
   c. All medications consumed are prescribed or approved by the beneficiary's physician or other health care practitioner.
   d. The beneficiary or legally responsible person is informed by the prescribing physician about the nature and effect of medication being consumed and consent to the consumption of those medications prior to consumption.
   e. Staff are implementing the service provider's policies and procedures as to medication management, appropriate to the beneficiary's needs as monitored by the direct care supervisor in accordance with acceptable personnel policies and practices and by the case manager at least monthly.
   f. If psychotropic medications are being used for behavior, the direct care supervisor and case manager are responsible to assure appropriate positive behavior programming is present and in use with programming reviews at least monthly.
   g. The consumption of medications is monitored at least monthly by the direct care supervisor to ensure that they are accurately consumed as prescribed.
   h. Toxicology screenings are conducted on a frequency determined by the prescribing physician with case manager oversight.
   i. Any administration of medication or other nursing tasks or activities are performed in accordance with the Nurse Practice and Consumer Directed Care Acts is monitored by the direct care supervisor in accordance with acceptable personnel practices and by the case manager at least monthly.
   j. Medications are regularly reviewed to monitor their effectiveness, to address the reason for which they were prescribed and for possible side effects.
   k. Medication errors are effectively detected by the direct care supervisor by review of the daily medication log and with appropriate response up to and inclusive of incident reporting and reporting to the Nursing Board.
   l. Frequency of monitoring is based on the physician's prescription for administration of medication.
   m. The physician approving the service level of support and the person centered service plan is responsible for monitoring and determining

contraindications when multiple medications are prescribed. A minimum review is at the annual continued stay review of the person centered service plan for approval and recertification.

Direct care staff are required to complete daily activity logs for activities that occur during the work timeframe with such activities linked to the person centered service plan objectives. The direct care supervisor is required to monitor the work of the direct care staff and to sign-off on timesheets maintained to document work performed. All monitoring activities, reviews and reports must be documented and available upon request from authorized DDS or DMS staff.

NOTE: Failure to satisfactorily document activities according to DMS requirements may result in non-payment of services.

Persons may access both supportive living and respite on the same date as long as the two services are distinct, do not overlap and the daily rate maximum is correctly prorated as to the portion of the day that each respective service was actually provided. DDS monitors this provision through retrospective annual look behind with providers responsible to maintain adequate time records and activity case notes or activity logs that support the service deliveries. Maximum daily rate is established in accordance with budget neutrality wherein both supportive living and respite independently and collectively cannot exceed the daily maximum.

Controls in place to assure payments are only made for services rendered include requirement by assigned staff to complete daily activity logs for activities that occurred during the work timeframe with such activities linked to the plan of care objectives; supervision of staff by the direct care supervisor with sign off on timesheets maintained weekly; audits and reviews conducted by DDS Quality Assurance annually and at random; DDS Waiver Services annual retrospective reviews, random attendance at planning meetings and visits to the home; DMS random audits; and oversight by the chosen and assigned case manager.

213.100 Supportive Living Arrangement Model 3-1-10

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 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).

213.200 Supportive Living Exclusions 3-1-10

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

The payments for these services exclude the costs of room and board, including general maintenance, upkeep or improvement to the beneficiary'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.

Waiver funding will not reimburse for overtime. It is the responsibility of the provider to assure compliance with State and Federal Department of Labor, Wage and Hour Laws.

213.300 Benefit Limits for Supportive Living 3-1-10

The maximum daily rate for the supportive living array, which includes both supportive living and respite services, collectively or individually is based upon the level of support identified in the beneficiaries person centered service plan. This daily rate includes provider indirect costs for each component of service. DDS must prior authorize daily rates for all levels of support.

Pervasive – maximum daily rate is $391.95 with a maximum annual rate of $143,061.75.

Extensive – maximum daily rate is $176.00 with a maximum annual rate of $64,240.00.

Limited – maximum daily rate is $176.00 with a maximum annual rate of $38,544.00.

See Section 260.000 for billing information.

See Section 224.000 for payment guidelines of relatives or legal guardians.

214.000 Respite Services 3-1-10

Respite services are provided on a short-term basis to beneficiaries unable to care for themselves due to the absence of or need for relief of non-paid primary caregivers. Room and board may not be claimed when respite is provided in the beneficiary's home or a private place of residence. Room and board is not a covered service except when provided as part of respite furnished in a facility that is approved by the State as a respite care facility.

Receipt of respite services does not necessarily preclude a beneficiary from receiving other services on the same day. For example, a beneficiary may receive day services, such as, supported employment on the same day as respite services.

When respite is furnished for the relief of a foster care provider, foster care services may not be billed during the period that respite is furnished. Respite may not be furnished for the purpose of compensating relief or substitute staff for supportive living services. Respite services are not to supplant the responsibility of the parent or guardian.

Respite services may be provided through a combination of basic child care and support services required to meet the needs of a child. When respite is provided in a licensed day care facility, licensed day care home, or other lawful child care setting, waiver will only pay for the support staff required by the beneficiary's developmental disability. Parents and guardians will remain responsible for the cost of basic child care fees.

Respite may be provided in the following locations:

A. Beneficiary's home or private place of residence;

B. The private residence of a respite care provider;

C. Foster home;

D. Medicaid certified ICF/MR;

E. Group home;

F. Licensed respite facility;

G. Other community residential facility approved by the state, not a private residence.

H. Licensed or accredited residential mental health facility.

I. Licensed day care facility, licensed day care home or other lawful child care setting. Waiver will only pay for support staff required due to developmental disability. Waiver will not pay for day care fees.

214.100 Benefit Limits for Respite Services 3-1-10

The maximum daily rate for the supportive living array, which includes both supportive living and respite services, collectively or individually is based upon the level of support identified in the beneficiaries person centered service plan. This daily rate includes provider indirect costs for each component of service. DDS must prior authorize daily rates for all levels of support.

Pervasive – maximum daily rate is $391.95 with a maximum annual rate of $143,061.75.

Extensive – maximum daily rate is $176.00 with a maximum annual rate of $64,240.00.

Limited – maximum daily rate is $176.00 with a maximum annual rate of $38,544.00.

See section 260.000 for billing information.

215.000 Supported Employment 3-1-10

Supported employment services consist of intensive, ongoing supports that enable beneficiaries for whom competitive employment at or above the minimum wage is unlikely or who, because of their disabilities, need intensive ongoing support to perform in a competitive work setting.
Supported employment is conducted in a variety of settings, particularly work sites in which individuals without disabilities are employed. When supported employment services are provided at a work site where persons without disabilities are employed, payment is made only for the adaptations, supervision and training required by beneficiaries receiving waiver services as a result of their disabilities. Coverage does not included payment for the supervisor activities rendered as a normal part of the business setting. The employer is responsible for making reasonable accommodations in accordance with the Americans with Disabilities Act.

Supported employment is a collaborative service with Arkansas Rehabilitation Services (ARS). All waiver beneficiaries receiving supported employment must be prior certified by ARS to assure the beneficiary is qualified for supported employment and that ARS funding has been accessed first.

Integration requires that a beneficiary work in a place where no more than eight people with disabilities work together and where co-workers without disabilities are present in the work setting or in the immediate vicinity. Supported employment services may be furnished by a co-worker or other job site personnel provided that the services which are furnished are not part of the normal duties of the co-worker or other personnel and these individuals meet the qualifications to be a provider of the supported employment service.

Supported employment includes:

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

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

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

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

Transportation between the beneficiary's place of residence and the site of employment, is included as a component part of supported employment services. The cost of this transportation is included in the rate paid to providers.

Personal assistance may be a component part of supported employment but may not need to comprise the entirety of the service.

Supported employment may include services and supports that assist the beneficiary in achieving self-employment through the operation of a business. However, Medicaid funds may not be used to defray the expenses associated with starting up or operating a business. Assistance for self-employment may include:

A. Aiding the beneficiary to identify potential business opportunities;

B. Assistance in the development of a business plan, including potential sources of business financing and other assistance in developing and launching a business;

C. Identification of the supports that are necessary for the beneficiary to operate the business; and

D. Ongoing assistance, counseling and guidance once the business is launched.

Beneficiaries receiving supported employment services may also receive educational, prevocational and day habilitation services. A beneficiary's service plan may include two or more types of non-residential habilitation services. However, different types of non-residential habilitation services may not be billed during the same period of the day.

215.100 Supported Employment Exclusions 3-1-10

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

Payment for employment services excludes:

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

B. Payments that are passed through to waiver beneficiaries.

C. Payments for training that are not directly related to the waiver beneficiary's employment.

D. Reimbursement if the beneficiary is not able to perform the essential functions of the job. The functions of a job coach are to "coach," not to do the work for the person.

E. ACS waiver supported employment services when the same services are otherwise funded under the Rehabilitation Act of 1973 or Public Law 94-142. This

means that such services must be exhausted before waiver-supported employment services can be approved or reimbursement can be claimed.

F. Services provided in a sheltered workshop or other similar type of vocational service furnished in a specialized facility.

215.200 Documentation Requirements for Supported Employment 3-1-10

Supported employment providers must maintain documentation in each waiver beneficiary's file to demonstrate the service is not available under a program funded under Section 110 of the Rehabilitation Act of 1973 or Individual with Disabilities Education Act (20 U.S.C. 1401 et.seq).

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

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

215.300 Benefit Limits for Supported Employment 3-1-10

Beneficiaries are limited to a maximum of $3.59 per 15 minute unit with a maximum of 32 units (8 hours) of supported employment services per date of service.

Supported employment, provided as long term support, requires monitoring at a minimum of two meetings with the beneficiary and one employer contact each month. The person is required to work a minimum of 15 hours per week in accordance with ARS regulation. Exceptions must be justified by the beneficiary's case manager and prior approved by ARS. ARS must approve any exception with monthly monitoring. The beneficiary's case manager must prepare in writing a justification citing why the person cannot work at least 15 hours per week must and submit to the ARS counselor assigned to the case.

See section 260.000 for billing information.

216.000 Adaptive Equipment 3-1-10

The adaptive equipment service includes an item, piece of equipment that is used to increase, maintain or improve functional capabilities of individuals to perform daily life tasks that would not be possible otherwise. The adaptive equipment service provides for the purchase, leasing and as necessary, repair of adaptive, therapeutic and augmentative equipment.

Adaptive equipment needs for supportive employment are included. This service may include specialized 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 beneficiary from any other source. Professional consultation must be accessed to ensure that the equipment will meet the needs of the beneficiary when the purchase will at a minimum, but not necessarily, exceed $500.00. Consultation must be conducted by an medical professional as determined by the beneficiary's condition for which the equipment is needed. All items must meet applicable standards of manufacture, design and installation.

All adaptive equipment must be solely for the waiver beneficiary. All purchases must meet the conditions for desired quality at the least expensive cost. Generally, any modifications over $1,000.00 will require three bids with the lowest bid with comparable

quality being awarded; however, DDS may require three bids for any requested purchase.

Computer equipment may be approved when it allows the beneficiary 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.

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.

NOTE: Adaptive equipment must be an item that is modified to fit the needs of the beneficiary. Items such as toys, gym equipment, sports equipment, etc. are excluded as not meeting the service definition.

Conditions: The care and maintenance of, adaptive equipment, vehicle modifications, and personal emergency response systems are entrusted to the beneficiary or legally responsible person for whom the aids are purchased. Negligence (defined as failure to properly care for or perform routine maintenance of) shall mean that the service will be denied for a minimum of two plan years. Any abuse or unauthorized selling of aids by the beneficiary or legally responsible person shall mean the aides will not be replaced using waiver funding.

Exclusions:

A. Swimming pools (in-ground or above ground) and hot tubs are not allowable as either an environmental modification or adaptive equipment.

B. Therapeutic tools similar to those therapists employ during the course of therapy are not included.

C. Educational aids are not included.

D. Computers will not be purchased to improve socialization or educational skills.

E. Computer supplies.

F. Computer desk or other furniture items are not covered.

G. Medicaid purchased equipment cannot be donated if the equipment being donated is needed by another waiver beneficiary residing in the residence.

216.100 Vehicle Modifications 3-1-10

Vehicle modifications are adaptations to an automobile or van to accommodate the special needs of the beneficiary. Vehicle adaptations are specified by the service plan as necessary to enable the beneficiary to integrate more fully into the community and to ensure the health, welfare, and safety of the beneficiary.

Payment for permanent modification of a vehicle is based on the cost of parts and labor, which must be quoted and paid separately from the purchase price of the vehicle to which the modifications are or will be made.

Transfer of any part of the purchase price of a vehicle, including preparation and delivery, to the price of a modification is a fraudulent activity. All suspected fraudulent

activity will be reported to the Program Integrity Section of the Division of Medical Services for investigation.

Reimbursement for a permanent modification cannot be used or considered as down payment for a vehicle.

Lifts that require vehicle modification and the modifications are, for purposes of approval and reimbursement, one project and cannot be separated by plan of care years in order to obtain up to the maximum for each component.

Permanent vehicle modifications may be replaced if the vehicle is stolen, damaged beyond repair as long as the damage is not through negligence of the vehicle owner, or used for more than its reasonable useful lifetime.

A. A vehicle has reached its reasonable useful lifetime when repairs are required to make the vehicle useable, and the cost of the repairs exceeds the fair market value of the vehicle in repaired condition.

B. Cost of repair shall be determined by repair estimates from three qualified repairers.

C. Vehicle value shall be determined by reference to sales listing for similar vehicles within a 200 mile radius of the beneficiary's home, and to listings in Dallas, Texas; Kansas City, Missouri; Saint Louis, Missouri and Memphis, Tennessee.

D. If the beneficiary or legally responsible party sells or trades a permanently modified vehicle before the vehicle reaches its reasonable useful lifetime, the modification will not be replaced on any replacement vehicle. Instead, the beneficiary may be eligible for partial payment based on the estimated remaining residual value of the vehicle at the time of sale.

   1. Estimated residual value shall be determined by comparing the purchase price of the modified vehicle when acquired by the beneficiary or legally responsible party when the vehicle value at the time of sale determined as stated above.
   2. Example: A permanently modified vehicle purchased for $30,000 is sold with a value of $20,000 (66% residual value). If parts and labor for the modification of the replacement vehicle are $10,000, the amount paid is $3,333 (33%).

E. Vehicle modifications apply only to modifications and not to routine auto maintenance or repairs for the vehicle.

F. The following are specifically excluded:

   1. Adaptations or improvements to the vehicle that are of general utility and are not of direct medical or remedial benefit to the beneficiary;
   2. Purchase, down payment or lease of a vehicle;
   3. Regularly scheduled upkeep and maintenance of a vehicle, except upkeep and maintenance of the modification.

216.200 Personal Emergency Response System (PERS) 3-1-10

PERS may be approved when it can be demonstrated as necessary to protect the health and safety of the beneficiary. PERS is an electronic device that enables beneficiaries at high risk of institutionalization to secure help in an emergency. The beneficiary may also wear a portable "help" button to allow for mobility. The system is connected to the beneficiary's telephone and programmed to signal a response center once the "help" button is activated. The response center must be staffed by trained professionals.

PERS services are limited to beneficiaries 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 routine supervision. Included in this service are assessment, purchase, installation, testing, and monthly rental fees.

216.300 Benefit Limits for Adaptive Equipment 3-1-10

The maximum annual expenditure for adaptive equipment is $7,687.50 per person per year. If the person is also receiving environmental modification services, the COMBINED annual expenditure cannot exceed $7,687.50.

217.000 Environmental Modifications 3-1-10

Environmental modifications are made to the waiver beneficiary's home, required by the person centered service plan and are necessary to ensure the health, welfare and safety of the beneficiary or that enable the beneficiary to function with greater independence and without which the beneficiary would require institutionalization.

Environmental modification may include the installation of ramps and grab-bars, widening of doorways, modification of bathroom facilities , installation of specialized electric and plumbing systems to accommodate medical equipment, installation of sidewalks or pads to accommodate ambulatory impairments, and home property fencing when medically necessary to assure non-elopement, wandering or straying of persons who have dementia, Alzheimer's disease or other causes of memory loss or confusion as to location or decreased mental capacity or aberrant behaviors.

Expenses for the installation of the environmental modification and any repairs made necessary by the installation process are allowable. Portable or detachable modifications that can be relocated with the beneficiary and that have a written consent from the property owner or legal representative will be considered. Requests for modification must include an original photo of the site where modifications will be done; to scale sketch plans of the proposed modification project; identification of other specifications relative to materials, time for project completion ad expected outcomes; labor and materials breakdown and assurance of compliance with any local building codes. Final inspection for the quality of the modification and compliance with specifications and local codes is the responsibility of the waiver case manager. Payment to the contractor is to be withheld until the work meets specifications including a signed customer satisfaction statement.

All services must be provided as directed by the beneficiary's person centered service plan and in accordance with all applicable state or local building codes.

Environmental modifications must be made within the existing square footage of the residence and cannot add to the square footage of the building.

Modifications are considered and approved as single, all-encompassing projects and, as such, cannot be split whereby a part of the project is submitted in one service plan year and another part submitted in the next service plan year. Any such activity is prohibited. All modifications must be completed within the plan of care year in which the modifications are approved.

All purchases must meet the conditions for desired quality at the least expensive cost. Generally, any modifications over $1,000.00 will require three bids with the lowest bid with comparable quality being awarded, however, DDS may require three bids for any requested modification.

217.100 Environmental Modifications Exclusions 3-1-10

Modifications or improvements to the beneficiary's home which are of general utility and are not of direct medical or remedial benefit to the beneficiary (e.g., carpeting, roof repair, central air conditioning, etc.) are excluded as covered services. Also excluded are modifications or improvements that are of aesthetic value such as designer wallpaper, marble counter tops, ceramic tile, etc. Outside fencing is limited to one fence per lifetime. Total perimeter fencing is excluded. Expenses for remodeling or landscaping which are cosmetic, designed to hide the existence of the modification, or result from erosion are not allowable. Environmental modifications that are permanent fixtures will not be approved for rental property without prior written authorization and a release of current or future liability by the residential property owner.

Environmental modifications may not be used to adapt living arrangements that are owned or leased by providers of waiver services.

Swimming pools (both in and out of ground) and hot tubs (spas) are not allowable.

The moving of modifications, such as fencing or ceiling tracks and adaptive equipment that may be permanently affixed to the structure or outside premises is not allowable.

Conditions: The care and maintenance of environmental modifications is entrusted to the beneficiary or legally responsible person for whom the modifications are purchased. Negligence (defined as failure to properly care for or perform routine maintenance of) shall mean that the service will be denied for a minimum of two plan years. Any abuse or unauthorized selling of aids by the beneficiary or legally responsible person shall mean the aides will not be replaced using waiver funding.

217.200 Benefit Limits for Environmental Modifications 3-1-10

A beneficiary's annual expenditure for environmental modifications cannot exceed $7,687.50 per person per year. If the beneficiary is also receiving adaptive equipment services, the COMBINED total cannot exceed $7,687.50.

218.000 Specialized Medical Supplies 3-1-10

Specialized medical equipment and supplies include:

A. Items necessary for life support and the ancillary supplies and equipment necessary for the proper functioning of such items.

B. Durable and non-durable medical equipment not available under the Arkansas Medicaid State Plan that is necessary to address beneficiary functional limitations.

C. Necessary medical supplies not available under the Arkansas Medicaid State Plan. Items reimbursed with waiver funds are in addition to any medical equipment and supplies furnished under the state plan and exclude those items that are not of direct medical or remedial benefit to the beneficiary. All items shall meet applicable standards of manufacture, design and installation.

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

A. Nutritional supplements

B. Non-Prescription medications. Alternative medicines not Federal Drug Administration approved are excluded from coverage.

C. Prescription drugs, minus the cost of drugs covered by Medicare Part D, when extended benefits available under the Arkansas Medicaid State Plan.

Item(s) must be included in the person centered service plan. When the items are included in Arkansas Medicaid State Plan services, a denial of extension of benefits by DMS Utilization Review will be required prior to approval for waiver funding by DDS.

218.100 Benefit Limits for Specialized Medical Supplies 3-1-10

The maximum annual allowance for specialized medical supplies, supplemental supports and community transition services is $3690.00, collectively or individually.

When a non-prescription or prescription medication is necessary to maintain or avoid health deterioration, the $3,690.00 limit may be increased with the difference in the specialized medical supplies maximum allowance and the required amount deducted from the supportive living maximum daily allowance. All such requests must be prior approved by the DDS Assistant Director of Waiver Services.

See Section 260.000 for billing information.

219.000 Supplemental Support Service 3-1-10

The supplemental support service helps improve or enable the continuance of community living. This service is only available in response to crisis, emergency or life threatening situations. Supplemental support service will be based on demonstrated needs as identified in a beneficiary's person centered service plan as emergencies arise. Waiver funds will be used as the payer of last resort.

Supplemental support service includes:

A. Ancillary supports such as non-recurring set-up expenses for beneficiaries in the event of a disaster, crisis, emergency or life threatening situation. Allowable expenses are those necessary to enable a person to establish a basic household that do not constitute room and board and may include:

1. Security deposits that are required to obtain a lease on an apartment or home;
2. Essential household furnishings and moving expense required to occupy and use a community domicile, including furniture, window coverings, food preparation items, and bed/bath linens;
3. Set-up fees or deposits for utility or service access, including telephone, electricity, heating and water;
4. Services necessary for the beneficiary's health and safety such as pest eradication and one-time cleaning prior to occupancy;
5. Moving expenses. This service is furnished only to the extent that it is reasonable and necessary as determined through the service plan development process, clearly identified in the service plan and the person is unable to meet such expense or when the services cannot be obtained from other sources.

B. Drug and alcohol screening in accordance with the beneficiary's treatment plan. A physician, psychologist or court of law must order drug and alcohol screening

C. Activity fees such as dues at YMCA, Weight Watchers, etc. used for behavior reinforcement or sensory simulation. Fees may be paid only for the waiver

beneficiary and for such time as to abate the life threatening condition. These services must be prescribed and monitored by medical professionals.

219.100 Supplemental Support Service Exclusions 3-1-10

The supplemental support service is not allowed for monthly rental, lease or mortgage expenses, regular utility charges, household appliances, items that are intended for purely diversional or recreational in nature (televisions, cable TV access, VCRs or DVD players).

Supplemental support may not be used to pay for furnishing living arrangements that are owned or leased by a waiver provider where the provision of these items and services are inherent to the service the provider is already delivering. Supplemental support may not be used for these or any other room-and board service.

219.200 Supplemental Support Service Benefit Limits 3-1-10

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

The maximum annual allowance for supplemental support, community transition services, and specialized medical supplies is $3,690.00, collectively or individually.

220.000 Case Management Services 3-1-10

Case management services assist beneficiaries in gaining access to needed waiver and other Arkansas Medicaid State Plan services, as well as medical, social, educational and other generic services, regardless of the funding source to which access is available.

Case management services include responsibility for guidance and support in all life activities. The intent of case management services is to enable waiver beneficiaries 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 beneficiary services included in the person centered service plan

C. Facilitating crisis intervention

D. Guidance and support to obtain generic services and supports

E. Case planning

F. Needs assessment and referral for resources

G. Monitoring to assure quality of care

H. Case reviews that focus on the beneficiary'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 determinations

L. Arranging for access to advocacy services as requested by the beneficiary in the event that case management and direct service are the same provider entity. The case manager and the direct care supervisor can never be the same person when the case manager and direct care supervisor work for the same provider entity. The direct care supervisor is the person responsible for the interviewing, hiring, firing, training, and scheduling of direct care staff providing supportive living services. This is separate and apart from the case manager responsibilities.

M. Monitoring and reviewing services to assure health and safety of the beneficiary.

N. Upon receipt of DDS approvals or denials of requested services, the case manager ensures that a copy is provided to the beneficiary or legal representative.

O. Provides assistance with the appeals process when the appeal option is chosen by the beneficiary or legal representative.

Case Management will be provided up to a maximum of a 90 day transition period for all persons who seek to voluntarily withdraw from waiver services. The transition period will allow for follow up to assure that the person is referred to other available services and to assure that the person's needs can be met through optional services. It also serves to assure that the person understands the effects and outcomes of withdrawal and to ascertain if the person was coerced or otherwise was unduly influenced to withdraw. During this 90 day timeframe, the person remains enrolled in the waiver, the case remains open, and waiver services will continue to be available until the beneficiary finalizes their intent to withdraw.

Case Management services may not include activities or services that constitute the provision of direct services to the beneficiary that are normally covered as distinct services (e.g. the transportation of beneficiaries to sites where waiver services are furnished or they receive state plan services).

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 face-to-face visit AND one other contact with the beneficiary or legal representative monthly. At least one visit must be made annually at the beneficiary's place of residence.

B. Extensive – Minimum of one face-to-face visit with the beneficiary or legal representative each month. At least one visit must be made annually at the beneficiary's place of residence.

C. Limited – Minimum of one face-to-face visit with the beneficiary or legal representative each quarter and a minimum of one contact monthly for the months when a face-to-face visit is not made. At least one visit must be made annually at the beneficiary's place of residence.

The level of support 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 260.000 for billing information.

220.100 Transitional Case Management 3-1-10

Case Management services may be available during the last 180 consecutive days of a Medicaid eligible person's institutional stay to allow case management activities to be performed related to transitioning the person to the community. The person must be approved and in the waiver program for case management to be billed. All transition services must be reasonable and necessary, not available to the participant through other means, and clearly specified in the waiver participant's service plan. Once the beneficiary has been approved for the waiver, a prior authorization for this service will be issued.

220.200 Benefit Limits for Case Management 3-1-10

There is a maximum reimbursement limit of $117.70 per month and $1,412.40 annually per person per year.

221.000 Consultation Services 3-1-10

Consultation services are clinical and therapeutic services which assist waiver beneficiaries, parents, guardians, legally responsible individuals, and service providers in carrying out the beneficiary's person centered service plan.

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

1. Psychologists
2. Psychological examiners
3. Mastered social workers
4. Professional counselors
5. Speech pathologists
6. Occupational therapists
7. Physical therapists
8. Registered nurses
9. Certified parent educators or provider trainer
10. Certified communication and environmental control specialists
11. Dieticians
12. Rehabilitation counselors
13. Recreational therapists
14. Qualified Mental Retardation Professional (QMRP)
15. Positive Behavioral Supports (PBS) Specialist

These services are indirect in nature. The parent educator or provider trainer is authorized to provide the activities identified below:

1. Screening, assessing and developing therapeutic treatment plans
2. Assisting in the design and integration of individual objectives as part of the overall individualized service planning process as applicable to the consultation specialty
3. Training of direct services staff or family members in carrying out special community living services strategies identified in the person centered service plan as applicable to the consultation specialty

4. Providing information and assistance to the individuals responsible for developing the beneficiary's person centered service plan as applicable to the consultation specialty

The provider agency will be responsible for maintaining the necessary information to document staff qualifications. Staff who meet the certification criteria necessary for other consultation functions may also provide these activities. Selected staff or contract individuals may not provide training in other categories unless they possess the specific qualifications required to perform the other consultation activities. Use of this service for provider training cannot be used to supplant provider trainer responsibilities included in provider indirect costs.

B. Activities involved in consultation services include:

1. Provision of updated psychological and adaptive behavior assessments
2. Participating on the interdisciplinary team, when appropriate to the consultant's specialty
3. Consulting with and providing information and technical assistance with other service providers or with direct service staff and/or family members in carrying out a beneficiary's person centered service plan specific to the consultant's specialty
4. Assisting direct services staff or family members in making necessary program adjustments in accordance with the person's person centered service plan as applicable to the consultation specialty
5. Determining the appropriateness and selection of adaptive equipment to include communication devices, computers and software consistent with the consultant's specialty
6. Training and/or assisting persons, direct services staff or family members in the set up and use of communication devices, computers and software consistent with the consultant's specialty
7. Screening, assessing and developing positive behavior support plans; assisting staff in implementation, monitoring, reassessment and modification of the positive behavior support plan consistent with the consultant's specialty
8. Training of direct services staff and/or family members by a professional consultant in:
   a. Activities to maintain specific behavioral management programs applicable to the person
   b. Activities to maintain speech pathology, occupational therapy or physical therapy program treatment modalities specific to the person
   c. The provision of medical procedures not previously prescribed but now necessary to sustain the person in the community
9. Training or assisting by advocacy to beneficiaries and family members on how to self-advocate
10. Rehabilitation counseling for the purposes of supported employment supports that do not supplant the Federal Rehabilitation Act of 1973 and PL 94-142 and the supports provided through Arkansas Rehabilitation Services
11. Training and assisting persons, direct services staff or family members in proper nutrition and special dietary needs.

The maximum amount payable per year for consultation services, per person is $1,320.00 or $136.40 per hour

See section 260.000 for billing information.

222.000 Crisis Intervention Services 3-1-10

Crisis intervention services are defined as services delivered in the beneficiary's place of residence or other local community site by a mobile intervention team or professional.

Intervention services must be available 24 hours a day, 365 days a year and must be targeted to provide technical assistance and training in the areas of behavior already identified. Services are limited to a geographic area conducive to rapid intervention as defined by the provider responsible to deploy the team or professional. Services may be provided in a setting as determined by the nature of the crisis, i.e., residence where behavior is happening, neutral ground, local clinic or school setting, etc. The following criteria must be met:

A. The beneficiary is receiving waiver services

B. The beneficiary needs non-physical intervention to maintain or re-establish behavior management or positive programming plan

C. Intervention is on-site in the community

A beneficiary may require one hour or a maximum of twenty-four hours of service during any one day. The maximum rate of reimbursement for this service is $127.10 per hour.

See Section 260.000 for billing information.

223.000 Community Transition Services 3-1-10

Community transition services are non-recurring set-up expenses for beneficiaries who are transitioning from an institutional or another provider-operated living arrangement to a living arrangement in a private residence where the person is directly responsible for his or her own living expenses. Waiver funds can be accessed once it has been determined that the waiver is the payer of last resort.

Allowable expenses are those necessary to enable a person to establish a basic household that do not constitute room and board and may include:

A. Security deposits that are required to obtain a lease on an apartment or home;

B. Essential household furnishings and moving expense required to occupy and use a community domicile, including furniture, window coverings, food preparation items, and bed/bath linens;

C. Set-up fees or deposits for utility or service access, including telephone, electricity, heating and water;

D. Services necessary for the beneficiary's health and safety such as pest eradication and one-time cleaning prior to occupancy;

E. Moving expenses; and

F. Necessary home accessibility adaptations.

Community transition services are furnished only to the extent that they are reasonable and necessary as determined through the service plan development process, clearly identified in the person centered service plan and the person is unable to meet such expense or when the services cannot be obtained from other sources.

Duplication of environmental modifications will be prevented through DDS control of prior authorizations for approvals.

Costs for community transition services furnished to beneficiaries returning to the community from a Medicaid institutional setting through entrance to the waiver, are considered to be incurred and billable when the person leaves the institutional setting and enters the waiver. The beneficiary must be reasonably expected to be eligible for and to enroll in the waiver. If for any unseen reason, the beneficiary does not enroll in the waiver (e.g., due to death or a significant change in condition), transitional services may be billed to Medicaid as an administrative cost.

Exclusions: Community transition services may not include payment for room and board; monthly rental or mortgage expense; food, regular utility charges; and/or household appliances or items that are intended for purely diversional or recreational purposes. Community transition services may not be used to pay for furnishing living arrangements that are owned or leased by a waiver provider where the provision of these items and services are inherent to the service they are already providing.

Diversionary or recreational items such as televisions, cable TV access, VCR's or DVD players are not allowable.

All transition services must be reasonable and necessary, not available to the participant through other means, and clearly specified in the waiver participant's service plan. Once the beneficiary has been approved for the waiver, a prior authorization for this service will be issued.

223.100 Benefit Limits for Community Transition Services 3-1-10

The maximum annual allowance for supplemental support, community transition services, and specialized medical supplies is $3,690.00, collectively or individually.

See section 260.000 for billing information.

224.000 Payment to Relatives or Legal Guardians 3-1-10

Payment for waiver services will not be made to the adoptive or natural parent, step-parent or legal representative or legal guardian of a person less than 18 years old. Payments will not be made to a spouse or a legal representative for a person 18 years of age or older. The employment of eligible relatives (regardless of the waiver beneficiary's age) shall require prior approval from DDS authority.

Payment to relatives, other than parents of minor children, legal guardians, custodians of minors or adults, or the spouse of adults, must be prior approved by DDS to provide services. For purposes of exclusion, "parent" means natural or adoptive parents and step parents. For any service provider, all DDS qualifications and standards must be met before the person can be approved as a paid service provider. Qualified relatives, other than as specified in the foregoing, can provide any service.

Employees will only be reimbursed for 40 hours per week, thus helping to assure the absence of undue influence in the person centered service plan.

In no case will a parent or legal guardian be reimbursed for the provision of transportation for a minor.

Controls for services rendered: All care staff are required to document all services provided daily according to their work schedules, direct care support service supervisors are responsible for the day to day supervision and monitoring of the direct care staff; case managers are responsible to periodically review with the beneficiary any problems

in care delivery and report any deficiencies to the Waiver DD Specialist and DDS Quality Assurance provider certification staff. DDS specialists conduct a 100% review of service utilization for each plan of care at the time of each plan of care 12 month expiration date to identify any gaps in approved services with corrective action by the provider to be taken; DDS Quality Assurance conducts annual provider reviews; and DMS conducts both random Quality Assurance audits and audits specific to the financial integrity of services delivered.

230.100 Categorical Eligibility Determination 3-1-10

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

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

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

230.200 Level of Care Determination 3-1-10

Based on intellectual and behavioral assessment submitted by the provider, the ICF/MR level of care determination is performed by the Division of Developmental Disabilities. The ICF/MR level of care criteria provides an objective and consistent method for evaluating the need for institutional placement in the absence of community alternatives. The level of care determination must be completed and the beneficiary deemed eligible for ICF/MR level of care prior to receiving ACS Waiver services.

Recertification, based on intellectual and behavioral assessments submitted by the provider at appropriate age milestones, will be performed by DDS to determine the beneficiary's continuing need for an ICF/MR level of care.

230.210 Levels of Support 3-1-10

Coverage is provided within three levels of support. Levels of support are defined as pervasive, extensive and limited and are based on the amount of need for assistance. The beneficiary can move from one level of support to another if there is documentation supporting the need for a higher degree of support. No exceptions are made if documentation does not support the beneficiary's need for a higher level of support.

Once the pervasive level of support is reached and all other funding sources have been accessed, if the provider cannot assure the health, safety and welfare of the beneficiary in the community, case closure proceedings are initiated.

230.211 Pervasive Level of Support 3-1-10

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 definition are determined eligible based on the Inventory for Client and Agency Planning (ICAP) assessment process.

C. 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.

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 changes in medical, behavioral or other condition that would justify the need for pervasive level of support. Include all incident reports.
   b. Copy of the current person centered service plan.
   c. Copy of the person's case management and supportive living staff notes for the past year if request is due to behavior or medical.
   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.
2. 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 secure e-mail. For emergency requests, all the required documentation listed in this rule must be submitted within two working days. If the documentation does not support there was an emergency, the emergency approval will be suspended or rescinded.

3. All requests for pervasive level of support will be reviewed at the weekly Plan of Care Review committee meetings.

230.212 Extensive Level of Support 3-1-10

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 24 hours a day, seven days a week.

230.213 Limited Level of Support 3-1-10

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 beneficiary.

230.300 Comprehensive Diagnosis and Evaluation 3-1-10

A comprehensive diagnosis and evaluation (D&E) must be administered in order to determine that applicants are persons with a developmental disability prior to receiving ACS Waiver services from the DDS.

The comprehensive diagnosis and evaluation includes a series of examinations and observations performed or validated and approved by professionals leading to conclusions and findings.

The examinations and/or assessments include, but are not limited to:

A. A thorough medical examination and other evaluations deemed necessary by the physician

B. A psychological assessment

C. A social history/sociological examination

D. An educational assessment, if applicable

E. An appraisal of adaptive behavior

F. All other examinations, assessments and evaluations necessary to describe the beneficiary's needs

G. Areas of Need form

Failure to submit the reassessments timely will result in the denial of case management reimbursement for the period the determination is overdue. Failure to obtain any required eligibility determination, whether initial or subsequent time-bound reassessments, may result in the beneficiary's case being closed.

When a beneficiary's case has been closed, the affected person must make a new request for services through the waiver program intake process in order for services to continue. This will be considered a new application to the waiver program.

230.400 Person Centered Service Plan 3-1-10

During the initial three months of DDS ACS waiver services, a beneficiary receives services based on a DDS pre-approved initial person centered service plan that provides for case management at the prevailing rate, up to three months; and supportive living

services for direct care supervision at a rate of $100.00 per month, up to three months. It may include transitional funding when the person is transitioning from an institution to the community. Persons residing in a Medicaid reimbursed facility may receive case management the last 180 consecutive days of the institutional stay.

NOTE: The fully developed person centered service plan may be submitted, approved and implemented prior to the expiration of the initial person centered service plan. The initial plan period is simply the maximum time frame for developing, submitting, obtaining approval from DDS and implementing the person centered service plan. An extension may be granted when there is supporting documentation justifying the delay.

Prior to expiration of the interim plan of care, each beneficiary eligible for ACS waiver services must have an individualized, specific, written person centered service plan developed by a multi-agency team and approved by the DDS authority. The members of the team will determine services to be provided, frequency of service provision, number of units of service and cost for those services while ensuring the beneficiary's desired outcomes, needs and preferences are addressed. Team members and a physician, via the DDS 703 form, certify the beneficiary's condition (level of care) and appropriateness of services initially and at the annual continued stay review. The person centered service plan is conducted once every 12 months in accordance with the continued stay review date or as changes in the beneficiary's condition require a revision to the person centered service plan.

The person centered service plan must be designed to assure that services provided will be:

A. Specific to the beneficiary'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 beneficiary's welfare. Participants of the multi-agency team included the beneficiary's chosen case manager, the beneficiary or legal representative and additional persons whom the beneficiary chooses to invite to the planning meeting, as long as all rules pertaining to confidentiality and conflict of interest are met. Mandatory attendance by the case manager is required to assure the written person centered service plan meets the requirements of regulations, the desires of the beneficiary or legal representative, is submitted timely, and is approved by DDS prior to service delivery.

D. Monitored and adjusted to reflect changes in the beneficiary's needs. A person centered service plan revision may be requested at any time the beneficiary's needs change.

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

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

G. Will assure the beneficiary's and others' health and safety. The person centered service plan development process identifies risks and makes sure that they are addressed through backup plans and risk management agreements. A complete description of backup arrangements must be included in the person centered service plan.

230.410 Person Centered Service Plan Required Documentation 3-1-10

A. General Information

Identification information must include:

1. Beneficiary's full name and address
2. Beneficiary's Medicaid number
3. Guardian or Power of Attorney with an address (when applicable)
4. Number of individuals with MR/DD residing in home of waiver beneficiary and type of residence.
5. Physician Level of Care Certification
6. Names, titles and signatures of the multi-agency team members responsible for the development of the beneficiary's person centered service plan.

B. Budget Sheet, Worksheets and Provider Information

Information must include:

1. Identification of the type waiver services to be provided
2. The name of the provider delivering the service
3. Total amount by service.
4. Total plan amount authorized
5. Beginning and ending date for each service
6. Supported Living Array worksheet listing units and total cost by service and level of support
7. Adaptive Equipment, Environmental Modifications, Specialized Medical Supplies, Supplemental Support, and Community Transition worksheets listing units and total cost by service
8. Provider Information sheet showing case management provider, case manager, supportive living provider, and direct care supervisor.

C. Narrative justification for the revision to the initial plan of care must, at a minimum justify the need requested services. Narrative justification for annual continued stay reviews must address utilization of services used or unused within the past year, justify new services requested and address risk assessment.

D. The person centered service plan must include:

1. Identification of individual objectives.
2. Frequency of review of the objectives.
3. List of medical and other services, including waiver and non-waiver services necessary to obtain expected objectives.
4. Expected outcomes including any service barriers

E. 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.

240.000 PRIOR AUTHORIZATION 3-1-10

ACS waiver services require prior authorization by the Division of Developmental Disabilities Services. **In the absence of prior authorization, reimbursement will be denied and will not be approved retroactively.**

241.000 Approval Authority 3-1-10

For the purpose of person centered service plan approvals, DDS is the Medicaid authority.

A. The DDS prior authorization process requires that all pervasive level of support service plans, problematic service plans, or plans not clearly based on documented need must have approval by DDS Plan of Care Review committee authority.

B. All extensive and limited service plans will be subject to a local level approval process.

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

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

E. Service requests that will supplant Department of Education responsibilities WILL NOT be approved. This includes voluntary decisions to withdraw from, or never enter the Department of Education, public school system. The waiver does not provide educational services, including educational materials, equipment supplies or aids.

F. All person centered service plan reviews are subject to review by a qualified physician and random audit scrutiny.

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 prior to the expiration of existing plans or expected implementation of revisions.

I. Initially, a beneficiary receives up to three months of DDS ACS waiver services based on a DDS pre-approved interim person centered service plan. The pre-approved interim plan will include case management and supportive living service for direct care supervision and may include community transition services when the person is transitioning from an institution to the community. For transitional case management, the three month interim plan begins with the date of discharge.

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. Failure to properly document proof of emergency shall result in approval being rescinded.

250.000 REIMBURSEMENT

251.000 Method of Reimbursement 3-1-10

The reimbursement rates for DDS ACS waiver services will be according to the lesser of the billed amount or the Title XIX (Medicaid) maximum for each procedure.

The maximum supportive living daily rate is inclusive of administration costs that cannot in any event exceed 20% of the total supportive living array for a beneficiary.

If fringe benefits exceed 25%, documentation must be submitted with person centered service plan and budget request. Fringe benefits cannot exceed 32%.

The administration and fringe costs are subject to audit and must be documented to support the rate charged.

252.000 Rate Appeal Process 3-1-10

A provider may request reconsideration of a 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 or procedure or the notification of the provider of its rate. Upon receipt of the request for review, the Assistant Director will determine the need for a program or provider conference and will contact the provider to arrange a conference if needed. Regardless of the program decision, the provider will be afforded the opportunity for a conference, if he or she wishes, for a full explanation of the factors involved and the Program decision. Following review, the Assistant Director will notify the provider of the action to be taken by the division within 20 calendar days of receipt of the request for review or the date of the program and/or provider conference.

When the provider disagrees with the decision made by the Assistant Director of the Division of Medical Services, the provider may appeal the question to a standing Rate Review Panel established by the Director of the Division of Medical Services. The rate review panel will include one member of the Division of Medical Services, a representative of the provider association and a member of the Department Human Services (DHS) management staff, who will serve as chairperson.

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 of the 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 panel will hear the questions and a recommendation will be submitted to the Director of the Division of Medical Services.

260.000 BILLING PROCEDURES

261.000 Introduction to Billing 3-1-10

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

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

262.000 DDS ACS Waiver Procedure Codes 3-1-10

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
H2016			Y	Supportive Living	1 Day	12, 99, 14
H2023			Y	Supported Employment	15 Minutes	99
S5151			Y	Respite Services	1 Day	12, 99, 14, 54
T2020	UA		Y	Supplemental Support Services	1 Month	12, 99, 14
T2022			Y	Case Management Services	1 Month	12, 99, 14
T2025			Y	Consultation Services	1 Hour	12, 99, 14
T2028			Y	Specialized Medical Supplies	1 Month	12, 99,14
T2034			Y	Crisis Center	1 Day	99, 12
T2020	UA	U1	Y	Community Transition Services	1 Package	99, 14, 54
T2020	U2		Y	Transitional Case Management	1 Package	99, 14, 54
K0108			Y	ACS environmental modifications	1 Package	12
S5160			Y	Adaptive equipment, personal emergency response system (PERS), installation and testing,	1 Package	12, 14
S5161			Y	Adaptive equipment, personal emergency response system (PERS), service fee, per month, excludes installation and testing	1 Package	12, 14
S5162			Y	Adaptive equipment, personal emergency response system (PERS), purchase only	1 Package	12, 14
S5165	U1		Y	ACS adaptive equipment Home modifications, per service	1 Package	12, 14

262.100 National Place of Service (POS) Codes 3-1-10

The national place of service code is used for both electronic and paper billing.

Place of Service	POS Codes
Patient's Home	12

Place of Service	POS Codes
Other	99
Group Home	14
ICF/MR	54

262.200 Billing Instructions - Paper Only 3-1-10

DHS' fiscal agent offers providers several options for electronic billing. Therefore, claims submitted on paper are lower priority and are paid once a month. The only claims exempt from this rule are those that require attachments or manual pricing.

Bill Medicaid for professional services with form CMS-1500. **View a sample form CMS-1500.**

Carefully follow these instructions to help the fiscal agent efficiently process claims. Accuracy, completeness and clarity are essential. Claims cannot be processed if necessary information is omitted.

Forward completed claim forms to the fiscal agent's claims department. **View or print fiscal agent claims department contact information.**

NOTE: A provider delivering services without verifying beneficiary eligibility for each date of service does so at the risk of not being reimbursed for the services.

262.210 Completion of CMS-1500 Claim Form 3-1-10

Field Name and Number		Instructions for Completion
1.	(type of coverage)	Not required.
1a.	INSURED'S I.D. NUMBER (For Program in Item 1)	Beneficiary's 10-digit Medicaid or ARKids First-A or ARKids First-B identification number.
2.	PATIENT'S NAME (Last Name, First Name, Middle Initial)	Beneficiary's last name and first name.
3.	PATIENT'S BIRTH DATE	Beneficiary's date of birth as given on the Medicaid or ARKids First-A or ARKids First-B identification card. Format: MM/DD/YY.
	SEX	Check M for male or F for female.
4.	INSURED'S NAME (Last Name, First Name, Middle Initial)	Required if insurance affects this claim. Insured's last name, first name, and middle initial.
5.	PATIENT'S ADDRESS (No., Street)	Optional. Beneficiary's complete mailing address (street address or post office box).
	CITY	Name of the city in which the beneficiary resides.
	STATE	Two-letter postal code for the state in which the beneficiary resides.
	ZIP CODE	Five-digit zip code; nine digits for post office box.

Field Name and Number		Instructions for Completion
	TELEPHONE (Include Area Code)	The beneficiary's telephone number or the number of a reliable message/contact/ emergency telephone.
6.	PATIENT RELATIONSHIP TO INSURED	If insurance affects this claim, check the box indicating the patient's relationship to the insured.
7.	INSURED'S ADDRESS (No., Street)	Required if insured's address is different from the patient's address.
	CITY	
	STATE	
	ZIP CODE	
	TELEPHONE (Include Area Code)	
8.	PATIENT STATUS	Not required.
9.	OTHER INSURED'S NAME (Last name, First Name, Middle Initial)	If patient has other insurance coverage as indicated in Field 11d, the other insured's last name, first name, and middle initial.
	a. OTHER INSURED'S POLICY OR GROUP NUMBER	Policy and/or group number of the insured beneficiary.
	b. OTHER INSURED'S DATE OF BIRTH	Not required.
	SEX	Not required.
	c. EMPLOYER'S NAME OR SCHOOL NAME	Required when items 9 a-d are required. Name of the insured beneficiary's employer and/or school.
	d. INSURANCE PLAN NAME OR PROGRAM NAME	Name of the insurance company.
10.	IS PATIENT'S CONDITION RELATED TO:	
	a. EMPLOYMENT? (Current or Previous)	Check YES or NO.
	b. AUTO ACCIDENT?	Required when an auto accident is related to the services. Check YES or NO.
	PLACE (State)	If 10b is YES, the two-letter postal abbreviation for the state in which the automobile accident took place.
	c. OTHER ACCIDENT?	Required when an accident other than automobile is related to the services. Check YES or NO.
	10d. RESERVED FOR LOCAL USE	Not used.
11.	INSURED'S POLICY GROUP OR FECA NUMBER	Not required when Medicaid is the only payer.

Field Name and Number	Instructions for Completion
a. INSURED'S DATE OF BIRTH	Not required.
SEX	Not required.
b. EMPLOYER'S NAME OR SCHOOL NAME	Not required.
c. INSURANCE PLAN NAME OR PROGRAM NAME	Not required.
d. IS THERE ANOTHER HEALTH BENEFIT PLAN?	When private or other insurance may or will cover any of the services, check YES and complete items 9a through 9d.
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE	Not required.
13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE	Not required.
14. DATE OF CURRENT: ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)	Required when services furnished are related to an accident, whether the accident is recent or in the past. Date of the accident.
15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE	Not required.
16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION	Not required.
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	Primary Care Physician (PCP) referral is not required for DDS Alternative Community Services (ACS) Waiver services. If services are the result of a Child Health Services (EPSDT) screening/ referral, enter the referral source, including name and title.
17a. (blank)	The 9-digit Arkansas Medicaid provider ID number of the referring physician.
17b. NPI	Not required.
18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES	When the serving/billing provider's services charged on this claim are related to a beneficiary's inpatient hospitalization, enter the beneficiary's admission and discharge dates. Format: MM/DD/YY.
19. RESERVED FOR LOCAL USE	Not used.
20. OUTSIDE LAB?	Not required.
$ CHARGES	Not required.

Field Name and Number			Instructions for Completion
21.	DIAGNOSIS OR NATURE OF ILLNESS OR INJURY		Diagnosis code for the primary medical condition for which services are being billed. Up to three additional diagnosis codes can be listed in this field for information or documentation purposes. Use the International Classification of Diseases, Ninth Revision (ICD-9-CM) diagnosis coding, current as of the date of service.
22.	MEDICAID RESUBMISSION CODE		Reserved for future use.
	ORIGINAL REF. NO.		Reserved for future use.
23.	PRIOR AUTHORIZATION NUMBER		The prior authorization or benefit extension control number if applicable.
24A.	DATE(S) OF SERVICE		The "from" and "to" dates of service for each billed service. Format: MM/DD/YY. 1. On a single claim detail (one charge on one line), bill only for services provided within a single calendar month. 2. Providers may bill on the same claim detail for two or more sequential dates of service within the same calendar month when the provider furnished equal amounts of the service on each day of the date sequence.
	B.	PLACE OF SERVICE	Two-digit national standard place of service code. See Section 272.200 for codes.
	C.	EMG	Not required.
	D.	PROCEDURES, SERVICES, OR SUPPLIES	
		CPT/HCPCS	Enter the correct CPT or HCPCS procedure code from Section 272.100.
		MODIFIER	Modifier(s) if applicable.
	E.	DIAGNOSIS POINTER	Enter in each detail the single number—1, 2, 3, or 4—that corresponds to a diagnosis code in Item 21 (numbered 1, 2, 3, or 4) and that supports most definitively the medical necessity of the service(s) identified and charged in that detail. Enter only one number in E of each detail. Each DIAGNOSIS POINTER number must be only a 1, 2, 3, or 4, and it must be the only character in that field.
	F.	$ CHARGES	The full charge for the service(s) totaled in the detail. This charge must be the usual charge to any beneficiary of the provider's services.
	G.	DAYS OR UNITS	The units (in whole numbers) of service(s) provided during the period indicated in Field 24A of the detail. .

Field Name and Number		Instructions for Completion
H.	EPSDT/Family Plan	Enter E if the services resulted from a Child Health Services (EPSDT) screening/referral.
I.	ID QUAL	Not required.
J.	RENDERING PROVIDER ID #	The 9-digit Arkansas Medicaid provider ID number of the individual who furnished the services billed for in the detail.
	NPI	Not required.
25.	FEDERAL TAX I.D. NUMBER	Not required. This information is carried in the provider's Medicaid file. If it changes, please contact Provider Enrollment.
26.	PATIENT'S ACCOUNT N O.	Optional entry that may be used for accounting purposes; use up to 16 numeric or alphabetic characters. This number appears on the Remittance Advice as "MRN."
27.	ACCEPT ASSIGNMENT?	Not required. Assignment is automatically accepted by the provider when billing Medicaid.
28.	TOTAL CHARGE	Total of Column 24F—the sum all charges on the claim.
29.	AMOUNT PAID	Enter the total of payments previously received on this claim. Do not include amounts previously paid by Medicaid. Do **not** include in this total the automatically deducted Medicaid co-payments.
30.	BALANCE DUE	From the total charge, subtract amounts received from other sources and enter the result.
31.	SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS	The provider or designated authorized individual must sign and date the claim certifying that the services were personally rendered by the provider or under the provider's direction. "Provider's signature" is defined as the provider's actual signature, a rubber stamp of the provider's signature, an automated signature, a typewritten signature, or the signature of an individual authorized by the provider rendering the service. The name of a clinic or group is not acceptable.
32.	SERVICE FACILITY LOCATION INFORMATION	If other than home or office, enter the name and street, city, state, and zip code of the facility where services were performed.
a.	(blank)	Not required.
b.	(blank)	Not required.
33.	BILLING PROVIDER INFO & PH #	Billing provider's name and complete address. Telephone number is requested but not required.
	a. (blank)	Not required.

Field Name and Number	Instructions for Completion
b. (blank)	Enter the 9-digit Arkansas Medicaid provider ID number of the billing provider.

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Not applicable to this program.